DRUG & ALCOHOL FINDINGS *Matrix cell*

Alcohol Treatment Matrix cell C1

Management/supervision; Screening and brief intervention

Seminal and key studies on management and supervision in screening and brief interventions for risky drinking. Highlights UK guidance which insists health service managers "must" support this work and the quandary over whether to insist on these procedures (taking time which could have been used in other ways) or to let practitioners and patients decide their priorities. See the rest of row 1 of the matrix for more on screening and brief interventions.

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

S Ongoing support needed for GPs to screen and advise (2005). World Health Organization trial in England and five other countries conducted in the late 1990s found personal contact and ongoing support as well as training were needed even to achieve modest levels of implementation by GPs. In England (1999) training plus support was the most cost-effective strategy, but still few doctors implemented the programme.

S Training plus ongoing support also best for primary care nurses (2003; free source at time of writing). Also in English primary care practices and at about the same time, as with GPs (study above) training plus support was found the most cost-effective strategy for engaging practice nurses, but still few patients were screened and advised. Research reports (2001) also freely available. For discussion click and scroll down to highlighted heading.

K Strong incentives and automatic reminders can dramatically increase screening and intervention rates (2010). Use this entry as your gateway to studies of the US 'VA' health care service for ex-military personnel, which showed that near universal screening is possible in primary care and that many more risky drinkers are counselled when electronic prompts are backed by management. Questions remained over quality (2011) and no reliable impacts on drinking were detected in the featured study or across (2014) the VA system. Related review below. For discussions click here and here and scroll down to highlighted headings.

K Near universal screening possible in emergency departments (2013; free source at time of writing). Integrating screening questions into the emergency triage system of a major US trauma department (where alcohol screening and brief advice are required) led to 97% of patients being screened and 60% who screened positive being advised about their drinking.

K Dutch primary care implementation drive may have been counterproductive (2012). At Dutch general practices which had been offered comprehensive training and support to implement brief interventions, risky-drinking patients were slightly *less* likely to remit to non-risky drinking than at comparison practices. Implementation rates (2012; free source at time of writing) were also poor, not significantly better among practices targeted with training and support, and fell back once these inputs ended. Possibly part of the explanation is that the programme did not significantly bolster (2014) doctors' feelings that that knew enough and had the skills to do alcohol-related work and that this was a 'legitimate' activity.

K Multi-behaviour change training for GPs not shown to impact on patient drinking and other lifestyle risks (2013) Bundling training for GPs on brief advice for drinking with similar advice on smoking, diet and exercise meant more patients were addressed about these behaviours and more tried to change them, but success rates generally and in respect of drinking were not significantly improved compared to patients at untrained practices.

K Research report (2016) and article (2016) on the role of training in delivering alcohol screening and brief interventions beyond usual medical settings to areas such as social and community services and policing. Based partly on a survey and interviews gaining the views of trainees in four English regions, which revealed that implementation levels remained low after training, partly because screening in particular was often felt inappropriate to the working context. Recommendations made for adapting training.

R Implementation programmes for primary care have modestly boosted implementation rates (2015; free source at time of writing). Synthesis of results from 29 trials found implementation efforts had boosted both screening and brief intervention rates but not significantly affected drinking. Greatest impacts were seen from multi-strand strategies addressing the organisation and/or the patient as well as the clinician, and screening benefited from involving staff such as nurses as well as doctors. For discussions click here and here and scroll down to highlighted headings.

R Accountability and feedback raise screening rates in primary care (2011). Found that the three most successful

screening implementation efforts (including by the US 'VA' service for ex-military personnel; study listed above) used electronic medical records to make staff aware of and accountable for their screening performance. How subsequent advice-giving rates could be improved was unclear, perhaps because intervention is more a matter of clinical judgement and priorities. For discussion click and scroll down to highlighted heading.

R Managerial action key to boosting implementation, finds review for NICE (2011). Assessment for the UK's health technology regulator highlights financial support, training, managing workload, incentives, and leadership which not only 'preaches' the need for screening/brief advice but uses management levers to ensure it happens. Notes that current UK strategy of screening when lifestyle issues are commonly addressed (eg, registering new patients, well-being clinics) goes with the grain of staff and patients' expectations. For discussions click here and here and scroll down to highlighted headings.

R Education and support not enough to embed screening and brief intervention (2008). Without management direction or incentives, education, training and support organised by researchers still left tiny proportions screened. See from page 8 for implementation trials in UK primary care practices. For discussions click here and here and scroll down to highlighted headings.

G In both its prevention (NICE, 2010) and treatment (NICE, 2011) guidance on addressing drinking, the UK's health technology regulator stresses that managers of NHS-commissioned services "must" ensure staff have enough training, time and resources to effectively carry out evidence-based screening and brief advice. For discussions click here and here and scroll down to highlighted headings.

G Screening and brief intervention training for England (Public Health England, accessed August 2019). Web-based courses for primary care, pharmacies, hospitals and dental teams, based on "the robust evidence-base of more than 60 controlled trials over 30 years" which, says England's public health authority, shows that a few minutes' advice reduces health risks from drinking.

G UK guidance on when and when not to be *very* brief (2013). Explains the different types of 'brief interventions' and when to offer just five minutes of simple advice, or to start with or step up to more extended interventions; identifies the pros and cons and the required time, training and staff.

G Three guides from the UK national charity Alcohol Concern (now absorbed into Alcohol Change UK) supported by the Safe Sociable London Partnership and Public Health England, focusing on: community health settings (2015) such as primary care, pharmacies, and drug services; hospitals (2015) including emergency departments; and criminal justice services (2015) including police, probation and prisons. Each recommends minimum standards for this work and suggests brief interventions are based on the FRAMES principles.

G Step-by-step guide to a successful programme mounted in London (World Health Organization, 2009). Turn to page 195 of the downloaded PDF (the whole document is titled *Alcohol and injuries: emergency department studies in an international perspective*) for a description of the programme which reduced (2004) drinking and re-attendances at an inner-London emergency department, an evaluation discussed in cell A1.

G UK screening and brief intervention implementation aids and guidance (accessed July 2019). Web site offers discussion, news, and a portal to screening instruments and guides on how to advise patients.

G WHO training manual for Europe (World Health Organization, 2018). Developed for member nations of the European Union to help them expand and improve the training of health professionals on alcohol screening and brief intervention, based on an international expert consensus. How to organise a training programme plus interactive activities and role plays to develop practitioners' skills.

G US resources and guidance on screening and brief intervention ([US] Substance Abuse and Mental Health Services Administration, accessed August 2019). US guidance and resources to support the national 'SBIRT' programme of screening and brief intervention including implementation, management, and staff training in a variety of health and other service settings.

G US guides on implementing screening and brief interventions for emergency departments ([US] Emergency Nurses Association, 2008), trauma centres ([US] Centers for Disease Control and Prevention and National Center for Injury Prevention and Control, 2009), primary care and mental health clinicians ([US] National Institute on Alcohol Abuse and Alcoholism, 2005), primary care practices (American Academy of Family Physicians, 2019; funded by US Department of Health) and community health workers (American Public Health Association for US Department of Transportation, 2008).

MORE Search for all relevant Effectiveness Bank analyses or for sub-topics go to the subject search page. See also hot topic on brief interventions.

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▶ Comment/query
▶ Suggest a new document to add to this cell
▶ Return to/go to Alcohol Matrix
▶ Open Effectiveness Bank home page
▶ Add your name to the mailing list to be alerted to new studies and other site updates

Close Matrix Bite

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

What is this cell about? In contrast to treatment, screening and brief interventions are usually seen as *public health* measures. Rather than narrowing in on dependent individuals or just those seeking help, the aim is to reduce alcohol-related harm across a whole population – including those unaware of or unconcerned about their risky drinking. Screening questions aim to spot drinkers at risk of or already experiencing alcohol-related harm when for some other purpose they come contact services whose primary remit is not substance use. In studies, the typical response to those who score in at-risk zones is from five minutes to half an hour of advice, counselling and/or information aiming to moderate their drinking or its consequences, delivered not by alcohol specialists, but by the worker the drinker came into contact with – the 'brief intervention'. Click here for more on typically studied screening and brief intervention activities.

Close supplementary text

In the UK, GPs' surgeries are the principal venue for screening and brief interventions, but programmes are also mounted in other medical settings such as emergency departments and sexual health clinics, on inpatient wards, at ante-natal clinics, as well as in non-medical settings such as criminal justice, social care, community and housing services.

Typically screening takes the form of a few standard questions meant either to be asked of all adult patients/clients, or instead 'targeted' at those in certain categories where alcohol-related harm is most common or who are undergoing procedures where screening seems 'natural'. In the UK programmes have focused on patients whose medical complaints might be due to excessive drinking, or those newly registering with a GP or undergoing a general health check.

For example, AUDIT-C is a popular screening questionnaire which assesses typical current drinking patterns. It asks:
1 How often do you have a drink containing alcohol? Answers: Never; monthly or less; 2–4 times a month; 2 or 3 times a week; 4 times a week.
2 How many standard drinks containing alcohol do you have on a typical day? Answers: 1 or 2; 3 or 4; 5 or 6; 7–9, 10 or more.
3 How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? Answers: Never; less then monthly; monthly; weekly; daily or almost daily.
A score of from 0–4 is given for each question. A total of 5 or more indicates increasing or higher risk drinking.

People whose responses indicate risky drinking are then engaged in a discussion about their drinking for what may be just a few minutes or one or two longer sessions. Content often includes feeding back the results of the screening test and using a motivational interviewing counselling style and associated techniques to elicit a commitment to cut down and/or drink more safely. Patients whose screening results indicate very serious problems may instead be referred for a fuller assessment and possible treatment.

Close supplementary text

This cell is not about the *content* of these interventions (for which see cell A1), but how implementation and impact are affected by support from the top and the management functions of selecting, training and managing staff and shaping the intervention programme. Management impetus is crucial because these procedures are usually implemented by practitioners (subjects of cell B1) who see neither non-dependent drinking nor public (as opposed to individual) health as core business. Enabling and persuading them to commit to screening and brief intervention is seen as the key task by people convinced that – if only they weren't undermined by typically poor implementation – these programmes would fulfil their promise to improve public health.

Where should I start? Britain's National Institute for Health and Care Excellence (NICE) set the agenda by giving an unequivocal steer to managers of publicly funded health services. NICE's guidance (1 2) listed above insists they "must" provide the training, resources and time to implement screening and brief intervention for risky drinking. It also falls to management to implement recommendations that medical staff use these resources to routinely screen and offer brief advice as an integral part of practice.

Managers would fail to comply with the guidance if they achieved quantity by sacrificing quality – a major issue in this sector. NICE says screening must be "systematic" and use scientifically validated questionnaires or other 'tools'. As a minimum, interventions should consist of "structured" advice lasting five to 15 minutes from trained staff using recognised evidence-based resources drawing on FRAMES principles – mandating an empathic style and content well beyond a simple warning to drink less. It is striking that despite these principles being widely recommended, evidence of their effectiveness is largely lacking.

How to find the resources for this work – above all, time – and how to persuade or incentivise staff to screen even when there are no signs of a drinking problem, are the tasks set managers by the guidance. Even with incentives and support of the kind made available in the SIPS trials (1 2 3), the generally very low implementation rates in British trials (review listed above) show this is no easy agenda. In SIPS, numbers screened seem to have been small – despite per-head incentive payments, under two per primary care practice per week, about 12 per emergency department per week, and one or two a fortnight in each probation office.

Highlighted study According to a review (free source at time of writing) listed above, for implementing screening and brief advice programmes primary care practice nurses are a better bet than the more expensive and time-pressed GPs. Conducted in the late 1990s, a British study (free source at time of writing) listed above was notable for its attempt to engage these nurses, and for findings which presaged a policy shift from aiming to screen every adult to 'targeted' screening only in situations where asking about drinking seems 'natural' or particularly warranted. Under the heading "Lock and Kaner 2000 and 2003", you can read about the findings on page 11 of the Effectiveness Bank review listed above.

Note that even nurses offered the most intensive support package typically conducted a brief intervention with just one patient every two months. Screening was the weak link; just 2% of patients seen by the nurses were screened. After that, a brief intervention was delivered to nearly two-thirds identified as risky drinkers. Screening fell short partly because instead of screening everyone, nurses screened when they had the time and "in specific contexts such as new patient registrations, well person checks or in chronic disease monitoring clinics" – among the targets for the selective screening strategy now recommended (documents listed above) by Britain's National Institute for Health and Care Excellence (NICE) and built into GPs' contracts.

Resistance to universal screening is neither confined to the UK nor does it seem to have receded as screening and brief interventions have developed a wider evidence base and wider policy support. It remained apparent in the ODHIN trial conducted in primary health care units in England and four other European countries during 2012 and 2013. Even the strongest package of incentives and support meant primary care clinicians screened during under 1 in 5 consultations, partly because "Despite their intrinsic motivation to prevent patients from [suffering] alcohol-related disabilities, GPs and nurses feel more rationale for selective screening rather than opportunistic screening."

As a review listed above undertaken for NICE suggests, the move towards targeted screening seems a case of policy yielding to what staff and patients see as manageable, natural and appropriate. Universal screening has come to be seen as an unrealistic ideal which, given current structures and resources, simply will not be implemented.

The qualification "given current structures and resources" is important: with strong enough management sticks, appealing enough carrots, and a reminder system which makes it hard to forget to respond to these, screening and brief intervention rates can be raised (study listed above) to heights rarely if ever achieved through exhortation and support alone. But that means overriding clinical discretion, extra costs, and lost opportunities to do other things which might have gained more health improvement, with (as a review listed above finds; free source at time of writing) no guarantee that incentivised alcohol screening and intervention will help prevent alcohol-related harm. More on this dilemma below.

Issues to consider and discuss

Are managers the key to ensuring quality? From cell E1 we know that commissioning systems featuring incentives and sanctions, and setting targets for which services are held accountable, can substantially push up numbers recorded as screened and advised. However, it is much harder for commissioning systems and policy mechanisms to ensure on-the-ground quality, or even that records reflect real activity. That seems to leave quality assurance resting largely on management tools such as

training, coaching and support, observing practice and gaining feedback from patients, and using this information in supervision and feedback to staff.

Among the "key ideas" to advance screening and brief intervention (they preferred the more generic term "identification and brief advice" – "IBA") identified in 2015 by attendees at a conference in England was, "No IBA without 'quality assurance'." Their concern was that "If the standard of interventions being reported is not in line with those conducted in research trials, is there any value to them at all?" An ideal solution was 'mystery shopping' approaches in which pretend patients report back on the interventions they did or did not receive. More manageable systems have been advanced in a *'Toolkit' for commissioning alcohol identification and brief advice* developed in 2016 by south London's Health Innovation Network. Though aimed primarily at commissioners, service managers and practitioner self-managers would have to devise and deliver the recommended mechanisms for determining and improving quality, among which "High quality staff training and support should be a central component."

Experience at the US 'VA' health care system for ex-military personnel (see documents listed above) shows what can happen when management systems linking higher level commissioning decisions to on-the-ground quality are insufficient to ensure quality and/or impact. Screening was incentivised to near universal levels and (where doctors knew management expected this) electronic prompts led to a recorded 71% of positive-screen patients being advised, but screening seemingly missed many risky drinkers, and advice had little if any impact on drinking.

Most disappointing was a study of an entire VA region conducted soon after the VA had implemented a national performance measure incentivising brief intervention, aided by an electronic clinical reminder available to all facilities. Records suggested that having received a brief intervention did not mean patients who screened as risky drinkers were more likely to have remitted from risky drinking when re-screened a year later. Another finding was that just 28% of these repeat-screen patients had been advised about their drinking, and they tended to be the higher-risk drinkers.

In cell E1 we give other examples from the UK of seemingly substandard practice or misleading recording of activity as staff do what it takes to justify payments or meet targets.

▸ **Should we leave practitioners and patients to decide?** In the section above we've seen that if management has the levers, clinicians can be persuaded to screen and advise at very high rates. However, this comes at a cost – not just in resources, but in what *could* have been done with the same time if practitioners and patients had been freer to decide their priorities. As the *Lancet* medical journal caustically observed, "lecturing" patients about their lifestyles takes up time in the average 12-minute GP consultation which could have been used to more fully address why the patient attended in the first place, or some other condition or lifestyle threat – uses which might more cost-effectively improve health than a diversion to drinking.

The foregone value of what might have been done is not (it is hard to see how it could be) accounted for in calculations such as those made on the basis of the EU-funded ODHIN trial. With this cost missing from the balance sheet, these calculations make screening and brief intervention for risky drinking look like a cost-effective use of resources. However, the potential for foregone value was apparent to probation and community service staff supervising offenders in Scotland, who felt the alcohol screening and intervention programme they were piloting "was not suited to their client groups, largely because they faced more serious issues such as money problems and housing, and addressing their drinking was not a high priority". Excessive drinking was, they thought, too intertwined with other problems to be dealt with in isolation.

How far should management tip the balance towards insisting alcohol is addressed, knowing that otherwise the topic may be avoided, versus letting practitioner and patient decide priorities? Before you answer, take a look at some of the evidence for or against making alcohol a priority, even if patients, doctors and nurses don't see it that way.

> Close supplementary text
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> If your instinct is to leave practitioners and patients to set the clinical agenda, reading this Effectiveness Bank entry may change your mind. Analysts predicted that in England screening and briefly intervening with newly registering primary care patients would not just improve the patients' health, but save money for the health service by averting the need to treat alcohol-related illness and injury. Rather than diverting resources from other health programmes, the implication is that tackling drinking through screening and brief intervention would (if implemented in the most cost-effective manner) free up resources. For health service managers, it should seem an unmissable bargain. Read our commentary

> on the study to help you judge whether this bargain is too good to be true (or at least, to be relied on) given the assumptions built into the calculations and what we know about the real-world performance of screening and brief intervention programmes.
>
> Another study aimed to give US primary care practices the information they needed to prioritise preventive interventions which gained the greatest extension in healthy life span across all their patients. The conclusion was that screening for risky drinking and offering brief advice was among the best uses a practice could make of its preventive intervention time, ranking in health gain per $ alongside widely accepted programmes such as screening for high blood pressure or immunising against influenza. But the estimated gains changed dramatically when the authors varied assumptions about impacts on drink-related problems. Like the analysis for England described above, confidence in these conclusions is undermined by uncertainty about impacts when the interventions modelled by the analysis transfer from a controlled clinical trial to real-world conditions – one of the issues addressed in cell A1's bite.
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> Close supplementary text

Most worrying is the possibility that 'pushing' clinicians to screen and briefly intervene when 'unpushed' they would not, will boost recorded delivery, but this 'perfunctory' (the term used to describe some GPs' incentivised advice in Scotland) and unwilling activity will fail to affect drinking or alcohol-related harm. In fact, on average that seems the usual outcome. In 2015 a synthesis of results (listed above) from 29 trials found implementation efforts had boosted both screening and brief intervention rates, but not significantly affected drinking. An example is the experience of the US 'VA' health care system for ex-military personnel discussed above.

▸ **Reserve brief interventions for non-dependent drinkers?** The assumption that already problematic or dependent drinkers should be excluded from brief intervention studies and programmes has been termed "curious" by two leading figures in brief intervention research and practice. They argued that though widespread, the belief that these drinkers will not benefit from brief interventions is based on a *lack* of evidence rather than concrete findings showing that brief interventions which work among moderate drinkers fail further up the severity scale. On the basis of the limited evidence, instead they speculated that if brief interventions were focused on drinkers *already* experiencing problems with their drinking – offering more scope to address and reduce these – they might more consistently be found not only to moderate drinking, but actually to reduce related problems.

For some corroboration, turn to page 7 of these Effectiveness Bank background notes. Under the heading, "Summary of UK effectiveness trials," note that the two UK primary care trials with the most convincing results recruited very heavy and possibly dependent drinkers. Though a fresh systematic analysis is needed, it seems that when brief interventions are effective at all, usually there is no evidence that they are less effective among heavier drinkers if they are included in the study.

Running this search uncovers more studies which shed light on whether brief interventions work only for moderate drinkers. Among them is a large US trial at major injury centres which found that on average the heaviest, most problematic (and probably dependent) drinkers responded best to motivational brief interventions. Relative to minimal advice, they reduced drinking more than less severely affected patients. Reports from the English SIPS trials – which like the US trial set no severity ceiling for their participants – have as yet given no evidence that the heaviest drinkers responded least well to brief interventions, and some from the probation trial that they profited more than less severe drinkers from being offered a fully-fledged brief intervention. Another English study, but in emergency departments, found that just a few (and often just one) counselling sessions by a specialist alcohol nurse substantially reduced drinking and problem severity among dependent drinkers identified while seeking medical care. From Taiwan comes a convincing demonstration that brief advice can lead heavy-drinking surgical and medical patients to cut back, most of all those who met criteria for alcohol dependence.

But there is a risk in lobbying for brief interventions also to be offered to dependent drinkers. Since the first brief intervention studies, a major concern has been that if on average these are seen to work even with heavy drinkers, more intensive treatment will be de-funded and become unavailable to individuals who really do need this support. Brief interventions can prompt dependent drinkers to cut back, but only if they are effective in the first place, and even if on average they are, many dependent drinkers will be left drinking at dangerous levels.

▸ **Where should management focus implementation efforts?** A review (listed above) for Britain's National Institute for Health and Care Excellence highlighted barriers management can address

including staff competence and confidence, their perceptions that management prioritises this work, workload pressures, concerns over patient reactions, and assumptions about what a risky drinker 'looks like'. Where to start, and how much can managers achieve if the broader organisational system is unhelpful?

A review listed above usefully offers a framework for conceptualising these layers of influence on implementation of screening and brief intervention programmes. "Leadership" is one feature of the so-called "Inner setting" domain of influences characterising the implementing organisation, and clearly plays a role in another domain, the "Process of implementation". Beyond these is the "Outer setting" domain – the economic, political, and social environment surrounding and influencing the organisation undertaking the implementation. In this context day-to-day management can be seen as a relatively small but probably essential element in an implementation drive, but one which could be obstructed or aided by other influences within (review listed above) or beyond the organisation.

Close Matrix Bite