U.S. and European Physicians - Strategies for A New Medical/Public Health Framework for Discussing Alcohol

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Reducing the Harm Caused by Alcohol: A Coordinated European Response

Tuesday, October 13, 2007

Royal College of Physicians, London, UK

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TOGETHER WE ARE STRONGER

US Frame of Reference – youth data

2005 YRBS - **sizeable youth population engaging in risky alcohol-related behaviors (last 30 days)** [CDC MMWR June 9, 2006]

- **43.3% grades 9 -12 (50.% of 12th graders) had at least one drink**
- **25.5% binged (5 or more drinks in a row)**
- **28.5% rode one or more times with drinking driver**
- **9.9% (19.2% of 12th grade males) drove after drinking**
- **23.3% of currently sexually active students drank or used other drugs before last sexual intercourse**

Negative consequences of underage drinking cost the US $62 billion per year (medical costs, lost productivity & quality-of-life costs due to motor-vehicle crashes, violence, property crime, suicide, burns, drowning, fetal alcohol syndrome, high-risk sex, poisonings, psychoses & dependency treatment). [Miller TR, Levy DT, Spicer RS, Taylor DM. Societal costs of underage drinking. *J Studies Alcohol and Drugs* 67: 519-528, 2006.]

Alcohol a leading contributor to the main cause of death—injury—for people under age 21 (ca. 5,000 deaths/yr related to underage drinking) - result of motor-vehicle crashes, unintentional injuries from other causes, homicides, and suicides. Faden V.B., Goldman M. (Co-Chairs), NIAAA Interdisciplinary Team on Underage Drinking Research. Alcohol development in youth – a multidisciplinary overview: The scope of the problem. *Alc Res & Health* 28(3):111-120, 2004/2005.

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Huge Number/Complexity of State and Local Governmental Bodies Influence Alcohol Policy, Commerce, Health Services, Education

- 50 state legislatures
- 50 state judicial systems
- 50 state executive seach with own
  - Alcohol/liquor control & licensing boards
  - Tax collections
  - Liquor and highway traffic enforcement
  - Health departments
  - Social services
  - Medical/professional licensing
  - State education departments
- 16 states involved in some way with alcohol sales (Control States)
- Local licensing, enforcement, judicial authorities
- Local (municipal, county) regulatory & health authorities: zoning, permits, advertising, sales taxes, public health, school boards, addiction services
- State and federal excise taxes
- State & local sales taxes

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Complex Federal Structures

Congress

Judiciary

Office of the President:

- Drug Czar's Office – fund coalitions, no alcohol related mandate

Alcohol research:

- National Institute on Alcohol Abuse and Alcoholism (NIAAA)/NIH – primarily biomedical & etiological research
- National Academy of Science –Institute of Medicine (identify research, issues, directions)
- CDC Alcohol Team (small epidemiology group)

Regulatory (tax, manufacture, sales, trade, advertising)**:**

- Alcohol and Tobacco Tax and Trade Bureau (Dept. of Treasury)
- Federal Trade Commission
- Federal Communications Commission
- Interstate Commerce Commission

Policy, funding, implementation research branches:

- National Highway Traffic Safety Admin. (NHTSA)
- Substance Abuse and Mental Health Services Admin.
  - Center for Substance Abuse Prevention
  - Center for Substance Abuse Treatment
  - National Clearinghouse for Alcohol and Drug Information

Plus various population surveys, special focus programs (cancer, worksite, aging, housing)

Key national concerns

- **Key consumer watchdog group (Food and Drug Administration)**: by law can not review, control alcohol or tobacco (they're not drugs or foods)
- **Federal Trade Commission - primary consumer protection agency:**
  - uses alcohol industry data regarding its advertising to kids (voluntary industry codes dominate)
  - underage drinking "prevention" campaign primarily uses alcohol industry materials
- **No government or private foundation funds research about alcohol industry behaviors** (except advertising impact on youth) – little support for alcohol policy advocacy
- **Alcohol not treated as a drug food or carcinogen**
- **No federal mass media alcohol campaigns since 1980's** (other than impaired driving)
- **Government agencies fear reprisals if they counter industry economic interests or messages**
- **Courts consistently support industry rights to free speech** –i.e., to advertise without restriction

Key US Medical Players in Alcohol issues

Comprehensive policy concerns:

- American Medical Association (AMA),
- Amer. College of Emergency Physicians,
- Amer. College of Surgeons,
- Amer. College of Preventive Medicine,
- American Public Health Association (APHA),
- Physicians & Lawyers for National Drug Policy

Treatment focus:

- Amer. Society of Addiction Medicine (ASAM),
- Amer. Psychiatric Association (APA)

Youth & Family focus:

- Amer. Academy of Pediatrics (AAP),
- Society of Adolescent Medicine (SAM),
- Amer. Academy of Family Physicians (AAFP)
- Amer. College of Obstetricians and Gynecologists (ACOG)

Physician education:

- Assoc. for Medical Education & Research in Substance Abuse (AMERSA);
- Amer. Assoc. of Medical Colleges (AAMC);
- Amer. Council for Continuing Medical Education (ACCME);
- Amer. Council for Continuing Graduate Medical Education (ACCGME);
- State and specialty medical examining and licensing boards

Ad hoc groups:

Screening and Brief Intervention collaboration (to promote training, use, funding)

White House Leadership Conferences & work groups on medical education on substance abuse

Some US peculiarities to note

- Health care and public health systems are separate and often do not interact
- Alcohol services: public services often handled through social service departments & substance abuse treatment in separate health system (often non-medical)
- Federal and many state public health agencies by and large do not focus on alcohol (or other drug abuse) – they do address tobacco

  CDC only has small alcohol focus – they work with state and local health
- A separate system and federal agencies handle substance abuse but at the federal level alcohol is separated from other drug issues (separate national institutes: drug abuse; alcohol)
- States vary – some state health departments handle alcohol, tobacco, illicit drugs but usually tobacco split off into public health, alcohol/other drugs into state drug abuse agency

Alcohol in U.S. Primary Care

- **Patients with all stages of alcohol problems frequently seen in clinical settings** (McDonald, 2004).
- **Patients screened in 22 primary care practices: 9% at-risk drinkers, 8% problem drinkers, 5% alcohol-dependent.** (Manwell 1998):
- **7-20% of patients in outpatient settings, 30-40% in emergency depts. & 50% of trauma patients meet criteria for an alcohol use disorder** (Saitz 2005):.
- **Compared to other primary care patients, binge drinkers have higher rates of related problems (injury, hypertension), utilize 1.5 times more primary care visits, engender higher per patient costs (psychiatry, emergency room, pharmacy)** (Mertens 2005):

Physicians in primary care

- **Widespread belief that intervention is part of their caregiver's role.**
- **National physician survey**:
  - *88% usually or always ask new patients about alcohol use,*
  - *82% routinely offer intervention to problem drinkers*
  - *only 13% use formal alcohol screening tools - so accuracy of their screening is not measurable.* (Friedmann 2000)

Physicians in primary care

- **Use of clinical practice guidelines and provision of clinical services regarding most types and levels of alcohol problems varies widely in level and consistency**
- *(An, 2004; Denny, 2002; DePue, 2002; Gunderson, 2005; Hartmann, 2004; McMenamin, 2003; Puffer & Rashidian, 2004; Sand, 2005; Winickoff, 2003)*

- **Physicians lack requisite skills & familiarity with screening tools - " *94%--of primary care physicians fail to diagnose substance abuse when presented with early symptoms of alcohol abuse in an adult patient*."**
  (CASA, Columbia U., 2000 Missed Opportunity: National Survey of Primary Care Physicians and Patients - nationally representative sample of primary care physicians)

Sources of Problem:
Physician Education

- **Training for alcohol, tobacco, other drug abuse interventions is inadequate at all levels of medical education**
  - **Few experienced teachers in medical schools**
  - **Most medical school administrators & faculty do not consider substance abuse a high priority**
  - **In clinical rotations, medical students see treatment (severe dependency- alcoholism) - rarely do they see recovery (or alcohol problems)**
    > reinforces impression that problems (& patients) are difficult, unpleasant, hopeless
  - **Substance abuse a low priority focus for most residency programs – residents lose what was learned in medical school**
  - **Little time allocated for behavioral change interventions in teaching or in practice**

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Additional problems

- **Ineffective training** (especially regarding counseling and communications skills) – rarely practice or skill-based (i.e., the least effective teaching methods are the most commonly used)
- **Uncertain reimbursement** for services
- **Lack of practice-based experiences using intervention tools** > you don't think about problems you don't look for or see (or recognize)
- **Sense of futility**: information about treatment outdated ("*doesn't work*")– lack knowledge of new, effective treatment, intervention and prevention strategies
- **Time to spend with patients diminishing** (ave. 7-12 minutes per visit) – behavioral interventions too time consuming
- **Myths**: patients are resistant to help or change; patients can't/won't change anyway; alcoholics are unpleasant patients; patients will get angry if I raise the subject; nothing works

Common Misperceptions:

- **Understand alcoholism as a disease, but not that it needs to be treated as chronic, relapsing**
  - Usually seek to cure patients but can't cure these patients
- **Don't understand concept of alcohol problems** as amenable to intervention – they look for alcoholism and fail to see the rest (which they see as social, not health problems) [myths about alcoholics applied to all problem drinkers]
- **Incorrect expectations** – expect rapid change but limited & infrequent time spent with patients (or lack of feedback from referrals) > failure to see change or to work with patients through change process
- **Some hold common beliefs fostered by alcohol industry, mass media & culture**:
  - **problems due to individual choice & irresponsibility – failure to change is individual failure**
  - **alcohol problems are social, personal failings not health problems**

Underlying dynamics

- **Inadequate medical education** and on-site training means that **doctors learn about alcohol from mass media, advertising, personal experience/feelings** – see patients through these lenses >
- **Failure of medical community to address alcohol use disorders as part of mainstream health care** diminishes its importance as a mainstream health issue
- **Public health community fails to address alcohol as a health issue** – focuses on individual etiologies, social disruption, particular alcohol-related problems – rarely as a overarching health problem.
- Not surprisingly, **media and government officials focus on social and not health impacts**.
- Confusing all of this is **steady stream of academic bandwagon of research indicating positive health impacts of alcohol** (are they finding what they're looking for?) - **summarized by media as "drinking is good for you"**

Underlying dynamics

- **Much of public health community accepts alcohol industry "expertise" in determining and discussing health issues – legitimizes their self interest & perspectives on problems**
- **Alcohol industry and the policies they support focus on individual choice & punishment – ignore their own role, environmental, even governmental roles in promoting problems**
- **Result: alcohol problems not viewed by physicians or the public as targets amenable to medical or public health interventions**

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consequences

- Lacking a clear medical/health framework – and confused by personal feelings, behaviors, experience – physician & other health professional paralysis leading to inaction and silence
- Alcohol problems treated as discreet, unconnected issues (DUI, FAS/FAE, alcoholism, violence, injury) – not usually part of most medical practice concerns
- Alcohol is a leading preventable cause of cancer and violence – often ignored
- Alcohol related violence, injury, death are attributed to individual excess, misbehavior or accident – not due to the drug, not expressions of health problems

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We need a better explanatory framework for thinking about alcohol & its health impacts. The J-curve concept makes it clear that

- for some people, some times, in some situations, low levels of alcohol use are relatively risk free and (if prospective studies validate recent findings) may be beneficial
- but risk & harm rise for everyone with the level of consumption (volume, frequency)
- for some people and some situations and some occasions any consumption is risky and more consumption even more harmful

Furthermore,

- Much of our research focuses on the etiology of discrete alcohol problems – individual, social, cultural, attitudinal, behavioral – and differences in risk factors, circumstances, consumption behaviors
- Treatment, intervention, prevention, public health strategies, medical strategies, etc. all separate fields with separate communications channels, give or take a few journals
- The alcohol industry especially emphasizes intent, personal responsibility, personal enjoyment of intoxication, and lower risk situations (it ignores alcoholism, alcohol use disorders, negative consequences of any type save impaired driving)

(an alternative framework)
What's not stressed is the whole - that

Regardless of why, when, where or how someone drinks, whatever they think or choose to do, alcohol

- **always acts as a drug,**
- **is a carcinogen, and**
- **consumption is never risk free.**

Alcohol's impact on the body is systemic and no one and no organs are free of its impacts – however small.

The most common forms of health problems related to alcohol are not due to, related to or even precursors of alcoholism (dependence) – binge drinking affects more people and is a better indicator of problems, and is amenable to change

In addition -

All problems associated with alcohol are

- **connected** (impaired driving, FAS/FAE, violence, accidents and injury, dependence, binge drinking, underage drinking, football riots, domestic violence, vandalism, etc., etc.) –
- **manifestations of alcohol consumption**
- **manifestations of alcohol's impact on the body (especially the brain)**

(In that sense it's like tobacco and many illicit drugs.)

For some people, some situations, some health conditions and some circumstances or occasions, risk begins from the initial intake of alcohol and harm rises with consumption (amount, frequency).

An alternative health framework:

In most people's daily lives, the times at which they can drink at low risk levels and the circumstances under which they can do so are extremely limited

Many can never drink without high-risk

Everyone's consumption carries a risk for the drinker and the non-drinker (of causing harm to themselves, the people around them and the society they live in.

The greater the consumption (amount, frequency, number of drinkers), the greater the potential for harm.




Obstacles to address

- **By and large governments and much of the public health community collaborate with the alcohol industry – this stifles criticism, analysis, and confrontation**
  - Keeps discussion and solutions focused on individual consumers and problems
  - Prevents looking at connections between the varieties of alcohol impacts
  - Keeps discussions off of health concerns: alcoholism, health impacts on families, negative impacts on individual health
- Strategy: the medical community can point to the links, can talk about the product (alcohol) and challenge the systems that promote excess use

Key concerns – US private sector

- Virtually no research on alcohol industry structure, behaviors or political impacts
- No major broad based national advocacy group focused on alcohol health issues or policy (groups are focused on treatment, or impaired driving, or recovery, or children of alcoholics) – no unified movement, no major health strategy
- Numerous community based coalitions concerned about alcohol and underage drinking – tied to government funds and lack understanding of and assistance for alcohol policy development, some treat alcohol as one of many issues
- Outside of drink/drive networks (full of alcohol industry groups) there's no true communications, advocacy network or core resources

Much of public dialog addresses the needs of commercial interests.

- Medical Strategy A: Develop health dialog that sidesteps these debates and focuses (demands discussion) on the health impacts that occur regardless of intent when consuming. [at least in the US this requires use of creative epidemiology & advocacy tools/materials as has been effective in tobacco control]
- Medical Strategy B: Develop public health strategies based on framework above and the European Charter on Alcohol

European Charter - Ethical principles

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.
4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.
5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

Summary of 10 strategies for alcohol action

1. **Educate people, beginning in early childhood, of the health, family and social consequences of alcohol consumption and effective measures to prevent or minimize harm**
2. **Promote public, private & work environments protected from accidents, violence & other negative consequences of alcohol consumption.**
3. **Establish & enforce effective anti-drink-driving laws.**
4. **Promote health by controlling availability & influencing alcohol prices (e.g. through taxes).**
5. **Strictly control (keeping existing limitations or bans) direct & indirect alcohol advertising - ensure that no advertising specifically addresses young people (e.g., by linking of alcohol to sports).**

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10 strategies for alcohol action

6. **Ensure access to effective treatment & rehabilitation with trained personnel, for people with hazardous or harmful alcohol consumption and their family members.**
7. **Foster awareness of ethical and legal responsibility among those marketing or serving alcohol, strictly control product safety, implement measures against illicit production & sale.**
8. **Enhance society's capacity to deal with alcohol through training of professionals in different sectors, & strengthening community development and leadership.**
9. **Support nongovernmental organizations and self-help movements - specifically those aiming to prevent or reduce alcohol-related harm.**
10. **Formulate broad-based programs in Member States, with clear outcome targets and indicators; monitor progress; ensure periodic updating based on evaluation.**

Overcoming conceptions

We need to develop strategies that allow the medical and public health communities to use concepts & tools that fit both and that can be communicated to the media and policy makers – e.g., Screening and Brief Intervention, common frameworks for discussing alcohol and its impacts as one albeit multifaceted subject

Advocates, policymakers, the media and the public all need to hear from physician organizations – not just a few activist doctors

In the public discussions about underage drinking, impaired driving and young adult binging, the impacts of alcohol on family well-being and health have been forgotten – keeping this invisible is a primary goal of the alcohol industry – they know when discussion of family harm, health problems, illness arise – they lose control of the debates