

## Will brief interventions in primary care change the heavy drinking culture in New Zealand?

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The state of alcohol in New Zealand has recently been examined by the Law Commission in the most comprehensive review ever conducted. The findings were an engrained normalised heavy drinking culture, causing enormous harm to individuals, families and society as a whole, and being driven by the “unbridled commercialisation of alcohol”.<sup>1</sup>

The Law Commission’s strongest recommendations were consistent with the best international evidence available, assembled in a World Health Organization (WHO)-sponsored publication “Alcohol: No Ordinary Commodity”.<sup>2</sup> These measures have been publicised as the 5+ Solution by a national alcohol advocacy group, Alcohol Action NZ<sup>3</sup> as follows:

1. Raise alcohol prices.
2. Raise the purchase age.
3. Reduce alcohol accessibility.
4. Reduce advertising and sponsorship.
5. Increase drink-driving countermeasures.

PLUS: Increase treatment opportunities for heavy drinkers.

These principles were endorsed by an authoritative *Lancet* review of effective alcohol policy<sup>4</sup> and reiterated in a second edition of the WHO publication.<sup>5</sup>

The evidence for reducing population-based alcohol-related harm through treatment of individuals with alcohol problems (the final principle of the 5+ Solution) is primarily associated with wide availability of brief interventions for heavy drinkers, rather than specialist treatment of people with alcohol addiction. This is why the Gifford and colleagues’ Whanganui research—in this issue of the *NZMJ*<sup>6</sup>—on the feasibility of conducting such interventions in primary care is important.

Brief alcohol interventions have been shown to have modest efficacy in research trials in primary care.<sup>7</sup> When the results of 21 randomised controlled trials investigating over 7000 patients were combined, patients on average reduced their drinking by about 6 standard drinks per week.

If there was a reduction of about 6 standard drinks on average across all drinkers in the population, there would be a significant impact on alcohol-related harm in New Zealand. The critical question therefore is whether these brief interventions can be effectively undertaken in primary care settings in a routine ongoing manner, like taking a patient’s blood pressure.

The Whanganui research is pioneering work which does not reflect routine primary care practice at the current time. The study provided financial compensations and enjoyed the dedicated ongoing support and encouragement of the Alcohol Advisory Council of New Zealand throughout. Further, the study was resourced with excellent information technology support providing electronic reminders to undertake alcohol screening and facilitated recording of results. Finally, the research was fortunate to have a medical champion with a long-record of specific interest and leadership.

Despite these special conditions, the study was still only able to screen 43% of all patients enrolled with the clinics involved over a 10-month period, dropping to 36% of Māori. Although these results are nevertheless impressive given the state of alcohol in New Zealand, only 1 of the 15 clinics achieved over 70% screening. It is going to take perhaps a 90% screening rate across 90% of primary care practices to really begin to impact on the heavy drinking culture in New Zealand as a whole.

The Whanganui research results are arguably the best that can be achieved at the current time and provide an excellent model to follow and try to improve. But it is a major challenge to screen for a condition in clinical practice that is essentially a normative social behaviour being condoned by a government unwilling to lead any substantial change.

At least 25% of New Zealand drinkers over the age of 15 have an Alcohol Use Disorders Identification Test (AUDIT) score of 8 or more indicating heavy drinking,<sup>8</sup> which approximates to 700,000 heavy-drinking citizens. These are the group particularly targeted by the alcohol industry and daily shepherded along through \$300,000+ of alcohol advertising and sponsorship (personal correspondence, Prof Sally Casswell, Massey University, 2010). Over half of alcohol industry profit is derived from these heavy drinkers.<sup>9</sup>

The Government continues to allow unrelenting promotion of alcohol as a normalised and glamorised product (like tobacco was in the past) and ultra-cheap alcohol for sale, sold virtually everywhere, anytime. It also continues to turn a blind eye to heavy drinkers continuing to drive their private motor vehicles in a drunken state while still under the legal drink-driving limit. Under these conditions, doctors and nurses are inevitably going to find it hard to swim against the tide and undertake effective clinical practice in the area of heavy drinking.

The Government has congratulated itself on incorporating 130 of the 153 final recommendations of the Law Commission into the Alcohol Reform Bill, which was the work of the Hon Simon Power, Minister of Justice in the previous government, and now being carried on by Hon Judith Collins in the same role. But this governmental response is conspicuous by the absence of all the major evidence-based measures that could make a real difference in influencing the excessive commercialisation of alcohol—effective regulation of marketing, pricing, trading hours and adult drink-driving limits—and therefore the nation's heavy drinking culture.

Screening for cigarette smoking in New Zealand's health care settings is now as routine as measuring patients' blood pressure. However, this has only come about following bold legislative moves which dismantled all tobacco promotion,

progressively increased the price of cigarettes, and began to place barriers up to the accessibility of tobacco for sale.

Screening for heavy drinking in New Zealand's health care settings remains somewhat out of step with social mores. This results in an inevitable degree of ambivalence on the part of primary health care practitioners to undertake this work, when with limited time they are also expected to routinely screen for (the more socially acceptable) breast and cervical cancers, immunisation status, cardiovascular risk factors, diabetes and smoking.<sup>10</sup>

As long as the Government refuses to lead a legislative public health programme to change the free-market commercial environment, brief alcohol interventions in primary care are unlikely to flourish, but will continue to be dependent on clinical champions and special incentives. Under these conditions the nation's heavy drinking culture is not going to change through brief interventions in primary care.

However, the latest Health Sponsorship Council survey<sup>11</sup> revealed high levels of public support for bold new alcohol policies in the areas of advertising and sponsorship, pricing, purchase age, liquor outlet density and trading hours. These findings suggest that the necessary legislative changes are now likely in the not too distant future. Then routine brief interventions in primary care will be widely undertaken and be an integral part of changing the heavy drinking culture.

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