

Brief physician advice reduced drinking in older adults

Fleming MF, Manwell LB, Barry KL, et al. *Brief physician advice for alcohol problems in older adults: a randomized community-based trial.* *J Fam Pract* 1999 May;48:378–84.

Question

In older adults with potentially excessive drinking, does brief physician advice reduce alcohol use?

Design

Randomised, single blind (patient), controlled trial with 12 months of follow up.

Setting

24 primary care practices in Wisconsin, USA.

Patients

158 patients who were ≥ 65 years of age (66% men) and consumed > 11 drinks/week (> 132 g of alcohol) (> 8 drinks/wk for women), had ≥ 2 positive responses to the CAGE questionnaire, or had ≥ 4 drinks each occasion ≥ 2 times in the previous 3 months (≥ 3 drinks for women). Exclusion criteria were attendance at an alcohol treatment programme or reported symptoms of alcohol withdrawal in the previous year, physician advice to cut down alcohol use in the previous 3 months, drinking > 50 drinks/week, or thoughts of suicide. Physicians (43 family physicians and internists) and patients received financial incentives for participating. 92.4% of patients completed follow up.

Intervention

Patients were allocated to a brief intervention group ($n = 87$) or a control group ($n = 71$). Both groups received a general health booklet and follow up at 3, 6, and 12 months. Intervention group patients also received a workbook from their physician with feedback on health behaviour, problem drinking prevalence, drinking cues, and a drinking agreement. The 2 intervention visits occurred 1 month apart with a follow up telephone call 2 weeks after each visit.

Main outcome measure

Change in alcohol use.

Main results

Intervention group patients had a greater decrease in alcohol consumption than did control group patients. During the 12 month follow up, intervention group patients had fewer mean drinks/week ($p < 0.001$), fewer episodes of binge drinking (> 4 drinks/occasion in men [> 3 in women]) ($p < 0.025$), and fewer episodes of excessive drinking (> 20 drinks/wk in men [> 13 in women]) ($p < 0.005$) (table 1). Binge and excessive drinking increased in control group patients.

Conclusion

In older adults, brief advice from their primary care physicians reduced excessive and binge drinking.

*Brief intervention v control for potentially excessive drinking in older adults**

Outcomes at 12 months	Intervention (baseline)	Control (baseline)	Mean difference (95% CI)	RRR (CI)	NNT (CI)
Number of drinks in previous 7 days	9.9 (15.5)	16.3 (16.6)	6.4 (3.2 to 9.6)		
Binge drinking in previous 30 days	31% (49%)	49% (40%)	38% (6.2 to 59)	6 (3 to 40)	
Excessive drinking in previous 7 days	15% (29%)	34% (30%)	55% (18 to 76)	6 (3 to 20)	

*Abbreviations defined in glossary; mean difference, RRR, NNT, and CI calculated from data in article.

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Commentary

Effective public health approaches for alcohol problems target whole populations, or large numbers of people who are drinking “not much too much,” because this is the group in which most of the harm occurs. Most studies support the idea of the “J shaped curve,” where moderate consumption of alcohol reduces mortality because of the reduction in some forms of cardiovascular disease.¹ This effect is seen in people > 50 years of age, and means that reductions in moderately heavy drinking towards “safe” levels may have disproportionate health gains in this group.

The study by Fleming *et al* targets an appropriate group of people. All are well over 50 years of age (this study is a welcome extension of previous work into elderly populations) and the selection cri-

teria require that they are all drinking “not much too much.” In this sample, the least severely affected are drinking within “safe” limits, and many of them will be the “pre-problem drinkers” that we should be targeting. The sample is heterogeneous, but this is an advantage because it covers most types of potentially harmful drinking.

These patients were recruited through opportunistic screening and subsequently treated in general practice, but the methodology would be applicable in any community setting. The intervention itself is simple, brief, and comfortably translatable to the “real world.” The results at 1 year are worthwhile, and it will be interesting to see if they are sustained in the longer term. The control group shows that general health advice does not trans-

late into changes in drinking behaviour, and specific advice related to alcohol in the context of the patient’s own usage is necessary. Furthermore, in the control group, some evidence showed that “untreated” problem drinking worsened.

This study should encourage primary care workers and community mental health workers to make screening for alcohol use and brief intervention part of the normal package of care. A little goes a long way!

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1 Chou SP, Grant BF, Dawson DA. Medical consequences of alcohol consumption—United States, 1992. *Alcohol Clin Exp Res* 1996; 20:1423–9.