AN ASSESSMENT OF THE PERCEPTION AND PRACTICES OF GENERAL PRACTITIONERS (GPs) IN CAPE TOWN REGARDING PROBLEM DRINKING AMONGST THEIR PATIENTS

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A mini thesis submitted in partial fulfilment of the requirements for the degree of

Masters in Public Health in the School of Public Health, University of the

Western Cape

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November 2005

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KEYWORDS

General practitioners

Private settings

City of Cape Town

Problem drinking

Effective management

GP Questionnaire

AUDIT

GP Training

Screening and Brief Intervention

Alcohol use reduction

ABSTRACT

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There is a dearth of literature on the involvement of general practitioners (GPs) in South Africa in early interventions to curb alcohol abuse, and since the anecdotal assumption is that GPs do not effectively diagnose and manage problem drinking amongst their patients, in this study I investigated the role of GPs in addressing problem drinking in Cape Town as well as the prevalence of problem drinking amongst their patients.
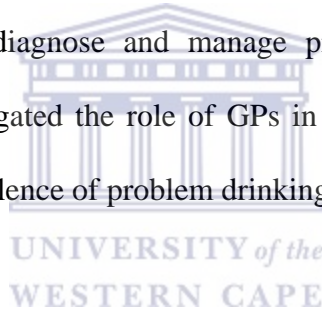
GPs practicing in private settings in the city of Cape Town as well as patients served by these GPs participated in the study. A cross-sectional descriptive design was utilised and 50 GPs were randomly selected from the telephone listings of GPs in the city of Cape Town. The sample of 384 patients included all adult patients who attended GP practices on one day during the survey. GPs completed a self-administered questionnaire that addressed demographic characteristics, practice type and location as well as the GPs' knowledge of alcohol dependence severity, their effectiveness in counselling and helping to achieve behaviour change amongst patients. The patients completed the Alcohol Use Disorders Test (AUDIT) questionnaire (Saunders et al., 1993) on one day during normal surgery hours.

The results of this survey suggest that more than a third of the adult patients seen by GPs present with problem drinking and that they are representative of the economically active population. This presents GPs with a substantial challenge regarding the identification and management of problem drinking in their practices.

Almost all the GPs reported that they work in solo family practices, that they saw up to 30 patients per day and that they worked an average of 6 days per week. A large percentage of the GPs (70%) reported that they felt ineffective in helping patients to achieve change in reducing alcohol consumption and all GPs indicated that they rely on physical symptoms mainly to trigger an enquiry about alcohol problems amongst their patients. More than 80% of the GPs indicated that they feel more prepared to counsel patients about not smoking than about alcohol problems. It was therefore not surprising that 68% of the GPs reported that they have received no post-graduate training on alcohol or alcohol-related problems. GPs also mentioned some of the barriers to their involvement in prevention work to be a lack of training and support and a lack of counselling and screening materials.

It is encouraging though that almost all GPs (90%) reported that they are willing to put a high priority on disease prevention and that they are keen to help patients with problem drinking. Almost 80% of the GPs indicated that they could become effective in helping their patients, and that they are likely to get more involved in helping their patients reducing alcohol consumption, if they (GPs) are given adequate training and support from other health providers working in the area of alcohol-related problems. Also, the GP practice can be considered suitable to intervene for alcohol problems, given the reported

reasonably low workload of GPs and the high potential of solo family practices to do work in this area.

November 2005

DECLARATION

I declare that *An assessment of the perception and practices of general practitioners (GPs) in Cape Town regarding problem drinking amongst their patients* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Fred Andrew Koopman   November 2005

Signed:……………………………………………

ACKNOWLEDGEMENTS

CONTENTS

CHAPTER 1

INTRODUCTION

Alcohol abuse and alcoholism are major public health concerns. Alcohol misuse contributes to an array of health and social problems that include liver and neurological disease, cardiovascular complications, nutritional deficiencies, respiratory problems, birth defects, intentional and non-intentional injuries, unemployment, homelessness and relationship problems. Although there is generally a direct relationship between the level of alcohol consumed and the extent of problems experienced (Babor et al., 1988), many of the primary effects of alcohol misuse occur from episodes of acute alcohol intoxication. Acute alcohol intoxication is strongly associated with increased mortality and morbidity arising from intentional and unintentional injuries, unsafe sexual practices and thus increased risk of contracting a sexually transmitted disease, and involvement in the criminal justice system either through committing crime, or being a victim of crime (Babor et al., 1988).

Because of the stigma attached to alcoholism, alcohol abuse is seldom the stated reason for requesting GP services. However, patients presenting with alcoholism (serious alcohol abuse problems) are more frequently managed by GPs than those patients at the early stages of 'problem drinking'. Despite the documented relationship between health problems and alcohol misuse, many people will seek help from their physicians without readily acknowledging, or being aware of, the critical role that alcohol consumption may be playing in the etiology of their complaints. Consequently, the responsibility for identification, and subsequent treatment of alcohol-related problems, rests within the physicians' domain (Deitz el al., 1994). Numerous studies have demonstrated that many

problem drinkers (i.e., people who fulfil the diagnoses of harmful drinking, alcohol abuse, or alcohol dependence) can benefit from physician interventions at the time of clinic visits or from referral for alcoholism treatment (Buchsbaum 1994). These interventions can take the form of referrals for patients with alcohol dependency to specialist treatment.

In her article Monteiro (1998) points out that there are gaps in the treatment of alcohol-related problems in primary health care settings and that the need exists for a public health approach to reduce the impact of alcohol use in society. This need led to the development of early and low-cost interventions that could benefit a larger number of people and be delivered before dependence and chronic disability has been established. During discussions with researchers in the substance abuse field, it was anecdotally said that it would be important to have evidence of the role of GPs in managing patients presenting with alcohol-related problems. They (researchers) believe that more work should be done to assess the involvement of GPs in dealing with alcohol-related problems.

Roche and Richard (1991) mention in their report that except for a small number of studies medical practitioners have rarely been questioned systematically and directly about their perceptions of their own roles in relation to alcohol (and drug) problems. There is also very little first hand information available on what it is like for general practitioners who attempt to deal with patients with alcohol (and drug) related problems.

Since alcohol remains the main substance of abuse for many, the involvement of GPs in managing alcohol-related problems may lead to the reduction in alcohol use. Discussions

between doctors and individual patients about the risks of alcohol misuse may result in people drinking "recommended limits"[1] of alcohol, or even being abstinent. Brief interventions implemented by GPs (such as providing written material and advice) may be beneficial to especially patients who are non-dependant drinkers.

Since no clear evidence can be found in the literature of the involvement of GPs in South Africa in early intervention to curb alcohol abuse, it was therefore decided to conduct this cross-sectional descriptive study to investigate the role of GPs in addressing problem drinking in Cape Town. A self-administered questionnaire with both open-ended and closed-ended questions was made available to each consenting GP for completion in order to identify the criteria and management strategies used by GPs for patients with alcohol-related problems. The Alcohol Use Disorders Identification Test (AUDIT) questionnaire was distributed for self–completion by patients presenting during normal surgery hours to determine the prevalence of patients with drinking problems who attend private GP settings

Chapters two and three that follow will provide a review of the literature and the methodology used to conduct this study. The results are discussed in chapter four, followed by the discussion in chapter five with chapter six the concluding chapter with recommendations.

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[1]For men, recommended drinking levels are no more than two drinks per day or four per occasion or 14 drinks per week; for women, those levels are no more than one drink per day or three per occasion or 7 drinks per week (NIAAA 1995).

CHAPTER 2

LITERATURE REVIEW

This chapter provides a review of the literature concerning the burden of alcohol consumption globally and alcohol use in South Africa. Literature relating to the treatment demand for alcohol abuse, alcohol misuse as a public health focus and strategies and interventions to reduce alcohol-related harm is also reviewed. The chapter concludes with a section on the purpose, aim and objectives of the study.

2.1 Burden of Alcohol consumption

Alcohol is estimated to be responsible for a considerable burden of disease in terms of both mortality and disability. Barbor et al. (2003) mention that according to the World Health Organisation (WHO), in 2000 alcohol-related death and disability accounted for four percent of the global burden of disease, ranking as the fifth most detrimental risk factor of 26 examined. It was noted though that alcohol was the third most detrimental risk factor, accounting for 9.2% of all burden of disease, in developed countries. In emerging economies such as China, alcohol was the most detrimental risk factor. Overall, injuries accounted for the largest portion of alcohol-attributable disease burden, which ranged from close to zero among females in the predominantly Moslem Eastern Mediterranean regions to more than 20% for males in Eastern Europe (Babor et al., 2003).

2.2 Alcohol use in South Africa

South Africa, like many developing countries, is experiencing high levels of alcohol-related problems, whilst a pattern of drinking until intoxication has become common in the country. Findings in the South Africa Demographic and Health Survey (SADHS) (1998) suggest that just under half of South African adult men (45 percent) and one-fifth of women (17%) currently consume alcohol. For the total population, the rate is 28%, which translates to 8.3 million South Africans 15 years or older who currently consume alcohol. The SADHS (1998) further suggests that by the time young people reach mid-adolescence many have begun to use alcohol, often irresponsibly. Fifteen percent of male adolescents (15-19 years old) and 7% of female adolescents acknowledge that they currently consume alcohol. For both sexes the rate is 11%, which translates to almost 406,000 persons in South Africa 15-19 years old who acknowledge currently consuming alcohol.
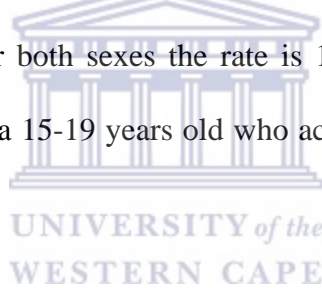
Young South Africans are among those most affected by alcohol misuse. Misuse of alcohol by young people has both short term and long term consequences, including a decrease in learning ability which impacts negatively on the education system. South Africa's future human resource – today's youth who comprises tomorrow's work force – is already being affected. Industry is severely affected in terms of absenteeism from work, loss of productivity, and damage to property at the work place. The home is affected by alcohol-related violence both from within and outside the family (Parry and Bennetts 1998).

To highlight the particular burden experienced by South Africa from alcohol abuse, a few statistics are presented below.

Research done at mortuaries in Cape Town, Durban, Gauteng, and Port Elizabeth (PE) in 2002 show that 45% of all non-natural deaths had blood alcohol concentrations (BACs) greater than or equal to 0.05g/100ml (Durban: 37%, Gauteng: 40%, Cape Town 53%, PE: 61%). Levels of alcohol were particularly high for transport-related deaths and homicides, with 63% of transport-related deaths and 69% of homicides in PE, for example, having levels above the legal limit for driving (0.05g/100ml) (Plüddemann et al., 2003).

Statistics from trauma units in Cape Town, Durban and PE in 2001 indicate that 39% of trauma patients had breath alcohol concentrations (BrACs) greater than or equal to 0.05g/100ml (Durban: 22%, Cape Town 36%, PE: 57%). Levels of alcohol were particularly high for transport- and violence-related injuries with, for example, 73% of patients with violence-related injuries in PE and 46% of patients with transport-related injuries in Cape Town having levels above the legal limit for driving (0.05g/100ml) (Plüddemann et al., in press).

Study results from 2003 indicated a great demand for specialist treatment services. Of 5886 persons treated at 52 specialist substance abuse treatment centres in Cape Town, Durban, Gauteng, Mpumalanga, and PE in the first half of 2003, 52% reported having alcohol as their primary substance of abuse, with a further 13% having alcohol as a secondary drug of abuse (Parry et al., 2003).

Research conducted in the Western Cape (Wellington) that investigated the prevalence of foetal alcohol syndrome reported a Foetal Alcohol Syndrome (FAS) prevalence of 40.5 to 46.4 per 1000 children aged 5 – 9 years. FAS is a totally preventable birth defect caused by maternal alcohol use during pregnancy. In South Africa, with the highest reported prevalence rates of FAS in the world, it is an urgent public health problem. The study demonstrates that the high prevalence rate of FAS in young children is not limited to wine growing communities of South Africa as described in earlier studies, but is found in many poor communities. With limited resources and many competing health problems in South Africa (e.g., HIV/AIDS, tuberculosis, malnutrition, injuries, and substance abuse) it is critical that prenatal alcohol exposure prevention activities for women and early educational intervention for children with FAS are integrated into existing prevention programs (CDC, 2003).

Recent research was conducted to evaluate the association between alcohol consumption and risky sex. Research conducted in Atteridgeville among persons aged 25-44 years found a significant positive association between various measures of alcohol use (past month use, frequency and problem use) and having multiple sexual partners or sexual relations that are regretted in the past 3 months. For example, the correlation between quantity of alcohol consumed and the number of sexual partners (lifetime) was 0.436 ($p<0.001$) (Morojele et al., 2003).

A study done in 2000 presented evidence that family violence can definitely be related to alcohol use. Between one-third to a half of arrestees in Cape Town, Durban, and Johannesburg charged with offences categorised as "family violence" reported being under the influence of alcohol at the time of the alleged offence (Parry et al., 2004).

7

Research results from a study in 1997 indicated that alcohol use has an effect on academic failure and absenteeism from school. It is noted from the results that among grade 8 and 11 learners in Cape Town a significant association exists between past month use of alcohol and the number of days absent from school and repeating a grade. For example, the odds of repeating a grade at school were found to be 60% higher for learners who consumed alcohol (Flischer et al., 2003).

In terms of drinking patterns exploratory figures in *Alcohol Beverage Review*, a local magazine targeted at liquor retailers in South Africa, reveal that almost three billion litres of alcoholic beverages were potentially consumed in South Africa in the twelve months July 2002 – June 2003 (Alcoholic Beverage Review 2003). This is an increase of 1.13% over the amount consumed in the twelve months preceding the mentioned period. The term 'potentially consumed' is used since some alcoholic beverages, such as wine, are purchased and consumed months or even years following their purchase. However, since the habit of buying alcohol and drinking it later is continual, this delayed consumption factor is unlikely to have a significant impact on using sales as a measure of current consumption. It is also suggested that in terms of future drinking trends, we are likely to see a continuing increase in consumption and alcohol related problems. Increased alcohol use is ensured by factors such as the rising spending power of low-income groups in South Africa, population growth, an increase in advertising aimed at black men and women, and products such as alcoholic fruit beverages that could lead to an increase in consumption among young people (especially females) (Parry and Bennetts,1998).

Parry and Bennetts (1998) further points out that substance abuse had received much attention in the National Health Plan of the ANC. In the section on mental health, the

development of prevention and health promotion programmes to counter alcohol, drugs and other substance abuse is advocated. Special attention was also paid to substance abuse in the government's Reconstruction and Development Programme (RDP). The RDP was described at the time if its initiation as an "integrated, coherent socio-economic framework to mobilize the population and resources towards the final eradication of apartheid and the building of a democratic, non-racial and non-sexist future" (ANC 1994) Alcohol was immediately identified as a contributing factor in the same issue as pointed out in the following abstract:

'Millions of South Africans abuse alcohol, tobacco, cannabis (dagga), solvents like petrol and glue, and other harder drugs. Unless action is taken, substance abuse is likely to increase enormously. Abuse of these substances causes immense physical, mental and social damage and costs the country millions of rands each year. The RDP must aim to reduce greatly the levels of substance abuse and to prevent any increase' (ANC 1994).'

A paper on South Africa was presented at the Mental Health in Africa conference in Zimbabwe in April 1995. In this paper it was made clear that alcohol misuse may come to be recognised as one of the most significant public health concerns facing South Africa over the next few years. It was also pointed out that this situation is a direct result of alcohol's impact on the health services, the economy and South African Society as a whole (Parry 1995).

Fleming and Manwell (1999) reported that many people consume alcohol at more than the moderate drinking levels recommended by the National Institute on Alcohol Abuse and Alcoholism (NIAAA 1995). These drinkers are considered at-risk, problem or

dependant alcohol users. According to the guidelines published by the NIAAA (1995) different types of alcohol use are distinguished. For the purpose of this study these different types of alcohol use are being taken into consideration when referring to the term 'problem drinking' as indicated in the title of the topic.

2.3 Definitions of problematic drinking

Alcohol consumption and its associated problems exist within a continuum. This ranges from consumption of alcohol without problems, to consumption with problems but at a level that allows relatively normal functioning, through to severe alcohol dependence and withdrawal symptoms (Prodigy Guidance – Alcohol – problem drinking 2004).

This concept of a continuum has led to the following definitions of alcohol consumption :

- **Teetotallers –**referring to people who never drink alcohol.

- **Non-problematic drinking –** referring to people who consume alcohol at the moderate drinking levels[1] recommended by the National Institute on Alcohol Abuse and Alcoholism (NIAAA 1995).

- **Problem drinking –** referring to people who consume above the recommended levels. They fall within the following categories:

   o **Hazardous drinking** defined as a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others.

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[1]For men, recommended drinking levels are no more than two drinks per day or four per occasion or 14 drinks per week; for women, those levels are no more than one drink per day or three per occasion or 7 drinks per week (NIAAA 1995).

- o **Harmful use** refers to alcohol consumption that results in consequences to physical and mental health of the individual as well as social consequences

- o **Alcohol dependence ('Alcoholism')** is characterized by a cluster of behavioural, cognitive and physiological phenomena and typically includes a strong desire to take alcohol, difficulties controlling its use, persistence in its use despite harmful consequences, increased tolerance, and a physical withdrawal reaction when use is discontinued.

This study uses the term "problem drinking" as above to include the hazardous and harmful and dependence categories on the continuum.

2.4 Strategies and interventions to reduce alcohol-related harm

The differences among countries in per capita consumption, patterns of drinking and alcohol-related problems suggest that alcohol policies may have to be tailored to fit the needs of each society. Babor et al. (2003) defined alcohol policy broadly as any purposeful effort or authoritative decision on the part of governments or non-government groups to minimise or prevent alcohol-related consequences. Policies may involve the implementation of a specific strategy with regard to alcohol problems (e.g. increase alcohol taxes, enforce minimum drinking age, brief intervention with hazardous drinkers, etc.) or the allocation of resources that reflect priorities with regard to prevention or treatment efforts. (Babor et al., 2003).

Babor et al. (2003) mention in their book that the following 10 policy options stand out as 'best practices': minimum legal purchase age, government monopoly of retail sales, restriction on hours or days of sale, outlet density restrictions, alcohol taxes, sobriety check-points, lowered blood alcohol concentration (BAC) limits, administrative licence suspension, graduated licensing for novice drivers and brief interventions for hazardous drinkers. According to Babor et al. (2003) alcohol policies can be effective at both the community level and the national level. Within each of these levels, policies can be targeted at the general population, at high-risk drinkers and at people already experiencing alcohol-related problems. Alcohol policies rarely operate independently or in isolation from other measures. Complementary system strategies that seek to restructure the total drinking environment are more likely to be effective than single strategies. Full-spectrum interventions are needed to achieve the greatest population impact.
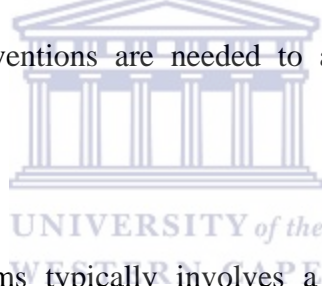
Treatment for alcohol problems typically involves a set of services, ranging from diagnostic assessment to therapeutic interventions and continuing care. These treatment modalities are delivered in a variety of settings, including freestanding residential facilities, psychiatric and general hospital settings, outpatient programmes and primary health care. Babor et al. (2003) further note that when patients enter treatment, exposure to any treatment is associated with significant reductions in alcohol use and related problems, regardless of the type of intervention used. Also, in contrast to treatment provided in specialised settings, brief interventions consist of one to three sessions of counselling or advise delivered in general medical settings.

The cumulative evidence of randomised controlled trials (conducted in a variety of settings) indicates that clinically significant changes in drinking behaviour and related problems can follow from brief interventions with non-alcoholic heavy drinkers. There is systematic review level evidence for the effectiveness of alcohol screening and interventions in hospital emergency departments in reducing hazardous/risky drinking (Irvin et al., 2000). There is also some systematic review level evidence that heavy drinkers receiving brief interventions (5-20 minutes) are twice as likely to moderate their drinking 6 to 12 months after an intervention when compared with drinkers receiving no intervention. These findings apply to both hospitals and PHC settings (Wilk et al., 1997). Systematic review level evidence also shows the effectiveness of patient education and counselling delivered by physicians and clinicians. These approaches can achieve preventive behaviour change in heavy drinkers and prevent the onset of alcohol dependence (Mullen et al., 1997). However, there is no conclusive evidence from systematic reviews for the effectiveness of practice-based lifestyle brief interventions to reduce heavy drinking (Ashenden et al., 1997).

2.5 Treatment demand for substance abuse

South Africa is currently facing major challenges in the delivery of health care and more specifically substance abuse services to the broader population. Provincial and local governments control the allocation of resources for substance abuse services. Cape Town is a large local area in the Western Cape that has been identified as having high levels of substance abuse and substance-related problems (Parry et al., 2002a/b). Treatment data was collected biannually from 23 specialist treatment centres in Cape Town for the period January 1997 to December 2001. Together these facilities serve over 3000 clients per

13

year. This represents at least 95% of the specialist treatment centres in Cape Town (Myers et al., 2004). The data reflects that alcohol remains the most common primary substance of abuse for 46% of the clients for the period July – December 2001. A large proportion of patients in these facilities also report abusing more than one substance. For example, 42% and 40% of the total proportion of patients in specialist centres in 2001a and 2001b respectively, reported poly-substance abuse, such as alcohol and cocaine, or alcohol, cannabis and Mandrax (Myers et al., 2004). Myers et al. (2004) point out that although findings from specialist substance abuse treatment services suggest that treatment demand for alcohol as a primary substance of abuse has decreased over time, when the overall proportion of substance use by patients in these facilities is considered, alcohol accounts for more than 60% of the treatment demand. Treatment, mortality and psychiatric indicators cited in other studies also point to the high need for alcohol-related treatment services in the general population (Parry et al., 2002a; Peden, et al. 2000).
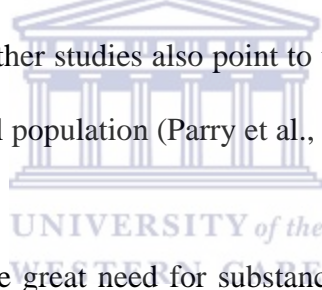
Although evidence points to the great need for substance abuse intervention services in Cape Town, the local Department of Social Services has significantly cut its funding to non-government organisations and state-subsidised treatment facilities. In recent years, the Western Cape Department of Health has closed a number of specialist substance abuse treatment centres. At present only two state specialist substance abuse treatment facilities are available to the population of the Western Cape. The number of beds in general state hospitals for patients with substance abuse problems has also been decreased. Given the high level of substance (especially alcohol) abuse in this province, and the limited number of state facilities, responsibility for the treatment of substance abusers (and people with alcohol-related problems) rest heavily on non-government organisations and the private sector. (Western Cape Department of Health, 2002).

There is evidence that an increase in the general level of substance use is associated with an increase in a wide range of diseases or health problems and, consequently, with an increased demand in health services. (Peltzer, 1998). The results of a study to investigate the extent and nature of substance abuse in primary health care (PHC) patients (Peltzer, 1998) showed that substance use in the past 6 months was found to be 61% among males and 22.3% among females reporting to the PHC clinic. The patients reported alcohol to be one of the major substances used. Many patients (31% men and 9% women) in this study expressed the desire to cut down on their use of substances. Another study done by Du Preez (1998) found among persons attending PHC services in Port Elizabeth that 6.5% of 155 patients were being treated for substance abuse problems. More than 60% of the 155 patients indicated that alcohol was their primary substance of abuse. Peltzer (1998) concluded that a moderate level of substance use (alcohol among others) was found in a rural PHC setting. Although many of these patients reported substance abuse problems none had gone for treatment. Early identification and intervention in a primary care context seem to be appropriate and needed. According to Mnisi and Mathe (1996) the PHC context is also well placed in terms of timeously and cost-effectively identifying and addressing substance related risks with respect to development of associated health problems. Chaulker-Burnett (1994) indicates that substance abuse is probably the most ignored or under-diagnosed disease in the primary care setting.

Since PHC facilities are so few in the communities and reportedly understaffed and in many cases inaccessible to a lot of people, many people make use of the services of general practitioners (GPs) in their communities. Patients also build and maintain a good and trusting relationship with their GPs. The role of GPs as a vital part of PHC delivery in the community can assist to reduce the harm of alcohol-related problems.

2.6 Alcohol misuse as a public health focus

Alcohol use above the recommended limits[1] (NIAAA 1995) is associated with a wide range of health-related concerns, including high blood pressure, trauma, accidents, domestic violence, cancer, foetal alcohol syndrome, and mental health problems. In fact, alcohol use disorders are some of the most common problems seen in health care settings. A study by Manwell et al. (1998) suggests that one in 5 men and 1 in 10 women who visit their primary care providers meet the criteria for at-risk drinking, problem drinking or alcohol dependence. Estimates further suggest that alcohol dependence is found in 25% of persons seen in primary care settings who drink above recommended limits of alcohol use.[1] Many of these patients do not consult alcohol treatment specialists; consequently, their primary health care providers have an important opportunity to identify and treat both potential and existing drinking problems.
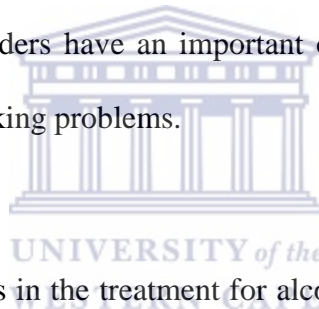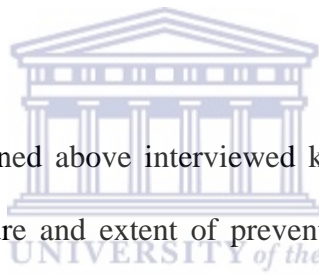
It is believed that there are gaps in the treatment for alcohol-related problems in primary health care settings. In her article Monteiro (1998) points out that traditionally, the medical approach to the management of alcohol-related problems has been limited to the treatment of 'alcoholism', based on intensive medical and social rehabilitation, made by psychiatrists with a specialisation in 'addiction', often in inpatient settings and for long periods of time. Treatment was given to those with presenting symptoms of dependence and withdrawal, severe medical and psychiatric problems, asking for help or brought by the family, after a long 'career' of heavy alcohol consumption and numerous attempts at stopping alcohol use without any success. She further points out that at the beginning of the 1980s, however, the need for a public health approach to reduce the impact of alcohol

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[1]For men, recommended drinking levels are no more than two drinks per day or four per occasion or 14 drinks per week; for women, those levels are no more than one drink per day or three per occasion or 7 drinks per week (NIAAA 1995).

use in society led to the development of earlier and low-cost interventions which could benefit a larger number of people and be delivered before dependence and chronic disability had been established.

There is evidence internationally on the potential of primary care-led health promotion to benefit patients and to reduce the burden of disease, as suggested by the 12-country study undertaken in Australia, Bulgaria, Canada, Denmark, France, Hungary, Italy, New Zealand, Norway, Poland, Russia and the UK. General practice has long been seen as an ideal setting for health promotion and disease prevention, and patients expect to receive lifestyle advice from GPs, especially in the area of smoking and excessive drinking (McAvoy et al. 2001).
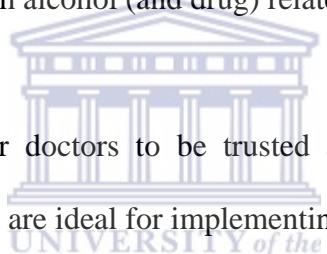
The international study mentioned above interviewed key informants (KI) and general practitioners (GPs) on the nature and extent of preventive medicine and early alcohol intervention in general practice (McAvoy et al. 2001). KIs were selected from health departments and authorities, government and non-government agencies, professional associations and senior university and research staff. This study of KI and GP attitudes to GP-delivered interventions for reducing alcohol-related harm provides a good idea of important and influential views across 12 countries. One of the most encouraging findings was the strong personal and professional support for GP-delivered preventive medicine in general and early intervention for alcohol-related problems in particular. Alcohol and smoking were clearly seen as the two key areas for preventive medicine.

This view is endorsed by the WHO Working Group on Lifestyle and Behaviour Change who commented that 'brief opportunistic interventions in primary care on smoking and

excessive drinking are much more cost effective health care interventions than exercise, diet and weight control' (WHO Working Group, 1999).

It is also noted in the report that KIs believed that preventive medicine and alcohol early intervention should be done in general practice and that GPs believed that they should be doing the work, but that these behaviours rarely happen in practice. Roche and Richard (1991) mention in their report that except for a small number of studies medical practitioners have rarely been questioned systematically and directly about their perceptions of their own roles in relation to alcohol (and drug) problems. There is also very little first hand information available on what it is like for general practitioners who attempt to deal with patients with alcohol (and drug) related problems.

Because patients consider their doctors to be trusted and credible sources of health information, health care settings are ideal for implementing alcohol-screening procedures. For patients who screen positive for alcohol use disorders, physicians can take action to promote healthy, successful outcomes. For example, both alcohol consumption and health care utilisation decrease when clinicians incorporate simple procedures (i.e. brief interventions, such as providing written material and advice) into routine consulting room visits with patients who are non-dependent drinkers and provide specialised treatment for patients who are alcohol dependent. Fleming (1997) points out that despite findings that support the implementation of routine alcohol screening and demonstrate its advantages, the rate of alcohol screening in health care settings remains lower than 50 percent. For example, Moore and colleagues (1989) conducted a survey in a large university hospital in Baltimore, Maryland and found that physicians recorded an alcohol use history for only about one-third of their patients. In another study researches assessed adults in two
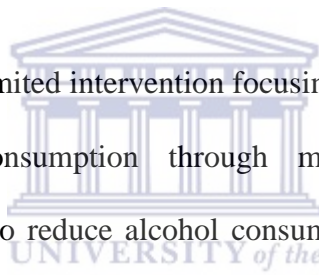
18

rural primary care practices on their alcohol use. Only 8.2% of those who met the criteria for alcohol abuse or dependence reported that their physicians had talked to them about their drinking in the last 6 months (Fleming et al., 1995).

Barriers and obstacles to GP involvement in prevention, especially in the area of alcohol misuse, were also investigated. The main barriers described by KIs included the following: non-reimbursement by the government or private insurance schemes, lack of time, lack of support by government health policies, inadequate knowledge and skills in behavioural counselling, lack of support from specialist services and patient resentment or annoyance at being asked about their alcohol consumption. The fact that the barriers and incentives identified implicate practitioners, policy makers, politicians and patients underlines the need for a systematic and collaborative approach to solutions. McAvoy et al. (2001) mention in their report that guidance on the way ahead is already available on a number of national and international reports, which cover areas such as guidelines and competencies for successful management of alcohol-related problems, models for improving clinical skills, education and training programmes. It is further noted in the same report that since the link between PHC intervention and a comprehensive public health policy is critical (WHO Working Group, 1999), it is encouraging to see evidence of this actually happening internationally. Mention is made of countries such as Australia, France, Belgium and the UK that employ multi-faceted national strategies to embrace both alcohol and drugs to promote the health of their communities. Such developments, coupled with the growing international trend towards more primary care-orientated health systems in most developed countries, offers real hope for increased involvement of GPs in this critical area of health promotion (McAvoy et al., 2001).

According to a statement made by Professor Nick Heather (director of the Centre for Alcohol and Drug Studies, Newcastle, England) it took a very long time for advice against smoking to be accepted as a normal part of general practice but that attitudes have however changed. He said that no one takes offence now when their GP or nurse asks them about their smoking habits. The same position can be reached with excessive drinking if the level of enquiry and intervention is increased.

2.7 Effective measures to reduce alcohol misuse

2.7.1 Screening and Brief Intervention
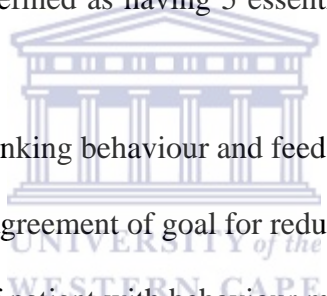
A brief intervention is a time-limited intervention focusing on changing patient behaviour with respect to alcohol consumption through motivational counselling. Brief interventions are mainly used to reduce alcohol consumption in people drinking above recommended levels but who are not dependent. Brief interventions may also have a role in improving compliance with other treatment regimens for alcohol dependent patients (Fleming and Manwell, 1999). Brief interventions have been evaluated across a wide range of population groups, in terms of demographic characteristics; men, women, and the elderly and the majority of studies have been conducted in primary care settings. Doctors have delivered the brief interventions in the majority of studies. Nurses and health educators have also been effective in delivering brief interventions.

Literature was consulted to review the effectiveness evidence relating to brief interventions used to treat problem drinking and alcohol abuse. Although the quality of the reviews is variable, overall they provide substantial support for the effectiveness of

brief interventions in reducing alcohol consumption. The reviews by Fleming and Manwell, 1991, Freemantle et al., 1993, Poikolainen 1999 and Wilk et al., 1997, are the most comprehensive. The reviews suggest that Brief interventions are effective in reducing alcohol consumption for at least 12 months in patients who are not alcohol dependent. The pooled results from clinical trials show a 24% reduction in alcohol consumption. The studies further illustrate brief interventions to be relatively cost-effective, due to fairly high levels of effectiveness and low costs.

2.7.1.1 Steps of brief interventions

A brief intervention has been defined as having 5 essential steps (Fleming and Manwell 1999);

- assessment of drinking behaviour and feed back (screening);
- negotiation and agreement of goal for reducing alcohol use;
- familiarisation of patient with behaviour modification techniques;
- reinforcement with self help materials;
- follow up telephone support or further visits.

The counselling strategy used in brief interventions has also been summarised as **FRAMES** (Miller and Rollnick, 1991);

Feedback   review problems experienced because of alcohol

Responsibility   patient is responsible for change

Advice   advise reduction or abstinence

Menu   provide options for changing behaviour

Empathy   use empathic approach

Self-efficacy   encourage optimism about changing behaviour

2.7.2 Effectiveness of brief interventions: Alcohol consumption and health outcomes

Most studies have found that brief interventions are effective in reducing alcohol consumption for at least 12 months in patients who are not alcohol dependent, and when compared with no intervention or usual care. A number of outcome measures are used including levels of alcohol consumption, change from heavy to moderate drinking and biochemical markers of alcohol consumption.

Formal meta-analysis of RCTs has been attempted in 3 reviews (Freemantle et al 1993; Poikolaninen, 1999; Wilk, Jensen and Havighurst, 1997).The former pooled results from 6 trials and estimated the effect of brief intervention as a 24% reduction in alcohol consumption (95% CI; 18%-31%). The last study analysed the proportion of patients reducing or moderating their drinking and concluded that those receiving motivational interventions were twice as likely as controls to change their behaviour (Odds Ratio 1.95; 95% CI; 1.66-2.30).

In Fleming and Manwell's (1991) study the population included were patients aged 18-65 years, attending routine general practice appointments and reporting drinking above threshold limits (defined as men consuming >14 drinks and women consuming >11 drinks per week), and comprised 482 men and 292 women. Health outcomes were based on self-reported alcohol consumption, at six and twelve months, completing a timeline follow back. The average number of drinks in the past seven days declined by 39.5% at

six months and 40.0% at 12 months. Binge drinking reduced by 49.1% (6 months) and 45.7% (12 months), which was significantly greater than the reduction in the control group. Fleming et al. (1991) found the average reduction in alcohol consumption was 45.7 % at the 12 month follow up. This is the same order of magnitude as the treatment groups in studies included in the effectiveness reviews (Fleming and Manwell, 1991).

Anderson (1996) measured the effectiveness of general practice interventions for patients with harmful alcohol consumption. The six studies included men and women who were heavy drinkers. The results suggest that very brief advice leads to reductions in alcohol consumption of 25-35% and reductions in the proportions of excessive drinkers of around 45%. The studies provide some understanding of the effective components of brief interventions. These include the target of brief intervention should be a reduction in the consumption of alcohol, also that among those with a long-term alcohol problem, brief counselling worked best, while among those with a recent problem, simple advice worked best. This suggests that the effect of minimal intervention is enhanced when the patient has experienced a recent problem caused by alcohol.

In a systematic review of the effectiveness of promoting lifestyle change in general practice Ashenden et al. (1997) reported that 2 out of 5 studies found significant change in alcohol consumption and 3 out of 6 studies found significant change from heavy to moderate drinking. The review included trials of lifestyle advice in GP settings with random allocation between experiment and comparison groups. Babor et al. (1986) also pointed out in a review of early intervention strategies regarding alcohol-related problems in the primary health care setting that low intensity, brief interventions have much to recommend as the first approach to the problem drinker in the primary care setting.

Brief intervention reduces drinking among early problem drinkers. Although most early problem drinkers do not go on to become alcohol dependent, they are a legitimate source of concern due to their significant numbers and the costs involved in treating their health and social problems. Alcohol dependent drinkers are likely to need specialised treatment (e.g. detoxification, rehabilitation and Alcoholic Anonymous meetings) and are unlikely to benefit from brief interventions. However, if the individual's drinking is found to be consistent with hazardous or harmful drinking or with alcohol abuse, brief intervention may be an effective tool. The WHO cross cultural trial on brief interventions found that heavy drinkers not reporting any recent adverse consequences benefited from a more extended intervention whereas those who had experienced a recent negative consequence benefited from the intervention of shorter duration (Modesto-Lowe and Boornazian, 2000).

Modesto-Lowe and Boornazian also identified barriers to implementing brief interventions that include: the physician's failure to screen patients, lack of skills and time, organisational issues, lack of professional reward and lack of diagnostic aids for alcohol disorders. Moralistic attitudes, stereotypes about the nature of alcoholism and poor communication between physicians and non-physician providers have also impeded progress in patient identification and treatment. Despite these research findings, screening and brief interventions have yet to exert a significant influence in clinical practice.

2.8 Training to implement screening and brief intervention (SBI) in health care settings

Primary health care is the first point of contact of individuals, families and communities in most countries' health systems (Kaner et al., 2001). Primary care is therefore a particularly valuable point of delivery for community-based interventions for excessive alcohol consumption due both to its universality and also to the large proportion of the population who access it each year (Department of Health, 2001). Moreover, problem drinkers present to primary health care twice as often as other patients and constitute approximately 20% of patients on practice lists (Anderson, 1993).

Screening procedures have been developed to identify at-risk drinkers (e.g., Babor, Higgins-Biddle, Saunders, & Monteiro, 2001), and significant reductions in drinking and related risks can be achieved by brief interventions (e.g., Moyer, Finney, Swearingen, & Vergun, 2001). Screening can also identify persons likely to be alcohol dependent, and referral for diagnostic evaluation may encourage patients to seek treatments that have been shown to be effective.

The White Paper for Transformation of the Health System in South Africa (1997) and the National Drug Master Plan (1999) in South Africa have prioritised prevention and management of alcohol abuse and the integration of substance abuse in PHC. The Department of Health (2001) has included in the service description of clinics the prevention and management of substance abuse. Standards for PHC include health-learning materials on alcohol in local languages and competence of health staff in

identifying alcohol abuse and provide basic counselling for behaviour changes and referral to NGOs specializing in substance abuse.

Although progress has been made in developing a scientific basis for alcohol screening and brief intervention (SBI), training is necessary for its widespread dissemination in primary care settings especially in developing societies. The World Health Organisation (WHO) developed a training package, the SBI programme, for this purpose.

Peltzer et al. (2004) conducted a study that involved the implementation and evaluation of the SBI programme in health care settings in one urban and one rural site in Limpopo Province, South Africa. This study evaluates the dissemination of the development of successful training packages that include programme implementation procedures in a developing country. The WHO SBI programme was developed to train medical providers to implement SBI in primary care settings. The study shows that health care providers significantly increased in knowledge, confidence in SBI and higher self-efficacy in implementing SBI at follow-up after 9 months after receiving the training. When delivered in the context of a comprehensive SBI implementation programme, this training is effective in changing providers' knowledge, attitudes, and practise of SBI for at-risk drinking.

2.8.1 Curriculum and Training

The training curriculum contains modules addressing practical issues deemed essential to implementing the programme. For early identification (screening) of alcohol problems in primary care the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 2001a)

and for the brief intervention the WHO brief intervention package for hazardous and harmful drinking (Babor et al. 2001b) is used. Both were adapted to the South African context, e.g. in terms of standard unit of alcoholic drink and drinking limits. The AUDIT was translated and back translated according to scientific standard procedures into four of the major languages in the project area. The self-help booklet for patients and a handout on "cutting back" showing the drinking limits and health effects of risky alcohol consumption were also made available in Tsonga, Northern Sotho, Venda, and Afrikaans.

The AUDIT manual explains the purpose of screening for alcohol problems in primary care, the context of alcohol screening, the development and validation of the AUDIT, administration guidelines, scoring and interpretation.

The Brief Intervention manual defines concepts and terms, roles and responsibilities of Primary Health Care, SBI: a risk management and case finding approach, alcohol education for low-risk drinkers, abstainers and others, simple advice for non-problematic drinkers, brief counselling for hazardous/risky drinkers, referral for drinkers with probable alcohol dependence, patient education, self-help booklet and training sources.

A total of 14 trainings of six hours duration were conducted at the sites.

A nurse and psychologist trainer and the project site consultant delivered the training. As many practice staff as possible were invited to the training, including physicians, professional nurses, and assistant nurses. Follow-up supervisory and support visits were also provided.

The evaluation of the effects of training and programme implementation were measured prior and by the same health care providers 9 months after the training, with a self-administered questionnaire. Quality assurance of training was conducted by tape-recording of 40 nurses-patient SBI interactions. Furthermore, a brief patient exit interview was used with 100 consecutive patients (18 to 65 years) from different health facilities leaving PHC premises after having seen a health professional for any reason.

The results of this study demonstrate that, when delivered in the context of implementing a comprehensive SBI programme, even relatively short training of health care providers in screening and brief intervention techniques can result in gains in provider knowledge, self-efficacy, and expectations about the value of SBI. Andersen et al. (2003) found among GPs that those who received more education on alcohol, who perceived their working environment as supportive, who expressed higher role security in working with alcohol problems and who reported greater therapeutic commitment to working with alcohol problems were more likely to manage patients with alcohol-related harm.

PROBLEM

Alcohol continues to be the most dominant substance of abuse and continues to place a major burden on society. Plüddemann et al. (2004) reported that alcohol is still the most common primary substance of abuse among patients seen at specialist treatment centres. In Cape Town alcohol accounts for 39% of admissions to specialist treatment centres. A study by Babor and colleagues (1988) indicated that there is generally a direct relationship between the level of alcohol consumed and the extent of problems experienced. Alcohol abuse has thus become a major public health concern. It is

28

suggested in reports that preventive medicine and alcohol early intervention should be done in general practice and that GPs believe that they should be doing the work, but that these behaviours rarely happen in practice (McAvoy et al., 2001). Roche and Richard (1991) mention in their report that except for a small number of studies medical practitioners have rarely been questioned systematically and directly about their perceptions of their own roles in relation to alcohol (and drug) problems. No clear evidence can be found in the literature of the involvement of GPs in South Africa in early interventions to curb alcohol abuse and during discussions with other researchers it became clear that it would be important to have evidence of the role of GPs in managing patients presenting with alcohol-related problems. This study thus aimed to assess the identification and management of problem drinking since many people with drinking problems choose to reduce their drinking rather than pursue abstinence as a solution to their concerns about their drinking.
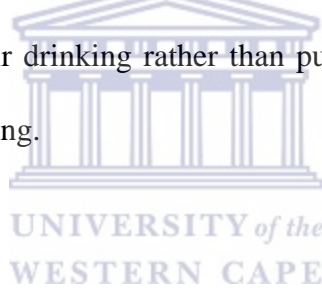
PURPOSE

Since no clear evidence can be found in the literature of the involvement of GPs in South Africa in early interventions to curb alcohol abuse, this study aimed to investigate the role of GPs in addressing problem drinking in the city of Cape Town. The study aims to describe the GPs' attitudes and practise regarding alcohol related problems amongst their patients. The treatment approaches of GPs are considered useful especially in the case of problem drinkers with low levels of physical dependence on alcohol who choose to reduce their drinking. If this group is identified with regular doctor's visits through screening, reduction in harmful quantities of alcohol use may be more successful than at the stage of total dependence.

AIM

The aim of this study was to assess the prevalence of problem drinking amongst patients attending GP practices in Cape Town and to assess the practises of general practitioners regarding the diagnosis and the management of alcohol-related problems.

OBJECTIVES

- To determine the prevalence of problem drinking amongst adult patients attending GP practices

- To determine the GPs' level of training and knowledge about diagnostic procedures on alcohol-related problems

- To determine how GPs manage problem drinking amongst their patients

- To determine how GPs perceive the importance of dealing with problem drinking in their practice

- To assess the views of GPs on the probability of implementing one or more screening and brief interventions
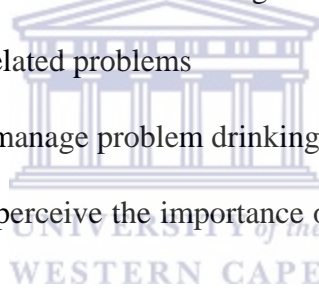
CHAPTER 3

METHODOLOGY

3.1 Study design

A cross-sectional descriptive survey design was utilised, because it was considered an appropriate design to determine the nature, extent and management of problem drinking in GP settings. This study design was selected as opposed to an experimental study design, since the study does not have as the aim to develop an intervention that would prevent or solve the assumed problem. An analytical study design would also not have been appropriate for this study, because the aim of the study is not to establish to what extent any factor contributes to the suspected problem.
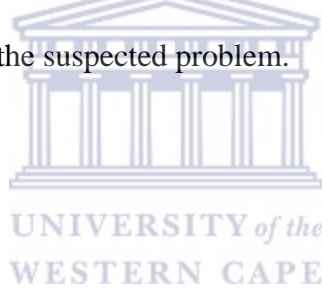
3.1.1 Study area

City of Cape Town in the Western Cape province.

3.1.2 Study population

GPs practising in private settings in the city of Cape Town as well as patients served by these GPs. There were 707 GPs listed in the telephone directory of Cape Town.

3.2 Sampling

Two-phase sampling was used. Patients were selected by convenience sampling and the GPs were randomly selected from the total population of GPs in the city of Cape Town as listed in the relevant telephone directory.

3.2.1 Sample size

The sampling frame was obtained from the "Medical Practitioners" section of the latest Cape Peninsula telephone directory, which lists 707 GPs. Based on an anecdotal estimation that 20% of the GP's are actively involved in managing problem drinking, and using a confidence level of 80% with an accepted error of 7% a sample size of 50 was calculated. A convenience sample of 384 adult patients that attended GP practices on one day during the survey participated in the study.
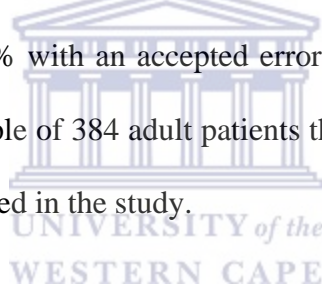
3.2.2 Sampling procedure

Doctors' names were obtained from the "Medical Practitioners" section of the Cape Town telephone directory. A randomly selected starting point was chosen in the table of random numbers and a method of moving through the table in a consistent pattern was determined for the GP sample selection. Only one GP per surgery was contacted to seek doctors' participation in the survey. All specialist or non-GP services had been excluded. Two of the originally selected GPs could not be included in the sample. The practice of one of these GPs was closed down and the other GP refused to participate. When asked why he refused, he responded with: "I'm too old and I'm just waiting for retirement. I'm

not interested in such things you know, … what I see is what I see and what I don't see is what I don't see". Two more GPs were randomly selected from the sampling frame to maintain a sample size of 50. Participants in the study also included a sample of 384 adult patients 18 years and older consulting the participating GPs on the day during the period of the study.

3.3 Data collection

GPs were contacted telephonically to inform them about the purpose and procedure of the study. This was followed by faxing the information and a consent form to GPs for completion if they agreed to participate. Upon completion of a study consent form (see Appendix A) by the GPs, a self-administered questionnaire (see Appendix B) was presented to each consenting GP for completion. The questionnaire addressed demographic characteristics, practice type and location. In addition the GPs' knowledge of alcohol dependence severity, their effectiveness in counselling and helping to achieve behaviour change amongst patients were assessed. An assessment of the perceived need to encourage doctors to do early interventions for alcohol-related problems had also been done. The GPs were required to place the completed questionnaire in an envelope and seal it. The researcher collected the completed questionnaires from the surgeries on the day when the survey with patients had been conducted.

The patients were approached to participate in the surgery on the day of the survey. Following patient consent (see Appendix C), the Alcohol Use Disorders Test (AUDIT) questionnaire (Saunders et al., 1993) (see Appendix D) was handed out for self-completion or interview (if requested) to patients during normal surgery hours. When it

was necessary to conduct interviews, this was done in a separate room. The AUDIT is a 10-item questionnaire, which is useful in assessing problem drinking and the time required to complete it was approximately 5 - 10 minutes. Additional questions had been added with regards to demographic information.

The AUDIT questionnaire is the first screening test designed specifically for use in primary care settings and currently the only one designed for international uses. The AUDIT was validated on primary health care patients in six countries (Norway, Australia, Kenya, Bulgaria, Mexico, and the United States of America) (Saunders et al., 1993). In 1982 the WHO asked an international group of investigators to develop a simple screening instrument. The purpose was to identify persons with early alcohol problems using procedures that were suitable for health workers to use in both developing and developed countries. The AUDIT will help the practitioner identify whether the person has hazardous (or risky) drinking, harmful drinking or alcohol dependence, thus identifying the problem drinker.

At a cut-off score of 8 of the possible 40 points Saunders et al. reported a 92% sensitivity and 94% specificity for hazardous and harmful drinking and a 100% sensitivity for alcohol dependence. For the question 'How many drinks containing alcohol do you have on a typical day when you are drinking?' a response 1 to 2 drinks would score 0 points (interpreted as a safe level of drinking), comparing well with recommended drinking levels (considered to be safe and/or beneficial levels of alcohol use) for men that are no more than two drinks per day or four per occasion or 14 drinks per week; and for women, no more than one drink per day or three per occasion or 7 drinks per week (NIAAA 1995), making the AUDIT a fairly safe measurement tool to use.

For the purpose of this study the following scoring procedure was used:

- A score of 0 identified teetotallers (people who never drink).

- Scores between 1 and 7 identified non-problematic drinkers.

- Scores of 8 and above identified problem drinkers (which include hazardous- and harmful drinking as well as dependence).

The researcher distributed the questionnaires to the patients in the waiting room on the day during the period of data collection. After completion (about 5 – 10 min.), the questionnaires were placed in an envelope to ensure confidentiality and handed to the researcher. The sealed envelopes with the completed GP and patient questionnaires were then placed in one larger envelope in order to link patients with GPs. Anonymity was assured by not writing GPs names and location addresses on the envelopes nor on the questionnaires.
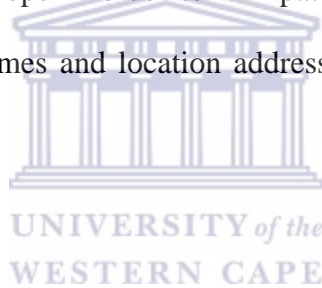
3.4 Piloting

Both the GP and the patient questionnaires had been piloted to ensure that questions were not misunderstood and the required information was collected. Two GPs and 15 patients who do not form part of the sample were selected to complete the pilot questionnaires. At the pilot phase the time required to complete the questionnaire was established at between 5 – 10 min for the Patient questionnaire and 20 – 25 min for the GP questionnaire. Diverse responses were given to a question, which did not leave drastic reason for concern about the questions. All the respondents answered all the questions in the questionnaire. From this could be derived that the questions were clear and sufficient

response options were provided and questions were not too intrusive and related to the response of the survey.

3.5 Validity

The GP questionnaire is designed to assess the diagnostic procedures and prevention strategies and has face validity having been constructed with the assistance of senior researchers active in the field of alcohol research.

Screening tests tools used to determine alcohol use disorders are validated by measuring for sensitivity and specificity of these tools. AUDIT scores were compared with other detailed and comprehensive measurement tools. Mackenzie et al. (1996) compared sensitivities and specificities of the AUDIT (10 items), CAGE (4 items) and the Michigan Alcoholism Screening Test (MAST) (25 items). Sensitivities for the identification of weekly drinking over recommended limits were 93%, 79% and 35% respectively. In detecting alcohol dependence or abuse, the most widely used instruments are the CAGE questionnaire with 4 items, because it is shorter than the AUDIT, but it is however insensitive for hazardous or dependent drinking patterns. The AUDIT is most effective in identifying subjects with hazardous or harmful drinking and alcohol dependence and was specifically designed for use in primary care settings (Saunders et al., 1993). At a cut-off score of 8 of the possible 40 points Saunders et al. reported a 92% sensitivity and 94% specificity for hazardous and harmful drinking and a 100% sensitivity for alcohol dependence. The AUDIT suits the objective of this study well.

36

Validity was enhanced by translating the AUDIT questionnaire from English to Afrikaans and Xhosa, since these are the three main languages spoken in the Western Cape. The questionnaire was back translated to English to ensure that translation was done effectively and the correct meaning for each question was captured. The AUDIT questionnaire was successfully used in similar studies determining the alcohol misuse in patients attending PHC settings (Babor and Grant, 1992).

Both the GP and patient questionnaires had been piloted and standard procedures were used in all settings under supervision of the researcher.

3.6 Reliability

Due to time and cost constraints reliability was not assessed, but a high level of reliability is presumed as the questionnaires consisted mainly of structured close-ended questions.
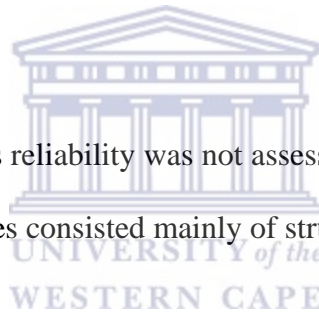
3.7 Generalisability

Findings are likely to be generalised to all GP practices in urban settings in South Africa because: the sample covered a variety of socio-economic areas in urban settings, the prevalence of problem drinking is high in South Africa, basic training for medical practitioners is the same for all general practitioners in South Africa, GP practices in South Africa are all similar pay for services practices where treatment is mostly curative in nature and few preventive measures are provided.

3.9 Data analysis

The patients were asked to complete the AUDIT questionnaire and the scores for each completed questionnaire were used to determine the prevalence of problem drinking amongst adult patients who attended the participating GP settings. Demographic questions such as age, gender, area of residence, marital and employment status and scholastic qualifications had also been used to compile a patient profile.

Scoring for the AUDIT questionnaire was done by hand. Questions 1-8 were scored 0, 1, 2, 3 or 4. Questions 9 and 10 were scored 0, 2 or 4 only. The minimum score (for teetotallers) was 0 and the maximum possible score was 40. Scores between 1 and 7 indicated non-problematic drinking and a score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption, as well as possible dependence (problem drinkers).
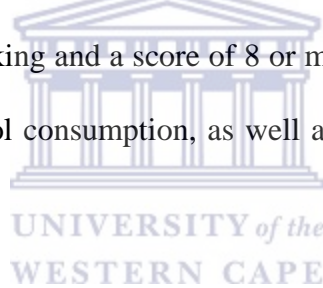
The GP questionnaire was utilised to investigate GPs' knowledge about diagnostic procedures as well as how they manage problem drinking amongst their patients. Analysis had then been done in the following categories: *'Training and knowledge in preventive medicine and early intervention', 'Diagnostic and Management skills', 'Current practices in preventive medicine and early intervention for alcohol', 'Self-efficacy', 'Role acceptance', 'Perceived barriers to early intervention for alcohol' and 'Perceived incentives to early intervention for alcohol'.*

Additional questions were added to determine the demographic characteristics of participating GPs.

Descriptive statistics (frequencies, means, cross-tabulations) using SPSS had been calculated on all relevant variables to analyse the data collected with the questionnaire for GPs and the AUDIT questionnaire for patients.

3.9 ETHICAL CONSIDERATION

Throughout the course of the study various ethical issues were considered. Firstly, informed consent was obtained from the GPs for their participation and to conduct the study at their practices. The purpose and procedure for the study were disclosed to the patients and informed consent was obtained from them. Confidentiality and anonymity were maintained at all times. Since the questionnaires of both the GPs and the patients had been placed in sealed unmarked envelopes anonymity was assured. Both GPs and patients were free to leave any questions unanswered and could have withdrawn from the study at any stage. Ethical approval to conduct this study was obtained from the University of the Western Cape research committee.

CHAPTER 4

RESULTS

4.1 Response rate and exclusions

Questionnaires were collected from the full sample size of 50 GPs, though two of the originally selected GPs could not be included in the sample. The practice of one of these GPs was closed down and the other GP refused to participate. A further two GPs had been randomly selected from the sampling frame to ensure that all 50 GPs completed the questionnaire. No patients refused to participate in the study. The total number of questionnaires collected was 384 that represented the total number of patients seen by the GPs on the day of the visit to each GP.
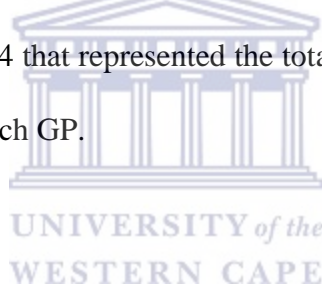
4.2 Patient Profile

Demographic questions such as age, gender, area of residence, marital and employment status and scholastic qualifications had been used to complete a patient profile. The scores from the completed AUDIT questionnaires were used to determine the prevalence of problem drinking amongst adult patients who attended the participating GP settings.

4.2.1 Characteristics of participating patients

The sample consisted of 384 adult patients that consulted the various participating GPs' practices on the day of the interview. They comprised 176 males (45.8%) and 208 females (54.2%) and their mean age was 40.49 years. Two hundred and thirty six (61.5%) of the respondents reported to be married, 82 (21.4%) to be single, never married and 47 (12.2%) either to be divorced, separated or widowed. The remainder of the respondents 19 (4.9%) were living with a partner / lover. The patient profile is illustrated in the following tables.

Table 1:Age distribution of participating patients

	Frequency	%
18 yrs – 20 yrs	14	3.6
21 yrs – 30 yrs	72	18.8
31 yrs – 40 yrs	100	26.0
41 yrs – 50 yrs	114	29.7
51 yrs – 60 yrs	66	17.2
61 yrs +	18	4.7
Total	384	100.0

Table 2:Employment status of participating patients

	Frequency	%
Employed (full -, part-time, self-)	339	88.3
Unemployed (do not work at all)	8	2.1
Student	20	5.2
*Other	17	4.4
Total	384	100.0

*Included: Homemaker, Retired, Disabled

Table 3: Educational status of participating patients

	Frequency	%
Primary	11	2.9
Secondary	195	50.8
Tertiary	174	45.3
None	4	1.0
Total	384	100.0

Table 4: Type of dwellings reported by participating patients

	Frequency	%
*Formal brick housing	358	93.2
Out-building/Outside room	14	3.6
Rent room in house	11	2.9
Shack	1	.3
Total	384	100.0

*Includes conventional houses, town houses, flats and apartments

4.2.2. The prevalence of Problem Drinking amongst participating patients

The AUDIT cut-off point of 8 or above was used to determine the proportion of patients presenting with problem drinking. The proportion of participants in the category "problem drinking" comprised 129 (33.6%) of the sample. Participants who scored high on questions 4-6 were identified as dependent drinkers. A nil score was calculated that is unusual, given the high proportion of total problem drinkers.

Table 5: Problem drinking amongst patients

	%		
	Teetotallers	Non-problematic drinkers	Problem drinkers
Gender:			
Males	24.4	13.1	62.5
Females	59.6	31.3	9.1
Age:			
18 – 20 yrs	61.5	30.8	7.7
21 – 30 yrs	38.9	18.1	43.1
31 – 40 yrs	37.0	27.0	36.0
41 – 50 yrs	37.7	27.2	35.1
51 – 60 yrs	53.0	16.7	30.3
61 yrs +	88.9	11.1	0.0
All patients	**62.5**	**9.1**	**33.6**

4.3 GP Profile

A self-administered questionnaire addressing demographic characteristics was presented to each consenting GP for completion. The questionnaire further investigated GPs' knowledge about diagnostic procedures as well as how they manage problem drinking amongst their patients.

4.3.1 Characteristics of participating GPs

The average age of GPs was 43 years (see Table 6 for age distribution) and 70% were male. Respondents had been in general practice for an average of 12 years (Table 7) and spent an average of 6 days per week in practice. Almost all the GPs reported that they see up to 30 patients per day (Table 8) and almost all GPs worked in urban practices (Table 9). The majority of GPs worked in solo practices (Table 10).

Table 6: Age distribution of participating GPs

Age	Frequency	(%)
33yrs – 40yrs	18	36
41yrs – 50yrs	26	52
51yrs +	6	12

Table 7: Reported years practising as GP

Years in practise	Frequency	(%)
0yrs – 4yrs	3	6
5yrs – 9yrs	12	24
10yrs – 14yrs	17	34
15yrs – 19yrs	13	26
20yrs +	5	10

Table 8: Reported number of patients seen by GPs per day

Number of patients	Frequency	(%)
0 – 20	32	64
21 – 30	17	34
31 - 40	1	2

Table 9: Setting of GPs' practices

GP's practice	Frequency	(%)
Urban	46	92
Peri-urban	4	8

Table 10: Type of GP practice

GP's practice type	Frequency	(%)
Solo	44	88
Group	6	12

4.3.2 Training and knowledge in preventive medicine and early intervention

Respondents were asked about post-graduate training on alcohol and alcohol-related problems as well as about their knowledge and awareness of alcohol problems and how they would deal with it. The largest proportion of respondents indicated that they had received no post-graduate training, continuing medical education or clinical supervision on alcohol or alcohol-related problems (Table 11).

Table 11: Reported hours of post-graduate training GPs (%) received on alcohol and alcohol-related problems

Post-graduate training on alcohol problems (hours)	Frequency	(%)
None	34	68
1 - 4hrs	1	2
5 – 9hrs	10	20
10 – 14hrs	4	8
15 hrs +	1	2

4.3.2.1 Conditions eliciting GPs to enquire about alcohol

Because alcohol is implicated in a wide range of diseases, disorders and injuries, as well as many social and legal problems, moreover, much more common medical conditions, a variety of conditions could lead the GP to enquire about alcohol consumption amongst their patients. In an open-ended question respondents were requested to record the conditions that would trigger an enquiry by them about alcohol consumption amongst patients. Problem drinking is normally associated with a combination of health problems and/or psychological and social disorders.

Table 12: Answers by Respondents (%) on Conditions eliciting GPs to enquire about alcohol amongst their patients

Symptoms	Percentage
Physical	100
Psychological	66
Social	44

Table 13: Typical symptoms cited by GPs

Conditions
Physical: Gastritis, Stomach complaints, High blood pressure, Hypertension, Diabetes, Hepatitis, Pancreatitis, Headache complaints, Heart condition, Dizziness, Heartburn, Epigastric pain, Numbness in hands and feet, Smell on breath, Blackouts, Unwanted pregnancy, Peptic ulcers, Tremors, Medical history, Appearance, Injuries, Cirrhosis, Withdrawal symptoms, intoxication, diarrhoea
Psychological: Depression, Anxiety, Stress, Psychological conditions
Social: Family violence, Spouse-/Child abuse, Complaints from spouse/family, Injuries from assaults/violence, Sick leave abuse

4.3.2.2 Reported upper-limits of alcohol consumption

The ways in which women and men metabolise alcohol differ significantly. After consuming a given dose of alcohol adjusted according to body weight, women have higher blood alcohol levels than men. The recommended alcohol limits are considered to be safe limits of alcohol consumption or it may even be beneficial to the health of the individual. If more than the recommended limits of alcohol are consumed, the person is likely to present with problem (risky) drinking. It would be useful for GPs to be aware of what these recommended levels are in order to advise their patients appropriately.

GPs were asked to report the upper limit of alcohol consumption before they would usually advise patients to cut down. All GPs answered this question in terms of standard drinks per week rather than ml of alcohol. The average upper limit reported by the GPS was 7.3 standard drinks/week and 4.7 standard drinks/week for adult males and females, respectively. It is worth to note that this was below the recommended upper limits of alcohol use; 14 drinks/week for men and 7 drinks/week for women (NIAAA 1995). It seems as if GPs are not aware of what the safe or beneficial limits of alcohol consumption are.

4.3.3 Diagnostic and management skills

To examine the GPs' diagnostic and management skills the questionnaire included two case histories. Both cases can be identified as problem drinkers as described by the definition referring to the continuum of alcohol consumption. The first, Case A, presented a person who was drinking hazardously with some evidence of problems associated with

the level of alcohol consumption. The second case, Case B, presented a person whose level of alcohol consumption and associated physical symptoms were suggestive of alcohol dependence.

4.3.3.1 Severity of drinking pattern, importance level to stop drinking, confidence in helping patients

The diagnostic skills were tested by asking the participating GPs to rate the severity of a drinking pattern, the importance level of the patient to stop drinking as well as rating their own confidence to help the patient to stop drinking. GPs rated the severity of the patients' alcohol problem as either 'Teetotaller' (0), 'Non-Problematic' (1-3), 'Hazardous' (4-6) or 'Dependent' (7-9) on a scale of 0 to 9. The importance to stop drinking was rated as 'Not important' (0), 'Somewhat important' (1-3), 'Important' (4-6) and 'Very important' (7-9). Regarding the GPs' confidence in helping the patient to alleviate his drinking problem, or even to stop altogether, the responses were either 'Not confident' (0), 'Somewhat confident' (1-3), 'Confident' (4-6) or 'Very confident' (7-9).(Tables 14-16).

Table 14: GPs'(%) responses to the perceived drinking severity of the patients

Rating option	Case A (Hazardous drinker)	Case B (Dependent drinker)
	%	%
Teetotaller	0	0
Non-problematic	0	0
Hazardous	36	0
Dependent	74	100

Table 15: GPs' (%) responses to the perceived importance for the patients to stop drinking

Rating option	Case A (Hazardous drinker)	Case B (Dependent drinker)
	%	%
Not important	0	0
Somewhat important	8	0
Important	32	10
Very important	60	90

Table 16: GPs' (%) responses to their perceived confidence in helping the patients to alleviate the drinking problem or even to stop altogether

Rating option	Case A (Hazardous drinker)	Case B (Dependent drinker)
	%	%
Not confident	0	0
Somewhat confident	14	4
Confident	60	86
Very confident	26	10
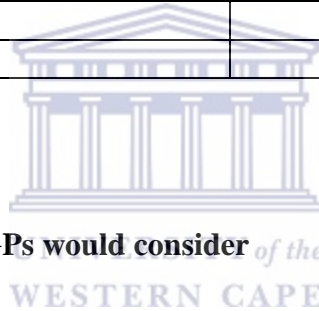
4.3.3.2 Management actions GPs would consider

GPs should consider it important that the patient with a drinking problem should get help

either from the GP in the surgery or the patient should be referred to a specialist if the GP

is unable to help. The respondents were further asked to indicate the actions they would

take considering the two case histories in order to indicate their management skills. The

GPs' responses are listed in Table 17.

Table 17: Summary of GPs' (%) management actions they would take if they were to be the GP in the mentioned case scenarios

Action	Case A (Hazardous drinker) %		Case B (Dependent drinker) %	
	Yes	No	Yes	No
Ask some further questions about drinking to gauge the possibility of an underlying alcohol problem	100	0	100	0
Indicate that alcohol is probably related to some of the patient's associated problems	74	26	100	0
Record the weekly alcohol consumption and advice the patient to cut back	100	0	98	2
Record the weekly alcohol consumption and advice the patient to abstain completely	60	40	100	0
Order a complete blood count	68	32	100	0
Ask the patient to return for a discussion on his alcohol use	84	16	100	0
Refer the patient to an outside specialist or agency for his drinking	36	64	60	40
Record alcohol consumption and take no other action concerning his alcohol use	0	100	2	98

4.3.3.3 Behaviours related to an individual's health

Some health professionals believe that certain behaviours are related to health and that these behaviours may be a risk to the health of the individual. General Practitioners were asked to rate the importance of various health behaviours 'in promoting the health of the average person'. Rating was on a four-point scale ranging from 'Very important' to 'Unimportant' (Table 18).

Table 18: Extent to which GPs (%) rate the importance of behaviours related to health in promoting the health of a person

Behaviour	Very important (%)	Important (%)	Somewhat important (%)	Unimportant (%)
Not smoking	100	0	0	0
Exercise regularly	54	46	0	0
Drinking alcohol moderately	12	88	0	0
Not drinking alcohol at all	18	50	8	24
Avoiding excess calories	18	54	28	0
Reducing stress	8	72	20	0
Responsible use of prescription drugs	20	50	28	2
Not using illicit drugs	90	10	0	0

4.3.4 Current practices in preventive medicine and early intervention for alcohol

4.3.4.1 Patients managed for alcohol problems

In some cases GPs do screen patients for alcohol-related problems in order to be able to implement interventions. GPs were asked to indicate about how many patients they have managed in the last year, specifically for their hazardous drinking or alcohol-related problems. None of the respondents indicated that they manage none of their patients for alcohol-related problems. (Table 19).

Table 19: An estimate of the number of patients managed by GPs (%), in the past year, specially for alcohol-related problems

Number of patients	Frequency	(%)
None	0	0
1- 10	0	0
11-20	24	48
21-30	19	38
31-40	6	12
41-50	1	2
50 +	0	0

4.3.4.2 Clinical time, advice and education, scale of priority on disease prevention

Often patients do not inform their doctors about the health risk behaviour they might expose themselves to. If they would, prevention intervention might be advantageous to their health. GPs were asked to indicate what percentage of their total general practice clinical time they would consider to be preventive in nature (Table 20). They also reported on how often they educate or advise their patients about lifestyle and health risks during preventive check-ups (Table 21) as well as with an illness visit (a visit with specific symptoms) (Table 22). GPs were also asked to indicate how high a priority they place on disease prevention, taking into consideration all their current responsibilities (Table 23).

Table 20: GPs' (%) response to percentage of total clinical time considered to be preventive in nature

% Clinical time	Frequency	(%)
0 – 9%	9	19
10 – 19%	24	48
20 – 29%	10	20
30 – 39%	3	6
40% +	4	8

Table 21: The frequency at which GPs (%) advise or educate their patients about lifestyle and health risks as preventive check-up

Frequency GPs advise or educate	Response (%)
All the time	22
Most of the time	60
Some of the time	18
Rarely or never	0

Table 22: The frequency at which GPs (%) advise or educate their patients about lifestyle and health risks with an illness visit

Frequency GPs advise or educate	Response (%)
All the time	6
Most of the time	70
Some of the time	24
Rarely or never	0

Table 23: Priority placed by GPs (%) on disease prevention in the surgery, given their current responsibilities

Frequency of priority	Response (%)
Very high	14
Somewhat high	74
Somewhat low	12
Very low	0

4.3.4.3 Health-related information from patients

It is important that GPs should ask their patients about health-related issues in order to know whether patients' lifestyle is a risk to their health. Respondents were asked to indicate the extent to which they obtained information from their patients in various health-related areas on a four-point scale. (Table 24).

Table 24: Extent to which GPs (%) obtain information from patients in various health-related areas

Behaviour	Always (%)	As indicated (%)	Occasionally (%)	Rarely/Never (%)
Not smoking	72	18	0	10
Exercise regularly	4	66	30	0
Drinking alcohol moderately	22	64	14	0
Not drinking alcohol at all	48	8	32	12
Avoiding excess calories	10	50	40	4
Reducing stress	12	70	14	4
Responsible use of prescription drugs	72	0	22	6

4.3.4.4 Alcohol-linked blood tests requested in the past year

Sometimes it is necessary for the GP to take a blood test to determine whether the patient has an alcohol-related problem. Participating GPs were requested to indicate how many

times in the past year they have requested blood tests because of concern about alcohol consumption amongst their patients (Table 25)

Table 25: Estimated number of times blood tests were requested by GPs (%) for all patients in the past year

Number of patients	Frequency	(%)
None	0	0
1—5 times	3	6
6-10 times	13	26
11-15 times	22	44
16-20 times	12	24
> 20 times	0	0

4.3.5 Self-efficacy

Doctors vary in their counselling skills and effectiveness and ability to help patients achieve behaviour change in health-related areas. However, given training and adequate information all GPs could have a positive effect on how prepared they might feel in helping patients achieve change in various health-related areas. Respondents were asked to rate their level of preparedness for counselling their patients in various health-related areas. Rating was on a four-point scale ranging from 'very prepared' (score 41) to 'very unprepared' (score 1). In a similar fashion GPs were asked to indicate how effective they felt in helping patients achieve change in the various health-related areas. Rating was on a four-point scale ranging from 'very effective' to 'very ineffective'. Respondents were then asked to rate how effective they could be, given adequate information and training, in helping patients achieve change in a variety of health areas (Tables 26 -28).

Table 26: GPs' (%) rating of how prepared they feel when counselling patients in various health areas

Behaviour	Very prepared (%)	Prepared (%)	Unprepared (%)	Very Unprepared (%)
Not smoking	82	18	0	0
Exercise regularly	42	52	6	0
Reducing alcohol consumption	2	80	14	4
Avoiding excess calories	4	90	6	0
Reducing stress	4	84	8	4
Responsible use of prescription drugs	6	86	8	0
Not using illicit drugs	40	48	8	4

Table 27: GPs' (%) rating of how effective they feel in helping patients to achieve change in various health areas

Behaviour	Very effective (%)	Effective (%)	Ineffective (%)	Very ineffective (%)
Not smoking	0	28	56	16
Exercise regularly	0	46	40	14
Reducing alcohol consumption	0	12	70	18
Avoiding excess calories	0	28	50	22
Reducing stress	0	30	56	14
Responsible use of prescription drugs	0	70	28	2
Not using illicit drugs	26	24	46	4

Table 28: Respondents' (%) rating of how effective GPs could be, when given adequate information and training, in helping patients to achieve change in various health areas

Behaviour	Very effective (%)	Effective (%)	Ineffective (%)	Very ineffective (%)
Not smoking	0	30	68	2
Exercise regularly	28	56	16	0
Reducing alcohol consumption	2	76	22	0
Avoiding excess calories	2	88	10	0
Reducing stress	28	46	26	0
Responsible use of prescription drugs	28	40	32	0
Not using illicit drugs	28	32	40	0

4.3.6 Role acceptance

The support given to GPs could influence their perception about how involved they would become in assisting patients to achieve behaviour change in order to improve their health. General practitioners were asked about the extent to which they felt GPs should be involved, given appropriate support, in helping their patients change various health-related behaviour patterns, including providing alcohol information and in treating alcohol-dependent drinkers. Rating was on a four-point scale ranging from 'definitely involved' to 'definitely not involved'. GPs were most accepting of their involvement in helping their patients with providing alcohol information and promoting non-hazardous alcohol consumption and (Table 29).

Table 29: Respondents' (%) rating to what extent they feel GPs should, when given appropriate support, be involved in helping patients change behaviour in various health areas

Behaviour	Definitely involved (%)	Involved (%)	Not involved (%)	Definitely Not involved (%)
Not smoking	72	28	0	0
Exercise regularly	68	32	0	0
Promoting non-hazardous alcohol consumption	90	10	0	0
Providing alcohol information	96	4	0	0
Treating alcohol dependent drinkers	64	2	34	0

Additionally, several components associated with an acceptance of a role in alcohol intervention were assessed. Table 30 shows the proportion of GPs agreeing with statements relating to the five variables of the Shortened Alcohol and Alcohol Problems

Perception Questionnaire (SAAPPQ: Anderson and Clement; 1987) when working with either hazardous drinkers or dependent drinkers. **Role adequacy** (e.g. *'I know enough about the causes to handle alcohol problems'; 'I can advise patients about alcohol effects'*) and **work satisfaction** (e.g. *It's rewarding working with problem drinkers/alcohol dependent persons'; 'I like problem drinkers /alcohol dependent persons'*) scores were higher for working with hazardous drinkers than for working with dependent patients. **Role motivation** (e.g. *'I want to work with problem drinkers/alcohol dependents'; 'Pessimism is appropriate attitude towards problem drinkers/alcohol dependents'*) and **role legitimacy** (e.g. *'I have the right to ask about drinking'; 'Patients feel I have the right to ask about* drinking') did not differ between hazardous drinkers and dependent patients. In contrast, **self-esteem** (*e.g. I'm not proud when working with problem drinkers/alcohol dependents', 'I feel a failure when working with problem drinkers/alcohol dependents')* scores were higher for working with dependent patients than for working with hazardous drinkers.
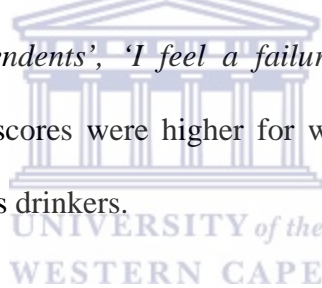
Table 30: GPs (%) agreeing with statements related to role acceptance for working with hazardous drinkers and dependent drinkers

	Hazardous drinkers		Dependent drinkers	
	Frequency	(%)	Frequency	(%)
Role legitimacy	50	100	50	100
Role adequacy	44	88	26	52
Task-specific self-esteem	19	38	28	56
Motivation	18	36	19	38
Work satisfaction	11	22	7	14

4.3.7 Perceived barriers to early intervention for alcohol

Inquiries in a number of countries have revealed that many doctors in general practice spend very little time or no time at all on early intervention for alcohol (McAvoy et al., 2001). A variety of reasons have been suggested as to why this might be so. Potential disincentives to early intervention for alcohol in general practice were examined by measuring the GPs' level of agreement with suggested barriers related to: government policy and reimbursement schemes; time/workload; and GP factors including knowledge and skills, access to appropriate materials and attitudes and beliefs. Level of agreement was on a four-point scale ranging from 'not at all' to 'very much'.

Amongst the strongly endorsed disincentives for brief alcohol intervention work were: that doctors did not have suitable screening devices to identify alcohol problems, that doctors were not trained in counselling for reducing alcohol consumption, that doctors did not know how to identify problem drinkers who have no obvious symptoms of excess consumption. The data is shown in Table 31.

Table 31: GPs' (%) agreement with suggested barriers to brief alcohol intervention

| Statement	Agreement ('very much', quite a bit')	
	Frequency	%
Doctors do not have suitable screening devices to identify alcohol problems	49	98
Government health policies in general do not support doctors who want to practise preventive medicine	49	98
Doctors are not trained in counselling for reducing alcohol consumption	49	98
Doctors do not have suitable counselling materials available	49	98
Doctors do not believe that patients would take their advise and change their behaviour	48	96
Doctors have a disease model training and they don't think about prevention	47	94
Medical Aids do not reimburse patients for alcohol counselling by doctors in general practice	45	90
The government health scheme does not reimburse doctors for time spent on preventive medicine	44	88
General practices are not organized to do preventive counselling	43	86
Doctors believe that alcohol counselling involves family and wider social effects and is therefore too difficult	43	86
Doctors are just too busy dealing with the problems people present with alcohol problems	37	74
Doctors do not know how to identify problem drinkers who have no obvious symptoms of excess consumption	35	70
Doctors think that preventive health should be the patient's responsibility not theirs	32	64
Doctors feel awkward about asking questions about alcohol consumption because saying someone has an alcohol problem could be seen as accusing them of being an alcoholic	31	62
Doctors themselves may have alcohol problems	25	50
Doctors believe that patients resent being asked about their alcohol consumption	24	48
Alcohol is not an important issue in general practice	24	48

4.3.8 Perceived incentives to early intervention for alcohol

Doctors in a number of countries have suggested a variety of things that could lead to more doctors doing early intervention for hazardous alcohol consumption (McAvoy et al., 2001). Potential incentives that would encourage GPs personally to do more early intervention for alcohol in general practice were examined by measuring the GPs' level of agreement with statements relating to: proven effectiveness of early intervention; patient factors; access to appropriate support services and materials; adequate training; and improved salary and working conditions. Level of agreement was on a four-point scale ranging from 'very much' to 'not at all'.

All the incentives for brief alcohol intervention work were evenly endorsed at 100% agreement. Amongst those incentives were: if training programmes for early intervention for alcohol were available; if quick and easy counselling materials were available and more readily available support services to refer patients to, as well as if patients were willing to pay a fee for alcohol counselling. These data is shown in Table 32.

Table 32: GPs' (%) agreement with suggested incentives for brief alcohol intervention

Statement	Agreement ('very much', quite a bit') (%)
Training programmes for early intervention for alcohol were available	100
Training in early intervention for alcohol was recognized for continuing medical education	100
Quick and easy counselling materials were available	100
Support services were readily available to refer patients to	100
Quick and easy screening questionnaires were available	100
Public health education campaigns in general make society more concerned about alcohol	100
Patients requested health advise about alcohol consumption	100
Early intervention for alcohol was proven to be successful	100
Patients were willing to pay a fee for alcohol counselling	100
Providing early intervention for alcohol was recognized for quality assurance credits	100
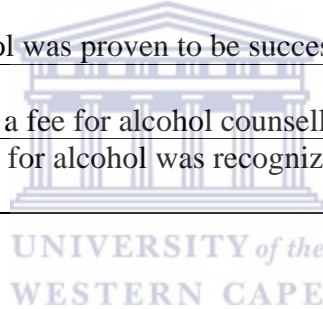
CHAPTER 5

DISCUSSION

General practitioners represent an indispensable resource for the promotion of community health, being in contact with a large proportion of the population in the course of a year. The GPs in this study reported that they see up to 40 patients per day and they spend an average of 6 days per week in practice. GPs become a virtual part of families' lives and act as "consultants" for all the health problems of their patients. GPs also gather a lot of knowledge of patients' social, family and work situations therefore they could play an important role in the prevention of high risk behaviours and the early recognition of alcohol-related problems.

Profile of participating patients:

In this study the sample consisted of 384 adult patients that consulted the various participating GP practices on the day of the interview. The patients are representative of the economically active population since a large proportion (92%) were between 21 and 60 years of age, almost all had some form of employment and only 1% had no education. If this group of people don't get help and their drinking problem gets worse, it could have negative consequences on the society, such as an increase in unemployment and social problems. Since this group of people are all employed and paying for consultations, it could ease the GPs' concern about payment for intervention work.

Similar to the findings in this study, the SADHS (1998) found that most among those who are employed and can afford to pay, prefer to use the private rather than the public

health sector. It was also found that the association between the educational level and utilization of health services is that people with higher educational levels are more likely to use the private health sector.

Prevalence of problem drinking:

The AUDIT questionnaire scoring cut-off point of 8 or above was used to determine the proportion of patients presenting with problem drinking. A high proportion (34%) of patients were classified as problem drinkers and less than half (43%) reported to be teetotallers, but strangely none were alcohol dependent. While more females participated in the study, a much higher proportion (62.5%) of males were identified as problem drinkers. Most problem drinkers (43.1%) were identified in the age group 21-30yrs.

This high proportion of problem drinkers in this study relates to the SADHS of 1998 that showed that a third of the South African population engaged in risky drinking (especially over weekends). This is much higher than in similar populations in other countries, therefore GPs should be concerned about problem drinking. A study by Manwell et al. (1998) in the USA showed that of the people who visit primary care clinicians, 17% are problem drinkers and 5% are dependent drinkers. In another study done in the USA Curry et al. (2000) pointed out that amongst patients with advance appointments for routine primary care, they observed an 11% prevalence of problem drinking. A study that was undertaken by Tang et al. (2005) in China indicated that 15.8% of those who ever drank are daily drinkers (problem drinkers).

Patients with an overall high AUDIT score would be suspected to fall in the category alcohol dependent, but they scored low on the questions that indicate dependence. This is strange and could be due to bias when answering the questions. One would then wonder about the suitability of the questionnaire for South Africa, since the SADHS (1998) point out that 17,2% of the population was identified as alcohol dependent and one would have expected similar proportions in this study, since the proportions of problem drinkers are the same in both studies. It is noted, however, that in the SADHS a set of questions, known as the CAGE questionnaire, were used to identify alcohol dependence. It is shorter than the AUDIT, that was used in this study, but it is insensitive for hazardous or dependent drinking patterns (Mackenzie et al., 1996). The AUDIT is considered most effective in identifying subjects with hazardous or harmful drinking and alcohol dependence and was specifically designed for use in primary care settings (Saunders et al., 1993). It is also worth noting fact that the adult population of South Africa and the adult patients attending GPs' practices are not equivalent. Patients attending GPs' practices are more likely to be employed and can afford to pay, and people with higher educational levels (SADHS, 1998).

Findings in the SADHS (1998) suggest that symptoms of alcohol problems were significantly associated with lower socio-economic status, no or little school education, and being above 25 years of age. Although this is the perception shared by many people, it is evident from this study that this perception is not necessarily true. A large percentage of the participating patients reported that they were employed and lived in formal brick housing, yet over a third of the patients seen by GPs present with problem drinking. It is thus clear that GPs should see this situation in a serious light and they should be urged to address this problem in their practices in order to assist to alleviate the problem. It might

63

be that some of the problem drinkers are not at the point of dependence yet, but without any intervention the problem could increase to that point. An economically active population with alcohol-related problems are likely to exhibit a decreased productivity and an increase in absenteeism from work, with a high probability of eventually becoming unemployed themselves.

Profile of participating GPs:

The participating GPs represent a wide age range as well as a wide range of years of experience practising as general practitioners, therefore this representivity can be applied to real world settings. Almost all the GPs reported that they saw up to 30 patients per day and that they worked an average of 6 days per week. This allows for an average of 15 minutes consultation time per patient which can be considered a fairly manageable workload. Under such conditions GPs are given a good opportunity to enquire about "non-presenting" conditions such as problem drinking as part of their routine consultation. GPs in this study typically work in solo settings which means that patients are most likely to consult the same doctor over a period of time and this allows for continuity of care that could have a potentially positive impact on identifying and ameliorating alcohol-problems. In solo practices the potential exists for GPs to build up a relationship with their patients, and in most cases even the whole family, that makes enquiry about alcohol-related problems amongst their patients easier to effect.

Current practices in preventive medicine and early intervention for alcohol:

The present study indicates that all GPs recorded a whole range of physical symptoms that they report would elicit an enquiry by them about alcohol problems amongst their patients. However, only a few GPs listed only psychological and social symptoms that would induce them to enquire about alcohol problems. A possible explanation for this could be because virtually all the GPs (94%) affirmed that they had a "disease model training" rather than a "health promotion model of training". In her article Monteiro (1998) points out that traditionally treatment was given to those patients presenting with symptoms of dependence and withdrawal as well as severe medical and psychiatric problems. GPs listed few psychological and social symptoms that would trigger them to ask about alcohol amongst their patients and this could be because they felt awkward talking to their patients about their alcohol problems. This situation may cause GPs to miss the chance to help people with risky drinking patterns that don't present with physical symptoms. This is most likely the reason why, despite a high prevalence of problem drinking amongst their patients (34%), none of the GPs reported that they managed more than 50 patients for alcohol problems in the past year. The vast majority of GPs reported that they managed only 30 patients for alcohol problems in the past year. These factors above present a substantial challenge to re-orienting GPs towards a more active stance with regards to problem drinking identification and management. This challenge could theoretically be addressed by training on detection and ways of intervening. GPs will most likely engage in a more holistic approach to dealing with alcohol problems rather than relying mostly on the physical symptoms that patients present with. In the end it is possible that more GPs will then feel that it is rewarding to work with patients presenting with problem drinking.

It is therefore not surprising that such a large proportion of the GPs (68%) reported that they have received no post-graduate training on alcohol and alcohol-related problems, since if they had, one would have expected a substantially better performance than that shown above. In the case scenario, (Case A), more than seventy percent of GPs wrongly diagnosed the person who presented as a hazardous drinker as a dependent drinker. GPs also indicated the cut-off point for the upper limits of alcohol use as much lower than the recommended levels. With their apparent higher index of suspicion GPs should intervene earlier, yet GPs reported that such a low percentage of their clinical time was preventive in nature, and also that they requested blood tests because of concern about alcohol only a few times for all patients in the past year. Considering the lack of training and apparent lack of knowledge it should be noted that all GPs reported that they advise and educate their patients about lifestyle and health risks with an illness visit 'all the time'. Almost 90% of GPs reported that, given their current responsibilities, they put a 'very high' or 'somewhat high' priority on disease prevention in the surgery. This is encouraging, because despite them not actually practicing this, with appropriate training and support it is highly likely that GPs will increase their preventive clinical time, increase the number of patients they manage for alcohol problems as, well as increase their effectiveness to help these patients to prevent alcohol-related consequences.

On rating their preparedness when counselling patients in various health areas, GPs indicated that they feel more prepared to counsel patients about 'not smoking' (82% 'very prepared'), rather than counselling them about reducing alcohol consumption. Eliminating the stigma that a person with alcohol problems is an alcoholic will remove the awkwardness between GPs and their patients when it comes to talking about alcohol problems, it will also help to prevent alcohol-related consequences. Patients don't take

offence when their GPs ask them about their smoking habits and the same position can be reached with problem drinking. This is highly likely since already more than 80% of GPs reported their confidence level in helping the patient who drinks hazardously to alleviate his drinking problem or even to stop drinking altogether as either 'confident' or 'very confident', even in the case of the dependent drinker.

Although 70% of the GPs said they felt 'ineffective' in helping patients to achieve change in reducing alcohol consumption, it is very encouraging to note that almost eighty percent of GPs indicated that they could be 'effective' in helping patients reducing alcohol consumption when they (GPs) are given adequate information and training. Almost all GPs felt that when they are given more support they should get 'definitely involved' in helping patients to change behaviour by providing alcohol information and more than 60% felt that they should get 'definitely involved' in treating alcohol dependent drinkers. There is thus, as mentioned before, a definite need for more education and training (especially in methods for behaviour change) as well as for more support from other health providers working in the area of prevention of alcohol-related consequences for GPs in order to boost their effectiveness. Indeed it may be necessary to develop this area of work with other health care providers such as primary health care nurses, social workers, psychologists and even community health workers and the family of patients. This approach is certainly consistent with The White Paper for Transformation of the Health System in South Africa (1997) and the National Drug Master Plan (1999) in South Africa that have prioritised prevention and management of alcohol abuse and the integration of substance abuse in PHC.

When given appropriate support and adequate training it is possible that GPs might not just call problem drinkers back for a discussion on their alcohol use, they might get more involved in the treatment of such patients and less patients would have to be referred to an outside specialist for their drinking problems.

Role acceptance

When asked about role legitimacy all GPs felt that they had the right to ask their patients about drinking and that their patients felt the same. Regarding role adequacy almost all GPs felt that they know enough about the causes to handle alcohol problems and that they can advise patients about the effects of alcohol. Considering the above it becomes clear that GPs have the basic knowledge on alcohol problems, however, only a small percentage feel effective in helping people to change behaviour. This again indicates a clear need for interventions skills training rather than dissemination of information.
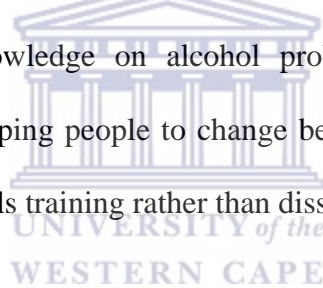
Screening and Brief Intervention (SBI):

People presenting with problem drinking are not likely to primarily seek help at formal substance abuse centres. They may not necessarily be dependent on alcohol, but they might have as many social and health problems as the dependent drinker. Since one third of all patients in this study, who attended GP practices, were identified as problem drinkers there is clear evidence that GPs should intervene to help prevent or at least minimise alcohol-related problems.

This seems to be doable for GPs because as mentioned almost all GPs reported that they work in solo practices. Also the reported manageable workload of GPs also lends itself to a higher likelihood of implementing interventions, because GPs can allow at least 15 minutes of consultation time per patient. This makes it possible to fit Screening and a Brief Intervention (SBI) into a standard consultation.

A brief intervention is a time-limited intervention focusing on changing patient behaviour with respect to alcohol consumption through motivational counselling. SBI for alcohol involves routine screening of the general practice population to identify 'at risk' drinkers and the subsequent delivery of brief structured advice. There are several brief interventions, but all of them comprise of no more than five to ten minutes of advice on reducing drinking, information on 'safe' levels of consumption and brief counselling and/or referral. There is strong evidence that SBI is effective. Randomised controlled trials over the past 12 years have demonstrated that excessive drinkers receiving SBI reduce their consumption by approximately 25 – 40% compared with controls receiving assessment only (Fleming et al., 1999).

Although progress has been made in developing a scientific basis for alcohol screening and brief intervention (SBI), training is necessary for its widespread dissemination in primary care settings, especially in developing societies. Since training in alcohol and alcohol-related problems is highlighted as a shortfall amongst GPs in this study it is essential that they should be introduced to a training programme that provides clear guidelines to the successful implementation of a brief intervention. The World Health Organisation (WHO) developed a training package, the SBI programme, for this purpose and the AUDIT as a tool has been successfully used in GP settings (WHO Working

Group, 1999; Fleming et al., 1999). Both were adapted to the South African context, e.g. in terms of standard unit of alcoholic drink and drinking limits. The AUDIT was translated and back translated according to scientific standard procedures into four of the major languages in the project area. The self-help booklet for patients and a handout on "cutting back" showing the drinking limits and health effects of risky alcohol consumption were also made available in Tsonga, Northern Sotho, Venda, and Afrikaans.

Perceived barriers and incentives to early intervention for alcohol:

GPs mentioned some barriers to their involvement in prevention work in the area of alcohol misuse. The barriers and incentives mentioned by the GPs in this study are very similar to those suggested by the 12-country study undertaken in Australia, Bulgaria, Canada, Denmark, France, Hungary, Italy, New Zealand, Norway, Poland, Russia and the UK (McAvoy et al. 2001). Amongst those mentioned were the lack of screening and counselling materials. Doctors also felt that they are inadequately trained in counselling for reducing alcohol consumption, that they have a disease model training and they don't think about prevention, that they do not know how to identify problem drinkers who have no obvious symptoms of excess consumption. GPs said that if these instruments and training programmes for early intervention were available that they would be willing to get involved in implementing interventions. GPs also felt that training in early intervention for alcohol should be recognized for continuing medical education. The accreditation of such training can be made possible by successful lobbying with the appropriate policy makers.

Lack of support by government health policies for doctors who want to practise preventive medicine, reimbursement by medical aids and government health schemes and the willingness of patients to pay a fee for alcohol counselling were further concerns mentioned by GPs. GPs asserted that the availability of support services, public health education, and proof of the effectiveness of alcohol interventions would be potential incentives for early intervening for alcohol misuse. Networking between other health care providers in the field of substance abuse could help alleviate the feeling of isolation GPs might experience when trying to help with alcohol-related problems. Public health education on alcohol could be implemented if GPs work closely with especially community based organisations and health initiatives suggested by health departments. The concern about paying for counselling services and the perception that GPs are too busy could be better understood if GPs recognised that they are actually not expected to do full blown counselling and that SBI should not be seen as separate from a standard consultation. Patients do pay a consultation fee and they would be responsible for the follow-up fee anyway should it be required. If GPs use the opportunity to build a good relationship with their patients in order to be able to ask them about their alcohol use, it is highly possible that patients would also feel comfortable to request health advice about alcohol consumption themselves. GPs will then also feel more comfortable to give advice to their patients and probably no longer have to feel that their patients would not take their advice and change their behaviour. Many of the concerns raised by GPs can be addressed by training in SBI. This will be discussed further in the recommendations.

Limitations of the study

- The questions (especially for patients) were of a very personal nature and it can be expected that some patients would have been inclined to minimise their alcohol consumption habits, which could have given rise to an underestimation of the prevalence.

- New GP practices and thus not listed in the telephone directory could not be included in the sample and they might differ in knowledge and practice habits from the established GPs.

- This study was urban-based and excluded GPs in non-urban areas so the results give no indication of the profile of GPs in peri-urban and rural areas and how they manage alcohol-related problems amongst their patients.

- The findings of this Quantitative study could be strengthened by a Qualitative study that explores the perceptions and feelings of GPs about their involvement in alcohol intervention. However, this Quantitative study allows identification of the most important factors affecting how GPs respond to interventions.

CHAPTER 6

CONCLUSION and RECOMMENDATIONS

Conclusion:

Since the results of this study show that more than a third of the adult patients attending GP practices in Cape Town present with problem drinking. GPs should indeed be concerned about problem drinking amongst their patients in general, but especially amongst males and patients in the age group 21-30 yrs.

GPs have the opportunity to give attention to problem drinking as part of their routine consultation, because of their fairly manageable workload and the fact that they work in solo family practice settings. It is also encouraging to note that almost all GPs reported that they are willing to put a high priority on disease prevention and that they are desirous of being able to help patients with problem drinking. However, a large proportion of GPs felt ineffective in helping patients to achieve change in reducing alcohol consumption. This was corroborated by the finding that a very high proportion of GPs reported that they rely on the presence of physical symptoms mainly to trigger an enquiry about alcohol problems amongst their patients. Their ineffectiveness could be influenced by the fact that problem drinking is normally associated with a combination of health problems and/or psychological and social disorders that are seldom highlighted in their training curriculum and which consequently are seldom taken into account by GPs. Further evidence of their ineffectiveness is that GPs indicated that they feel more prepared to counsel patients about not smoking than counselling them about alcohol consumption.

It was therefore not surprising that such a large proportion of GPs reported that they have received no post-graduate training on alcohol or alcohol-related problems. GPs mentioned some of the barriers to their involvement in prevention work to be a lack of training and support and a lack of counselling and screening materials. Despite these it is encouraging that most GPs felt that they could become effective in helping their patients, and that they are likely to get more involved in helping their patients reducing alcohol consumption, if they (GPs) are given adequate training and support from other health providers working in the area of alcohol-related problems. A definite need for training thus exists to enhance GPs' knowledge and skills to facilitate the implementation of effective alcohol interventions in their practices.

Recommendations:

- Training and education for GPs is essential in order to increase their knowledge and awareness of alcohol problems and to adequately equip them to identify and manage problem drinking amongst their patients.

  o Training should include:

    - Screening

    - Structured Brief Interventions

    - Counselling skills

- There is a need for other health care providers, such as primary health care nurses, social workers, psychologists and even community health workers, in the alcohol-related field, to support GPs working in the area of managing alcohol-related problems in order to increase their effectiveness and make them feel less isolated.

- Institutions like the Medical Research Council SA (MRC), Human Sciences Research Council (HSRC), and South African National Council for Alcoholism and Drug Dependency (SANCA) should advocate for the Health Professions Council and the South African Medical Association to prioritise interventions for problem drinking, and to have SBI training as a compulsory part of accredited continuous professional development.

- The SBI training programme developed by the WHO and screening instruments such as the AUDIT should be available to GPs since they mentioned the availability of suitable material as an incentive for carrying out more work in the area of problem drinking.

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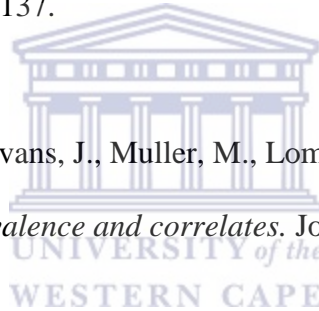
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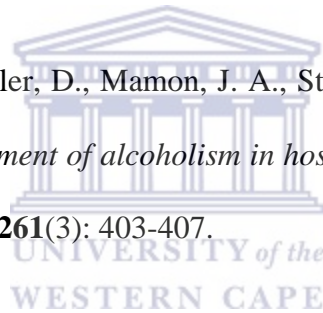
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Appendices

    A. Introduction and Consent form for GPs

    B. Questionnaire for GPs

    C. Introduction and Consent form for Patients

    D. Questionnaire for Patients

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25 November 2004

Dr _____

Address _____

Dear Dr _____

Re: Study to investigate the role of GPs in addressing problem drinking

INTRODUCTION

I am Fred Koopman, a research intern with the Alcohol and Drug Abuse Research Group (ADARG) at the Medical Research Council (MRC). For my Masters in Public Health mini-thesis at the University of the Western Cape I will be investigating the role of GP's in addressing problem drinking. My study methodology includes the systematic selection of GPs practicing in private settings in the Cape Town metropole. The study will also involve patients served by these GPs during the period of the study on any given day. The Director of ADARG, Prof. Charles Parry, can be contacted at the MRC at 938 0419 should you require details about the study in addition to those given below.

PURPOSE OF THE STUDY

Since no clear evidence can be found in the literature on the involvement of GPs in South Africa regarding early intervention to address alcohol related medical problems, the proposed study aims to investigate the role of GPs in addressing problem drinking in the Western Cape region. Depending on the level of involvement, recommendations will be made to both encourage GPs to more actively participate in the effective management of alcohol-related problems experienced by their patients and also to guide continuing education and other training initiatives aimed at GPs.

PROCEDURE OF THE STUDY

A self-administered questionnaire that will take about 15-20 minutes to complete will be made available to each consenting <u>GP</u> for completion. GPs will be asked to identify the

criteria and management strategies used by them (GPs) for patients with alcohol-related problems.

A 10-item questionnaire will be given for self-completion or interview to patients during normal surgery hours. The questions aim to determine the prevalence of alcohol misuse in <u>adult patients</u> attending GP settings. The time required to complete it is approx. 2 minutes. The researcher will distribute the questionnaires to the patients in the waiting room on a given day during the period of data collection for self-completion. After completion (about 5 – 10 min.), the questionnaires will be placed in an envelope to emphasize anonymity and handed to the researcher who will be available to assist with any problems that might arise in completing the questionnaire.

All efforts will be made to minimize the time required to conduct the survey. It is anticipated that I will only need to be in the surgery for about 30 minutes. During this time I expect the adult patients present to have completed the self-administered questionnaire. I will collect the GP questionnaires from the surgeries on the day when conducting the survey with patients.

PARTICIPANTS RIGHTS DURING THE STUDY

Participation in the study is voluntary (GPs and/or patients do not have to be part of the study). Participants will be free to withdraw from the study at any stage without having to state a reason for withdrawing.

ETHICAL APPROVAL

The study protocol has been given written approval by the Higher Degrees Commission of the University of the Western Cape.

SOURCES OF ADDITIONAL INFORMATION

If you have any questions or need more information, please feel free to contact:

Fred Koopman
Alcohol and Drug Abuse Research Group
Medical Research Council
P O Box 19070
Tygerberg
7505
Tel no: (021) 938 0364
Fax no: (021) 938 0342
E-mail: fred.koopman@mrc.ac.za

CONFIDENTIALITY

The confidentiality and anonymity of the participants will be guaranteed at all times. The completed questionnaires will be placed in an envelope and sealed. Only the research team at the MRC in Cape Town will see this information. Participants will not be required to write their names on the questionnaire. The participants' names and locations will not be used in any report of the results of the study. All the information obtained will be treated very privately.

CONSENT

I would be grateful if you would complete the form indicating your willingness to participate in this study. In addition, please provide information regarding the average number of patients attending your surgery on any given day. This information is required to prepare for the study and printing of questionnaires. Please return the completed GP consent form by fax to me at 938 0342.

I am also attaching a copy of the patient consent form that we intend using.

Yours sincerely

_____
Fred A. Koopman

GP CONSENT FORM

I hereby confirm that I have been informed by the researcher, Mr. Fred Koopman, about the purpose and procedure of the proposed study to investigate the role of GPs in addressing problem drinking.

Permission is hereby granted for the study to be conducted at my practice. (Please tick one box)

YES	
NO	

Name of GP:_____

Address of practice:_____

_____

_____

(If consenting): **Average number of patients on any given day:**

Morning: _____

Afternoon: _____

Signature:_____**Date**:_____

PLEASE RETURN THIS FORM BY FAX TO 938 0342

MANY THANKS

APPENDIX B

ID no

Questionnaire for General Practitioners

Please tick the box corresponding to your answer or write your answer where indicated.
All answers to this questionnaire will be treated in confidence.

1. How many years have you been practising as a general or family practitioner?

[   ] years

2. What is your age?

[   ]

3. What is your gender?

Male [   ]

Female [   ]

4. **Where is** your practice located?

Suburb:……………………………………………………………………………………………

Location: (specify if necessary)…………………………………………………………………...

5. Is you practice a:

Urban practice? [   ]

Rural practice

Mixed Urban/Rural practice

6. Is it a:

Solo practice? [   ]

Group practice? [   ]

Other? [   ] Please specify ………………………………………

7. How many partners are there in the practice, including yourself?

[   ]

8. How many days per week do you work in general practice?

[   ]

9. How many general practice patients would you see in an average week? (An estimate)

[   ]

10. In total, how many hours of post-graduate training, continuing medical education or clinical supervision **on alcohol and alcohol-related problems** have you ever received?

None [   ]

Hours [   ]

Other exposure [   ] Please specify:

91

11. On an average week, about what percentage of your total general practice clinical time would you say was **preventive** in nature? (*That is, visits where the patient's principal reason for the visit is primarily preventive care, such as annual or periodic check-ups, pre-natal, or pap smears etc.)*

_____ percent of time

12. As part of a **preventive check-up,** how often do you educate your patients or advise them about their lifestyles and health risks? Would you say –

All the time? ☐
Most of the time? ☐
Some of the time? ☐
Rarely or never? ☐

13. For patients who come in for an **illness visit**, that is, with specific symptoms, how often do you educate or advise them about their lifestyles or health risks? Would you say –

All the time? ☐
Most of the time? ☐
Some of the time? ☐
Rarely or never? ☐

14. If the patient doesn't ask you about alcohol, do you ask about it?

All the time? ☐
Most of the time? ☐
Some of the time? ☐
Rarely or never? ☐

15. Please list the typical conditions which elicit your talking about alcohol

_____

_____

_____

_____

_____

16. At the present time**, taking into consideration all your current responsibilities** with patients, how high a priority do you place on **disease prevention** as an aspect of your practice?

Very high ☐
Somewhat high ☐
Somewhat low ☐
Very low ☐

17. **Compared to other medical practitioners** you know, how much **emphasis** do you place on disease prevention in your practice?

Much more ☐
Somewhat more ☐
Somewhat less ☐
Much less ☐

18. The following are behaviours that some health professionals believe to be related to health. How important do you think each of the following behaviours are in **promoting the health of the average person?** *(Please circle one number for each).*

Behaviour	Very important	Important	Somewhat important	Unimportant
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Drinking alcohol moderately	4	3	2	1
d. Not drinking alcohol at all	4	3	2	1
e. Avoiding excess calories	4	3	2	1

f. Reducing stress	4	3	2	1
g. Responsible use of prescription drugs	4	3	2	1
h. Not using illicit drugs	4	3	2	1

19. Please indicate **the extent to which you obtain information** on your patients in each of the following areas: *(Please circle one for each)*

Behaviour	Always	As indicated	Occasionally	Rarely/Never
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Drinking alcohol moderately	4	3	2	1
d. Not drinking alcohol at all	4	3	2	1
e. Avoiding excess calories	4	3	2	1
f. Reducing stress	4	3	2	1
g. Responsible use of prescription drugs	4	3	2	1

20. Doctors vary in their counselling skills and training. How **prepared** do you feel when counselling patients in each of these areas: *(Please circle one for each).*

Behaviour	Very Prepared			Very Unprepared
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Reducing alcohol consumption	4	3	2	1
d. Avoiding excess calories	4	3	2	1
e. Reducing stress	4	3	2	1
f. Responsible use of prescription drugs	4	3	2	1
g. Not using illicit drugs	4	3	2	1

21. How **effective** do you feel you are in helping patients achieve change in each of the following areas? (*Please circle one number for each*).

Behaviour	Very Effective			Very Ineffective
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Reducing alcohol consumption	4	3	2	1
d. Avoiding excess calories	4	3	2	1
e. Reducing stress	4	3	2	1
f. Responsible use of prescription drugs	4	3	2	1
g. Not using illicit drugs	4	3	2	1

22. In general, **given adequate information and training**, how **effective** do you feel general practitioners **could** be in helping patients change behaviour in each of the following areas? *(Please circle one number for each).*

Behaviour	**Very Effective**			**Very Ineffective**
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Reducing alcohol consumption	4	3	2	1
d. Avoiding excess calories	4	3	2	1
e. Reducing stress	4	3	2	1
f. Responsible use of prescription drugs	4	3	2	1
g. Not using illicit drugs	4	3	2	1

23. For a **healthy adult man**, what would you consider the **upper limit** for alcohol consumption before you would advise him to cut down?

Please record as ………………………… grams of alcohol per week

or as ……………………….. standard drinks* per week

For a **healthy adult woman**, who is not pregnant, what would you consider the **upper limit** for alcohol consumption before you would advise her to cut down?

Please record as ………………………… ml of alcohol per week

or as ……………………….. **standard drinks*** per week

* 1 standard drink = 1 bot (pint) of beer (330ml) = 1 glass of wine (125ml) = 1 small glass of sherry or port = 1 single measure (tot) of spirits (25ml)

24. **Case History A**

Mr M is a 48 year old man who presents for a physical examination. The patient lives alone and has been a member of your practice for about three years.   He has attended intermittently during this time. He provides a history of sleep disturbance, which consists of waking some 3-4 hours after falling asleep and then experiencing difficulty getting back to sleep. He also reports occasional dyspepsia relieved by ingestion of alkali preparations from the chemist. Upon your inquiry, he reports giving up smoking about four years ago. He does, however, report drinking alcohol and states that his average weekly consumption is about 20 bottles (330ml) of beer and about 5-6 glasses of table wine. History and functional inquiry are unremarkable in all other respects.

On physical examination, the patient is noted to be moderately obese, of neat appearance and otherwise unremarkable. Pulse was 88 beats per minute and regular. Blood pressure was 144/94. Respiratory rate was 20 per minute. The remainder of the physical examination was completely normal.

With respect to Mr M's use of alcohol: *(Please circle on number for each question).*

a. Please **rate the severity** of this particular patient's drinking

Not a problem									An extremely severe problem
0	1	2	3	4	5	6	7	8	9

b. Please rate the **importance** for this particular patient to **stop drinking** altogether.

Of no importance									The greatest possible importance
0	1	2	3	4	5	6	7	8	9

c. Please rate **your confidence** in helping this particular patient to alleviate drinking problems even if not to stop altogether

No confidence									The greatest possible confidence
0	1	2	3	4	5	6	7	8	9

Which of the following **courses of action** would you take, if you were his general practitioner?
(Please tick one box for each question).

d.	Ask some further questions about drinking to gauge the possibility of an underlying alcohol problem	Yes ☐	No ☐
e.	Indicate that alcohol is possibly related to some of his associated problems	Yes ☐	No ☐
f.	Record Mr M's weekly alcohol consumption in the chart but otherwise take no action concerning his use of alcohol at this time	Yes ☐	No ☐
g.	Record Mr M's weekly alcohol consumption in the chart and advise him to cut back on his drinking	Yes ☐	No ☐
h.	Record Mr M's weekly alcohol consumption in the chart and advise him to abstain completely from alcohol	Yes ☐	No ☐
i.	Order a complete blood count, indices and liver enzymes	Yes ☐	No ☐
j.	Ask Mr M to return for a discussion of his alcohol use	Yes ☐	No ☐
k.	Refer Mr M to an outside specialist/agency for his drinking	Yes ☐	No ☐

25.   **Case History B**

Mr R is a 54 year old man presenting with a chest infectioninvolving the lower respiratory tract. The patient lives on his own and first attended your practice about three and a half years ago. He has attended intermittently during this time. His chest infection has been recurring and this is the third presentation in the past 12 months. The patient was a heavy smoker but reports giving it up about five years ago. He does, however, report drinking alcohol and states that his weekly consumption averages about 20 bottles (330ml) of beer and one bottle of vodka.

Investigation reveals evidence of early pneumonia. On examination of his abdomen, his liver is significantly enlarged with a firm, tender lower border. He has a fine tremor in his hands and his blood pressure was noted to be 180/110

With respect fo Mr R's use of alcohol: *(Please circle one number for each question).*

a.   Please **rate the severity** of this particular patient's drinking

Not a problem								An extremely severe problem
0	1	2	3	4	5	6	7	8	9

b.   Please rate the **importance** for this particular patient to **stop drinking** altogether.

Of no importance								The greatest possible importance
0	1	2	3	4	5	6	7	8	9

c.   Please rate **your confidence** in helping this particular patient to alleviate drinking problems even if not to stop altogether

No confidence								The greatest possible confidence
0	1	2	3	4	5	6	7	8	9

Which of the following **courses of action** would you take, if you were his general practitioner?
(Please tick one box for each question).

		Yes	No
d.	Ask some further questions about drinking to gauge the possibility of an underlying alcohol problem		
e.	Indicate that alcohol is possibly related to some of his associated problems		
f.	Record Mr R's weekly alcohol consumption in the chart but otherwise take no action concerning his use of alcohol at this time		
g.	Record Mr R's weekly alcohol consumption in the chart and advise him to cut back on his drinking		
h.	Record Mr R's weekly alcohol consumption in the chart and advise him to abstain completely from alcohol		

i.	Order a complete blood count, indices and liver enzymes	**Yes** ☐	**No** ☐
j.	Ask Mr R to return for a discussion of his alcohol use	**Yes** ☐	**No** ☐
k.	Refer Mr R to an outside specialist/agency for his drinking	**Yes** ☐	**No** ☐

26. Indicate how much you agree or disagree with each of the following statements about working with **"problem drinkers".** For this part of the question, "problem drinkers" refers to **people who drink heavily or experience occasional problems with drinking**, but who do **not** have a history of dependence on alcohol

Statement	Strongly agree	Agree	Disagree	Strongly disagree
a. I feel I know enough about the causes of drinking problems to carry out my role when working with problem drinkers	7	5	3	1
b. I feel I can appropriately advise my patients about drinking and its effects	7	5	3	1
c. I feel I do not have much to be proud of when working with drinkers	7	5	3	1
d. All in all I am inclined to feel a failure with drinkers	7	5	3	1
e. I want to work with drinkers	7	5	3	1
f. Pessimism is the most realistic attitude to take towards problem drinkers	7	5	3	1
g. I feel I have the right to ask patients questions about their drinking when necessary	7	5	3	1
h. I feel that my patients believe I have the right to ask them questions about drinking when necessary	7	5	3	1
i. In general it is rewarding to work with drinkers	7	5	3	1
j. In general, I like problem drinkers	7	5	3	1

27. Indicate how much you agree or disagree with each of the following statements about working with people who are **dependent on alcohol or have a severe problem with alcohol.**

Statement	Strongly agree	Agree	Disagree	Strongly disagree
a. I feel I know enough about the causes of drinking problems to carry out my role when working with "alcoholics"	7	5	3	1
b. I feel I can appropriately advise my patients about drinking and its effects	7	5	3	1
c. I feel I do not have much to be proud of when working with drinkers	7	5	3	1
d. All in all I am inclined to feel a failure with drinkers	7	5	3	1
e. I want to work with drinkers	7	5	3	1
f. Pessimism is the most realistic attitude to take towards "alcoholics"	7	5	3	1

g. I feel I have the right to ask patients questions about their drinking when necessary	7	5	3	1
h. I feel that my patients believe I have the right to ask them questions about drinking when necessary	7	5	3	1
i. In general it is rewarding to work with drinkers	7	5	3	1
j. In general, I like "alcoholics"	7	5	3	1

28. In the last year, how many times have you taken or requested a blood test (*eg blood alcohol, MCV, GGT*) **because of concern** about alcohol consumption? *(An estimate).*

> …………………times

29. In the last year, about how many patients have you managed specifically for their problem drinking or alcohol-related problems? *(An estimate).*

30. In general, **given appropriate support**, to what extent do you feel General Practitioners **should** be involved in helping patients change behaviour in each of the following areas?

Behaviour	Definitely involved			Definitely not involved
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Promoting non-hazardous alcohol consumption	4	3	2	1
d. Providing alcohol information	4	3	2	1
e. Treating alcohol dependent drinkers	4	3	2	1

31. The final two questions are about early intervention for hazardous* alcohol consumption. This involved screening patients to identify those whose alcohol consumption places them at increased risk of disease, and then counselling identified problem drinkers* about reducing their alcohol consumption.
*Those whose alcohol consumption places them at increased risk of disease

Inquiries in a number of countries have revealed that many doctors in general practice spend very little or no time at all on early intervention for alcohol. A variety of reasons have been suggested as to why this might be so. For each one please indicate to what **extent you think that reason applies** by circling the appropriate number.

Statement	Very much	Quite a bit	Little	Not at all	Don't know
a Alcohol is not an important issue in general practice	5	4	3	2	1
b. Doctors are just too busy dealing with the problems people present with	5	4	3	2	1
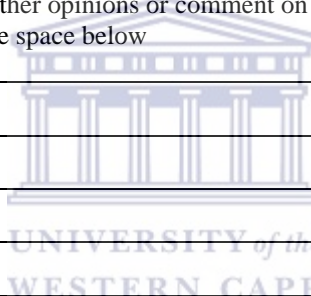
Statement					
c. Doctors have a disease model training and they don't think about prevention	5	4	3	2	1
d. Doctors think that preventive health should be the patients responsibility not theirs	5	4	3	2	1
e. General practices are not organised to do preventive counselling	5	4	3	2	1
f. Doctors feel awkward about asking questions about alcohol consumption because saying someone has an alcohol problem could be seen as accusing them of being an alcoholic	5	4	3	2	1
g. Doctors do not know how to identify problem drinkers who have no obvioius symptoms of excess consumption.	5	4	3	2	1

Statement	Very much	Quite a bit	Little	Not at all	Don't know
h. Doctors do not have a suitable screening device to identify problem drinkers who have no obvious symptoms of excess consumption	5	4	3	2	1
i. Doctors do not have suitable counselling materials available	5	4	3	2	1
j. Doctors are not trained in counselling for reducing alcohol consumption	5	4	3	2	1
k. Doctors believe that alcohol counselling involves family and wider social effects, and is therefore too difficult	5	4	3	2	1
l. Doctors do not believe that patients would take their advice and change their behaviour	5	4	3	2	1
m. Doctors themselves have a liberal attitude to alcohol	5	4	3	2	1
n. Doctors themselves may have alcohol problems	5	4	3	2	1
o. Doctors believe that patients would resent being asked about their alcohol consumption	5	4	3	2	1
p. The government health scheme does not reimburse doctors for time spent on preventive medicine	5	4	3	2	1
q. Government health policies in general do not support doctors who want to practise preventative medicine	5	4	3	2	1
r. Medical Aids do not reimburse patients for alcohol counselling by doctors in general practice	5	4	3	2	1

32. Doctors in a number of countries have suggested a variety of things that could lead to more doctors doing early intervention for hazardous alcohol consumption. Please indicate for each item **to what extent it would encourage you** personally to do more early intervention for hazardous alcohol consumption, by circling the appropriate response.

Statement	Very much	Quite a bit	Little	Not at all	Don't know
a. Public health education campaigns in general made society more concerned about alcohol	5	4	3	2	1
b. Patients requested health advice about alcohol consumption	5	4	3	2	1

c.	Patients were willing to pay a fee for alcohol counselling	5	4	3	2	1
d.	Quick and easy screening questionnaires were available	5	4	3	2	1
e.	Quick and easy counselling materials were available	5	4	3	2	1
f.	Early intervention for alcohol was proven to be successful	5	4	3	2	1
g.	Training programs for early intervention for alcohol were available	5	4	3	2	1
h.	Training in early intervention for alcohol was recognised for continuing medical education credits	5	4	3	2	1
i.	Providing early intervention for alcohol was recognised for quality assurance credits	5	4	3	2	1
j.	Support services were readily available to refer patients to	5	4	3	2	1
k.	Salary and working conditions were improved	5	4	3	2	1
l.	Other 1: (Explain)					
m.	Other 2: (Explain)					
n.	Other 3: (Explain)					

33. If you would like to express further opinions or comment on the questionnaire or any other aspect of alcohol problems, please use the space below

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Adapted from the WHO Collaborative Study questionnaire

AN INVESTIGATION OF GP PARTICIPATION IN ADDRESSING PROBLEM DRINKING

PARTICIPANT INFORMATION AND CONSENT FORM

INTRODUCTION

You are invited to participate in a study conducted by the University of the Western Cape and the Medical Research Council to investigate the role of GPs in addressing alcohol-related problems. You will be asked to complete a 10-item questionnaire. You may refuse to take part if you are not completely clear and happy about the procedures involved.

PURPOSE OF THE STUDY

The main purpose of the study is to determine whether GPs address alcohol-related problems in their practices. The information is being obtained from GPs themselves. We are also conducting a patient survey (this survey) to assess the drinking behaviour of patients attending GP practices in Cape Town. You will be asked questions about your alcohol use and you will complete the questionnaire in the doctor's surgery. (You may ask for assistance at any time).

ETHICAL APPROVAL

The study protocol has been given written approval by the Higher Degrees Committee of the University of the Western Cape.

RISKS and PARTICIPANTS' RIGHTS INVOLVED IN THE STUDY

The only potential risk involved in the study is the chance that some of the participants may feel uncomfortable about some of the questions, as they could be perceived as sensitive. Participation in the study is entirely voluntary and you may withdraw at any time without giving any reasons. Refusing to be part of the survey will not affect your treatment with the doctor in any way.

THE BENEFITS INVOLVED IN THE STUDY

The information gained from this study may help to encourage more GPs to actively participate in the effective management of alcohol-related problems amongst their patients. The aim is to reduce alcohol-related medical or other problems among communities living in Cape Town

CONFIDENTIALITY

The confidentiality of information and the anonymity of participants will be guaranteed at all times. The completed questionnaires will be placed in an envelope and sealed. You will not be required to write your name on the questionnaire. Your name will not be used in any report of the results of the study. All the information obtained will be treated very privately.

Please ask me if you have any questions about matters that are not fully clear to you.

INFORMED CONSENT FORM

I hereby confirm that I have been informed by the researcher about the purpose and procedure of the study to investigate the role of GPs in addressing problem drinking.

I have also received, read and understood the above written information regarding the risks and benefits of the study. I am aware that all information will be treated confidentially and that the results of the study, including personal details will be anonymously processed into a study report.

I may at any stage, without prejudice, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

Participant's name (please print):_____

Participant's signature:_____

Date:_____

Signature of witness:_____

Date:_____

Please ask me if you have any questions that are not fully clear to you.

SOURCES OF ADDITIONAL INFORMATION

If you have any questions or need more information, please feel free to contact:

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Alcohol and Drug Abuse Research Group
Medical Research Council
P O Box 19070
Tygerberg
7505

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QUESTIONNAIRE FOR PATIENTS
GP PARTICIPATION STUDY

1. DEMOGRAPHIC INFORMATION

Survey Reference number		
Date of interview		
Place of interview	Suburb: Location:	

1.1 Gender of respondent	1. = Male 2. = Female	
1.2 How old are you in years?		

1.3 What is the name of the area in which you live/reside on a regular basis?

Suburb: _____

Town/Village: _____

1.4 What type or style of dwelling structure do you live in?

1. = Formal brick & mortar house	8. = Shack/imonjondolo
2. = Town house	9. = Temporary shelter
3. = Block of flats/apartments	10. = Caravan
4. = Out-building /khaya/ outside room	11. = Tent
5. = Rent a single room in a house	12. = No fixed residence; on the street
6. = Traditional rural African hut/house	13. = Hostel
7. = Mud and wood structure	14. = Other: (specify)_____

1.5 How many people live at your place of residence?: (number)

1.6 What is your current marital status?

1. = Single, never married	4. = Divorced
2. = Married	5. = Living with lover/partner
3. = Separated	6. = Widowed

1.7 What is the highest level of school qualification you personally have achieved?
(Circle grade/ option)

None	Gr. 1	Gr. 2	Gr. 3	Gr. 4	Gr. 5	Gr. 6	Gr. 7	Gr. 8	Gr. 9	Gr.10	Gr.11	Gr.12	Tertiary

1.8 Which of the following describes your work situation?

1. = Employed full-time	8. = Retired
2. = Employed part-time	9. = Disabled
3. = Self-employed	10. = Unemployed
4. = Student	11. = Other (specify)_____
5. = Homemaker	

1.9 What is the highest post school qualification you have achieved?

1. = Technikon diploma / degree obtained	4. = Technical certificate
2. = University degree obtained	5. = Secretarial certificate
3. = Professional certificate	6. = Other: (specify) _____

2. Screening for Problem Drinking

<div style="border:1px solid">

The Alcohol Use Disorders Identification Test (AUDIT)
CHOOSE AN APPROPRIATE ANSWER WITH AN (X)

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

   ☐ Never   ☐ 2 to 3 times a week

   ☐ Monthly   ☐ 4 or more times a week

   ☐ 2 to 4 times a month

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

   * LOOK AT THE ILLUSTRATIONS OF A STANDARD DRINK ON THE LAST PAGE

   ☐ 1 or 2   ☐ 7 to 9

   ☐ 3 or 4   ☐ 10 or more

   ☐ 5 or 6

3. How often do you have 6 or more drinks on one occasion?
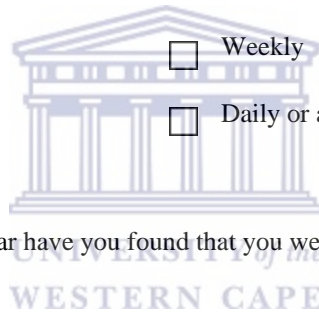
   ☐ Never   ☐ Weekly

   ☐ Less than monthly   ☐ Daily or almost daily

   ☐ Monthly

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

   ☐ Never   ☐ Weekly

   ☐ Less than monthly   ☐ Daily or almost daily

   ☐ Monthly

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

   ☐ Never   ☐ Weekly

   ☐ Less than monthly   ☐ Daily or almost daily

   ☐ Monthly

</div>

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

    ☐ Never   ☐ Weekly

    ☐ Less than monthly   ☐ Daily or almost daily

    ☐ Monthly

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

    ☐ Never   ☐ Weekly

    ☐ Less than monthly   ☐ Daily or almost daily

    ☐ Monthly

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

    ☐ Never   ☐ Weekly

    ☐ Less than monthly   ☐ Daily or almost daily

    ☐ Monthly

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

    ☐ No   ☐ Yes, during the past year.

    ☐ Yes, but not in the past year

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

    ☐ No   ☐ Yes, during the past year.

    ☐ Yes, but not in the past year

The Alcohol Use Disorders Identification Test (AUDIT). *WHO Collaborative Project On Early Detection Of Persons With Harmful Alcohol Consumption--II. Addiction 1993;88:791-804*

Quantities of different drinks that are the same as ONE standard drink

1 glass wine (125ml)	1 single measure spirits (25ml)	1 bottle beer/cider (330ml)	1 can beer/cider (330ml)	1 carton ijuba (1L)	R2-00 jar isiqatha/injemane

The number of standard drinks in commonly purchased quantities of alcohol

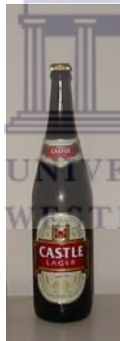|					Isiqatha or injemane		
1 bottle spirits (750ml)	1 bottle wine (750ml)	1/2 bottle spirits (375ml)	1 quart beer/cider	Double measure spirits (50ml)	R4-00 jar	R2-00 jar	R1-00 jar
30	6	16	2	2	2	1	1/2