DRUG & ALCOHOL FINDINGS *Matrix cell*

Alcohol Treatment Matrix cell D1

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Organisational functioning; Screening and brief intervention

Seminal and key studies on how organisational functioning affects screening and brief intervention. Highlights a striking illustration of the importance of organisational context emerging from the unprecedented implementation drive at the US health care system for ex-military personnel. 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 London emergency department pioneers systematic screening and brief advice (1996). Innovations which led to a 10-fold increase in the proportion of patients advised about their drinking included: developing a very quick screening test tailored to the setting; allowing doctors to restrict screening to categories of patients most likely to be drinking heavily; and employing a specialist to shoulder most of the intervention load. For discussion click and scroll down to highlighted heading.

K Standard screening and brief intervention inappropriate in range of working contexts in Scotland (2015). Move beyond the usual medical settings for screening and brief intervention and even after training, seven out of nine practitioners did not engage in these activities at all because they felt them inappropriate for their clients. Message is that implementation efforts must accept the possible downsides of discretionary, non-standardised approaches, including loss of impact. For discussion click and scroll down to highlighted heading.

K Abandon researched packages in favour of a 'conversation' about drinking, say midwives in Scotland (2019). Fitting screening and brief interventions into the working context of midwives meant abandoning the standard, scripted approaches tested in research in favour of a more individualised and nuanced conversation – and then not initially about current drinking, but the less threatening topic of pre-pregnancy consumption. For discussion click and scroll down to highlighted heading.

K Non-health contexts in England demand flexible 'chats' not scripted questions and advice (2016). Discussions with housing, probation and social work practitioners indicated that standard screening methods and structured brief advice are unlikely to be implemented in many non-health settings. For discussion click and scroll down to highlighted heading.

K Research report (2016) and article (2016) on the role of training in delivering screening and brief interventions in sectors such as social and community services and policing, based partly on feedback from trainees in four English regions. Implementation levels remained low after training, partly because screening was often felt inappropriate to the working context. Suggests "Training needs to be related more directly to organisational cultures, behaviour, and development needs." For discussion click and scroll down to highlighted heading.

K 'Advise this patient' reminders little use without organisational backing (2010). Contrasting this study with another from the same US primary care system for ex-military personnel shows that screening/intervention rates can hinge on how the organisation handles implementation in general. For discussions click here and here and scroll down to highlighted headings.

K Implementation at US primary care clinics ranges from zero to near universal (2005). Implementation rates at clinics offered training and support depended on complex provider and organisational characteristics. These differed for screening versus brief advice and contributed to a 0–95% range in the proportion of risky drinkers offered advice. For discussions click here and scroll down to highlighted heading, and click here, scroll down to the highlighted heading, and unfold the supplementary text.

K Positive organisational climate fosters widespread screening and brief intervention (2013). From Brazilian primary care clinics comes a rare confirmation that a positive organisational climate is associated with overcoming barriers to widely implementing screening and brief intervention programmes. For discussion click here, scroll down to the

highlighted heading, and unfold the supplementary text.

R Strategies to implement alcohol screening and brief intervention in primary care (2011). Provides a useful map of a large and complex territory enabling you to identify which implementation levers you are already pulling and which you might also turn your hand to. For discussions click here, here and here, and scroll down to highlighted headings.

R Barriers and facilitators to implementing alcohol screening and brief intervention (2011). UK-focused review for Britain's National Institute for Health and Care Excellence.

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

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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 and for whom this does not yet constitute a 'problem' justifying treatment. Screening aims to spot risky drinkers while for some other purpose they come in contact with 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 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.

This cell is not, however, about the *content* of these interventions (for which see cell A1), but whether implementation and impact are affected by the manner and degree to which the organisation responsible for the programme supports managers, supervisors and staff, and offers an environment conducive to screening and brief intervention.

Though not commonly researched, such issues are crucial. Screening and brief intervention are often implemented at services where harm arising from 'normal', non-dependent drinking, and making public health gains, are not naturally seen as 'our business'. Without a conducive organisational context which *makes* screening and brief intervention part of the business, this work is likely to be sidelined and/or of poor quality. The not inconsiderable task is to make these activities happen not as discretionary add-ons, but as a routine way to find and respond to risky drinking – even when there are no obvious signs of excessive drinking, even if 'risky' means low-level risk, and even if alcohol is not why the client made contact nor the primary mission of the service.

Where should I start? A map of a large and complex territory showing its extent and identifying continents and sub-continents is always helpful. That's what is provided by a comprehensive review listed above of strategies to foster implementation. It ranges from the micro-level of designing an effective and suitable intervention, out to the economic, political, and social environment. In the middle, and from US experience (see "Highlighted study" section below) very important, are the so-called "Inner setting" influences – features of the implementing organisation including the degree to which its structures, communication mechanisms, resources, leadership, and culture facilitate the adoption of innovations, and the degree to which the innovation 'fits' its needs and circumstances.

You could use the map provide by this review to locate the focus of your own implementation efforts, as a checklist of the factors which might be obstructing or promoting those efforts, or to identify where else levers might be pulled to aid implementation. In the remainder of this commentary we return to this map several times, an indicator of its utility.

Highlighted study More than any other health provider yet documented, the US Veterans Affairs or 'VA' health care system for ex-military personnel has made a determined effort to implement routine brief alcohol counselling in its primary care clinics. Its efforts were found uniquely successful by our starting point review listed above, partly because the VA marshalled the organisational influences described under the previous heading.

Within this uniquely successful context, our highlighted study (listed above) revealed a telling failure. It showed that electronic reminders to advise risky drinkers were usually ignored at a clinic where there were no active implementation efforts, little leadership encouragement to use reminders of any kind, no culture of routinely responding to clinical reminders, and no incentives for their use or for brief alcohol interventions. For just 15% of patients who screened positive did clinicians react to the reminders to advise risky drinkers, and just 6% of these patients were offered brief counselling. Instead, clinicians gravitated towards advising abstinence to a few very heavy drinkers – not the public health role envisaged for brief interventions.

At other (report listed above) VA clinics, the story was very different. Though again the reminder system

was implemented without provider training or support, at these clinics the culture was that reminders were to be responded to and their use was routine. When the alcohol counselling reminder was inserted into this culture, its use also became routine, being documented for 71% of positive-screen patients, and there was no indication that intervention was reserved for heavier drinkers.

Taking these two studies together, the authors' warning that results from the more successful implementation might not be replicated "where clinical reminder use is not routine" seems well founded – a striking illustration of the difference organisational context can make. For confirmation from elsewhere, take a look at these non-VA studies.

> Close supplementary text
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> Another US primary care study listed above found organisational features strongly related to screening and intervention rates. Seemingly partly reflecting complex provider and organisational characteristics, at different provider organisations the proportion of patients screening positive for risky drinking who were advised about their risks ranged from none at all to nearly all. Associated with more frequent implementation were stable parent organisations supportive of screening and intervention, the presence of an influential, on-site coordinator for the programme, the clinic's access to and willingness to take advantage of the study's technical assistance, and the staff's ability to implement the necessary changes in operational procedures. Related in the other direction were competing organisational priorities and lack of time – perhaps in reality both to do with organisational priorities.
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> Further confirmation of the importance of organisational features comes from (study listed above) the very different context of Brazilian primary care clinics, where 'community link' workers without medical training play an important role. The more a clinic was seen by its staff to have a good organisational climate, the greater the implementation of screening and brief intervention and the more confident staff were about these activities. The results suggest that certain types of organisations are much more capable and willing than others to make the changes needed to embed screening and brief intervention, and that this can depend on generic features like their commitment to staff development, relationships with and concern about their catchment population, and leadership quality.
>
> Close supplementary text

One very wet dampener must be thrown over the VA's implementation successes: there is little evidence that these helped curb drinking – perhaps a reflection on the quality of screening and intervention. But of course, unless they are implemented, there is no chance that interventions of this kind can work, and no chance that they can be made to work by improving quality.

Issues to consider and discuss

Are there 'good' reasons for 'bad' implementation? It has become accepted that implementation – how well interventions root when transplanted from research to routine practice – is the weak link in screening and brief intervention. But in any such situation, there are at least two ways to interpret a low level of implementation. First, that this truly is a 'failure' – that even the organisation concerned will acknowledge that it *should* have implemented better, and that some deficit prevented this happening. But sometimes what looks like a 'failure' from the outside is not seen that way from within, but rather as a justifiable de-emphasis on an intervention which does not meet the needs of clients, or not as well as other interventions which could be mounted with the same resources.

In this context it is relevant to return to the caustic observations of the *Lancet* medical journal cited in cell C1. Their editorial complained that "lecturing" patients takes up time in the short primary care consultation which might have been used to more cost-effectively improve health than a detour to drinking or other lifestyle issues.

Note also that the review listed above and discussed in the "Where should I start?" section, says one implementation determinant is whether the innovation 'fits' the organisation's needs and circumstances. Perhaps this is why an inner-London emergency department led the way (listed above) in Britain, while in the USA it was (studies listed above) the health care system for mainly male former military personnel. But what if there is no 'fit'? Could it be that sometimes an appreciation of the needs of your population,

good leadership, the maintenance of a trusting relationship with clients, or overriding priorities, will actually mean *rejecting* routine alcohol screening and brief intervention programmes for reasons indicative of organisational quality rather than the lack of it?

Can you conceive of any such circumstances in medical, welfare and offender supervision services of the kind targeted for such programmes? For possible examples, turn to the section below headed "Horses for courses?" and unfold the supplementary text. But before accepting these reasons for rejecting standardised screening and brief intervention, play devil's advocate and consider whether really they are less reasons and more excuses for not moving beyond the practitioner's and the organisation's comfort zones.

Is what it takes to successfully implement screening the same for brief advice? We talk of 'screening and brief intervention' as a package – and justifiably so, because often they are done seamlessly by the same person. Even so, could the organisational influences which affect screening differ from those which affect brief interventions?

In primary care settings, a review listed above found evidence this was the case. It could make a stab at identifying the characteristics shared by services which achieved widespread screening. Among these were requiring documentation of whether screening had been done, and making the doing of it matter to the organisation and to the staff – in the examples it cited, through a mandatory entry in electronic medical records used to hold organisation and staff accountable. In contrast, what promoted widespread brief intervention was unclear. The reviewers reasoned this was because screening can be a quasi-'mechanical' procedure completed by patients filling in a questionnaire, or by non-medical or junior staff following a set script, while whether then to offer advice and of what kind involves judgement and individualised assessment. (In passing, it should be pointed out that while this may be the case in the primary care settings on which the review focused, in other settings screening can be a highly sensitive issue requiring tact and judgement; for examples turn to the section below and unfold the supplementary text.)

The review was unable to incorporate the findings of the major test of screening and brief intervention implementation strategies in Europe – the five-country ODHIN trial. A striking finding was how much the different components of the strategies affected the proportion of patients screened, but how relatively little the proportion then advised about their drinking. Once faced with evidence of risky drinking, even before the implementation strategies were applied, generally the GPs, nurses, and other clinicians in the study felt they should respond and did so; to do otherwise would be contrary to their duties of care and place them in the position of having ignored health-threatening behaviour. But very rarely did they actively and systematically *go looking* for evidence of risky drinking to respond to. As a result, implementation strategies had more scope to raise the screening rate; most successful among these was paying for each patient screened.

Another way to approach this question is to examine organisational dimensions associated with screening versus brief intervention rates. If what promotes screening differs from what promotes brief interventions, we would expect to find organisational dimensions which were associated more strongly with one than the the other – just what was found in a US study listed above of the impacts of training and continuing support in primary care clinics.

For our purposes the study's key measures were the proportion of patients screened (screening rate), and the proportion who received advice after screening positive for risky drinking (intervention rate). There were factors strongly associated with both, such as time pressures on practitioners and support from the top, but also notable differences. Four particularly salient organisational factors were significantly associated with either screening or intervention rates, but not both. Of these, three were significantly related to the intervention rate, but not to screening: a negative link with competing organisational priorities, and positive links with assistance from the research team's expert and with the degree to which clinic staff were able to change relevant operating procedures. Only one factor – involvement of clinic staff in planning – was related (positively) to screening but not to intervention rates.

Compared to screening, it seemed that achieving high rates of intervention was more dependent on technical and managerial support and on the scope afforded to staff to change how the organisation works. Only a randomised study or the equivalent could test whether these truly were causal factors

which differentially affected screening and intervention – but deliberately creating poorly functioning health services in order to test this proposition is unlikely to be acceptable.

From this US study as we have told the story so far there is of course an important missing chapter – the one recounting whether implementation efforts actually reduced drinking. To finish the story, unfold the supplementary text.

Close supplementary text

We can add a final chapter to the story of these US clinics – whether the effort to implement screening and brief intervention was worthwhile in terms of reduced drinking, and, by extension, whether the degree to which implementation was promoted by organisational features could also have helped reduce drinking and alcohol-related harm. This chapter can be added because another set of clinics did not implement and were not trained in the brief interventions and the more detailed screening procedures promoted by the study.

In fact, patients at trained clinics did reduce drinking more than those at the untrained clinics, but the effect was very small and under some assumptions, not statistically significant. Undermining confidence in the findings and in their applicability to all risky drinking patients was the fact that patients at trained clinics were only followed-up if they had actually received the intended interventions, and that many could not be re-assessed. As at the VA clinics described above and more generally in primary care (free source at time of writing), it seems possible to stimulate appreciable increases in implementation rates of screening and brief interventions without being able to substantiate any corresponding change in drinking.

Close supplementary text

Horses for courses? Though treatment is essentially individualised, at a deeper level the fundamentals of the encounter are set – generally a patient who wants help in the form of treatment has sought that help from a service geared to providing it. From the start it is accepted that the patient has a substance use problem and both patient and service see engaging in treatment as their business and what they are there for; at this deep level, the 'rules of the game' are clear and mutually agreed.

In contrast, in research studies screening and brief interventions are often highly de-individualised, yet the contexts in which these activities take place lack the shared foundations found in treatment. Instead, someone is intercepted in the course of engaging with a service for a reason nothing to do with drinking, and the service itself has a different primary agenda. It means that different working contexts demand different approaches, partly because neither party wants to undermine their primary objectives by baldly raising drinking, spend time on this issue when others may be more of a priority, or admit to/address risky consumption if the consequences of doing so might threaten other aims. The organisational context demands adjustments, meaning 'ideal' interventions which may have proved themselves in research studies are often substantially abandoned.

A quartet of UK studies listed above testify to this conundrum. They found that to insert addressing alcohol into the service mix requires departing from research scripts, meaning the 'intervention' that's left has not yet been shown to be effective, and at worst, may be counterproductive. Based on interviews and discussions with practitioners and managers, the results of all four studies are freely available and accessibly written (1 listed above; 2 listed above; 3 listed above; 4 listed above). Outside primary and emergency care settings, in general the findings reveal that in housing, probation, social work, antenatal care, social and community services, policing, and sexual health clinics, standard screening and brief interventions approaches are felt inappropriate to the working context and the nature of the caseload. Screening questions in particular can be seen as posing a threat to the client-worker relationship and unlikely to elicit honest answers. In practice, what looks like a simple set of questions followed (if the scoring indicates) by brief advice which could be rolled out by any modestly trained practitioner, becomes in these settings far more complicated. Though such adaptations risk compromising the effectiveness of research-validated screening and intervention packages, commonly there was a strong feeling that less formal and more flexible approaches to drinking were likely to work best and fit best with current practice.

Points relevant to this cell from these and other studies are detailed in the supplementary text. For

more see Alcohol Change UK's web page dedicated to reports it funded on broadening the base for alcohol screening and brief intervention out from health to non-health contexts such as housing, probation and social work.

Close supplementary text

Via discussions with practitioners, the most 'meaty' of the reports (listed above) explored the exigencies of implementing alcohol screening and brief intervention in three 'case studies' involving respectively housing, probation and social work sectors in England. The conclusion was that in these and other non-health settings, 'IBA' (identification and brief advice) is unlikely to be implemented in the form of standardised screening methods and structured advice, due largely to the practice contexts demanding different approaches.

Across the three sectors, "the extent to which organisational structures and working practices are conducive to incorporating and sustaining IBA intervention, emerged clearly … as a key requirement if IBA training is to be followed by delivery … A shift away from a standardised 'manual' approach towards a more flexible menu of optional contents and methods of delivery may be required to suit the diverse and changing needs of professional groups and their organisations." 'Parachuting in' a set intervention seemed unlikely to work because "the individual and the organisation/agency [are] parts of a network of services and systems of care (or control) which may differ from one occupational setting or service context to another, from one geographical area to another, and over time."

Complicating implementation in the three studied sectors was the dual caring and 'enforcement' role of the practitioners – one apparent to their clients, who know these workers held sway over their freedom, their children, or their homes. Practitioners felt that baldly raising the issue of drinking by asking questions set down in a research-validated screening questionnaire was likely to provoke defensive and misleading responses and jeopardise trust; exploring the reasons for excessive drinking and ways to reduce this takes tact and judgement in the context of an established, trusting relationship. In practice, what seems like a simple set of questions followed (if the scoring indicates) by brief advice which could be rolled out by any modestly trained practitioner, to these practitioners looked like a far more complicated interaction requiring advanced judgement.

In housing there was a further complication: concern for the resident's welfare had to be balanced by the need also to support and protect neighbours and the neighbourhood, dual roles thought to create barriers to communication and disclosure, especially because underpinned by the ultimate sanction of evicting a resident for antisocial behaviour. Instead of themselves screening and intervening, staff's main role was seen as responding to drinking when raised as a problem by signposting to additional help, a strategy in line with their general approach to support.

At the time of the study the probation sector was grappling with the aftermath of reorganisation, and fewer alcohol interventions were recorded than had been expected. Officers' alcohol-related caseloads focused on court-ordered treatment for dependent drinkers. Among the less problematic drinkers commonly targeted by screening and brief interventions, "resistance … to disclose or discuss their drinking was noted among almost all staff," leading them to abandon "systematic and standardised" screening in favour of a less formal approach to discussions about drinking.

For most social work and social care staff, alcohol-related problems were common among their caseloads, but (like housing staff) they focused on relatively severe problems too entrenched (they felt) for brief interventions. Associated with this focus, usually workers offered referral to specialist services rather than dealing with problems directly. Clients may have been reluctant to address drinking, but so too were the staff: "There was widespread anxiety … about encouraging service users to articulate risk around increasing alcohol use. Participants feared that this would require them to intervene more substantially, a responsibility which did not sit comfortably with a role of screening and giving brief advice." In other words, screening was seen as opening a 'can of worms', in response to which both brief advice and their skills and confidence in offering fuller support were seen as inadequate. Trust and rapport with clients were see as threatened by interventions not led by service users and "There was much concern related to the issue of disclosure in terms of the statutory role that social workers perform in relation to risk assessment and, in particular, they referred to how this aligned with their safeguarding roles." As in the other sectors, some staff said they would not implement standardised programmes but would adapt depending on clients' needs. Standard approaches of the kind tested in

research "did not sit easily within naturalistic conversations and sensitivity was needed as to when to broach the subject of drinking". The demand to implement widespread, standardised screening and brief intervention "seemed to them to be in conflict with some of the core principles of their roles and to undermine the fundamental structures and working practices of social work".

Another arm of the same study (research report listed above along with related journal article) sought the views of trainers, experts, and trainees from four English regions on the role of training in delivering alcohol screening and brief interventions in sectors such as youth services, housing, probation, policing, social services, and other local authority services. It can be thought of as a test of whether the type of training they received helped them do screening and brief intervention (or more generically, identification and brief advice – 'IBA') despite the barriers revealed in the sector case studies described above.

On page 12 the research report delivered its verdict: "Training does not result in IBA delivery." Had the researchers only gone as far as the trainees' views they might have declared the training a success. Levels of satisfaction were high and 8 in 10 who responded to a survey said the training helped them apply IBA practices within their work. This rosy picture was substantially dimmed when the researchers went on to ask about actual implementation. Despite appreciating the training, "very few had put their training into practice". Of the 82 who answered this question, nearly 6 in 10 had not done so at all and nearly all the rest used their IBA training infrequently – only nine did so at least once or twice a month.

The main blockage came at the very first stage. Trainees had found that "in many work contexts, screening using a standard tool such as AUDIT is not seen as appropriate or practical" – yet this was the strategy they had been trained in. For example, social workers dealing with families whose children were at risk preferred to engage the family in a less threatening discussion rather than ask set questions, and screening and advice was considered impossible when police were faced with drunk, disorderly or violent people. For the researchers, flexibility in response to the working context was the key to implementation: "Training needs to be related more directly to organisational cultures, behaviour, and development needs … Prior to delivering training, efforts may be needed to assess and incorporate organisational factors into training programmes." But there was a line across which adaptation effectively became the abandonment of screening and brief intervention as originally conceived as a public health strategy. As the study progressed, "These questions became as, if not more, important than the original focus on training. They centred on the extent to which the 'classic' IBA approach was appropriate to the working practices of different professional groups, *and in addition, raised questions regarding the extent to which IBA could be adapted and still be considered as IBA*" (emphasis added). In particular, screening and brief intervention which effectively abandons screening becomes simply another way to respond to people already known to have a drinking problem, no longer a way to find those problems across a population, even if they are not apparent.

Scotland's national drive to implement screening and brief intervention – initially in primary care, emergency departments and antenatal care – has provided an opportunity to explore what helps and hinders delivery and what form delivery actually takes. In health services other than primary care, managers and clinicians said implementation "required a willingness to be flexible and pragmatic about the design of the programme, balancing what was desirable with what was possible. A key lesson is not to be afraid to tweak the model." Accident and emergency departments were the clearest case, demanding minimal screening approaches. One interviewee explained that they now asked just the first question of the Fast Alcohol Screening Test (FAST), and if the patient admitted to drinking eight (or for women, six) or more standard drinks on one occasion, a conversation on alcohol was indicated. This strategy omits the three follow-up questions intended to identify risky drinkers not picked up by the first question. The researchers cautioned that the perceived "need to adapt the intervention to fit with current practice in each setting in order to make it easier and more acceptable to implement … carries a risk of compromising the effectiveness of the intervention in ways that are currently unknown".

Since this was one of the priority settings, the Scottish programme also offered a chance to explore delivery in the under-examined antenatal care sector. The themes were familiar from other sectors including probation, housing and social work. The huge sensitivity of drinking while pregnant led midwives (study listed above) to abandon the standard, scripted approaches tested in research in favour of a more individualised and nuanced conversation – and then not initially about current

drinking, but the less threatening topic of pre-pregnancy consumption. Only in these ways might the responses of pregnant patients get close to the accuracy and honesty needed to identify risky drinking. Screening rates were low in many health boards, meaning midwives delivered few interventions. In several areas, reported alcohol use elicited through standard questions was lower than expected.

Further driving departure from standard approaches was the conviction among many midwives that the maximum drinking guidelines on which research-based screening and brief interventions were built were inappropriate at a time when 'no drinking at all' should be the message. Midwives also felt that the screening and brief intervention programme they were being asked to implement "did not necessarily align" with the Scottish government's Getting It Right For Every Child agenda or other relevant lifestyle and health agendas. For some staff, screening was irrelevant because "if somebody had a significant problem they would already be known and if they didn't … but were drinking, they were unlikely to tell you, the others who were happy to talk about it had already reduced or stopped drinking anyway".

The result was that in the antenatal sector the researchers "found no universal adoption of a validated screening tool across health boards, as many adapted instruments to fit the local context". Instead, "conversation and asking questions in a locally appropriate language" were the preferred approach. Such flexible approaches with the emphasis on building trust were felt to lead to more frequent and/or more complete disclosures of alcohol consumption.

The Scottish national programme later sought to broaden out from its three initial priority sectors, but the Glasgow area aimed to do this from the start, spawning a study listed above of attitudes to screening and brief intervention among a variety of staff who underwent training to support this expansion. Among other sectors, they came from community mental health and social work teams, including several practitioners working in criminal justice and with children and young people, health visiting and primary care nursing, services supporting women who have suffered or are at risk of abuse, and community services for older people.

Even after training "designed specifically for multidisciplinary staff including health, social care and other practitioners," seven out of nine practitioners for whom this information was available and relevant did not engage in screening and brief intervention at all, and another was unsure. The reason was that they felt these activities were inappropriate for their clients. As in the studies discussed above, they were focused on more severe drinking problems than brief interventions were meant to deal with, and saw their roles as referring on for specialist help rather than directly delivering an intervention, no matter how brief. Others worked with caseloads among whom they felt heavy drinking was unlikely: "You wouldn't just routinely raise it with somebody just because you want to make sure that's not something that's there. There would have to be something that would make you feel [it was] appropriate to raise the issue of drinking," said one social worker – ironically missing the whole point of routine screening, which is precisely to identify excessive drinking when there are no signs of its presence. However, there were caseloads – such as elderly people injured by falling – where raising drinking did seem more appropriate.

Standard screening questionnaires were not usually deployed and the practitioners preferred to discuss drinking if the issue came up rather than to 'deliver' a brief intervention. The researchers advised bending to this reality: "Avoiding an excessively narrow conceptualisation of [alcohol brief intervention] seems important here. These practitioners see the need for different varieties of [alcohol brief intervention] but do not define them in this way." However, the researchers also acknowledged that alcohol brief intervention programmes "can only produce the benefits expected of them, if well implemented" – yet 'flexible' conversations and non-validated 'screening' methods cannot be assumed to meet quality standards.

Also in Scotland, another study explored the feasibility of extending screening and brief intervention beyond healthcare settings, this time by piloting these activities in community justice settings. In 2010 and 2011 three local authority areas offered training to 121 probation and community service staff to enable them to screen offenders they were supervising for risky drinking using the AUDIT questionnaire. A randomly selected half were also trained to offer a brief intervention based on motivational interviewing to offenders who screened positive for risky drinking.

Among staff there was widespread commitment to dealing with drinking problems, but often they felt

the piloted intervention was unsuited to their client groups, largely because they faced more serious issues such as money problems and housing, and addressing drinking was not a high priority. Some staff said if it was a priority it would already have been incorporated in sentence planning, that they would have dealt with it anyway in normal practice and perhaps more adequately than through five minutes of brief advice, that their clients were often too extreme in their drinking to be suitable for a brief intervention, and that excessive drinking was too intertwined with other problems to be dealt with in isolation. Although the AUDIT questionnaire and the brief intervention seemed to have been easy for them to administer and were seen as useful tools, staff were in some ways negative about the appropriateness and likely success of alcohol screening and intervention in this environment.

In England too, probation officers were not convinced of the value of brief interventions for their caseload. The study also tested brief interventions in primary care and emergency departments. Compared to these medical settings, screening and brief intervention were felt to meld more naturally with routine probation work, but staff were less convinced these procedures would be useful and tended to feel they were best reserved for offenders with obvious drinking problems. Of the 197 staff in the trial, 44 did not recruit any offenders to the study, and just 45 were able to implement screening and brief intervention as intended without extra help from researchers and specialist alcohol workers.

Also in England, between 2010 and 2012 a major study examined the effectiveness and cost-effectiveness of a brief intervention for people attending sexual health clinics who had been identified by screening tests as drinking excessively. No impacts were found on drinking. Researchers suspected that the intervention's impact may have foundered on the mismatch between levels of drinking seen by national guidelines as excessive and the views of this mainly young, sexually active group, who saw their 'excessive' drinking – probably usually confined to weekends – as a normal feature of their social life, and generally unrelated to the problems which brought them to the clinics. While in emergency departments and trauma centres excessive drinkers are likely to have suffered an unintended repercussion of their drinking in the form of an injury, for the sexual health caseload, having fun, and perhaps too having sex, were often desired and intended consequences of drinking. Persuading these drinkers that their consumption has led to a problem rather than on balance enhanced their life seemed a difficult task.

Close supplementary text

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