DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell E1

Treatment systems; Screening and brief intervention

Key studies and reviews on local, regional and national systems for implementing alcohol screening and brief intervention. Context is that Britain's National Institute for Health and Care Excellence insists commissioners and managers "must" provides the resources needed for brief intervention to become part of everyday work. Can these interventions be widely implemented, and even if they are, will they improve public health? 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

K Scottish national implementation drive worked best in primary care (NHS Health Scotland, 2011). Numbers of patients talked to about their drinking testified to what can be done in primary care when national policy is backed by funding, training, resources and per-patient payments (2017). Still, most risky drinkers were not screened and the quality of screening was suspect. Implementation was patchy in antenatal services (2010) and emergency departments; more on both settings in study below. For discussions click here, here and here, and scroll down to highlighted headings.

K In Scotland barriers formidable outside primary care (2015). Experiences of staff who implemented Scotland's national programme (main evaluation report above) in emergency departments and ante-natal services suggest system planners should be prepared to flexibly adapt researched interventions. Related review below. For discussions click here, here, and here, and scroll down to highlighted headings.

K In GPs' surgeries (2013), emergency departments (2014) and probation offices (2014), the policy-critical SIPS trials in England seemed to justify commissioning only terse and basic feedback to patients on the implications of their screening results. Doing more raised costs and hardened barriers to implementation, yet could not be shown to gain anything in consumption reductions. For discussion click and scroll down to highlighted heading.

K Simulation study suggests lives cost-effectively improved in England and health costs reduced (2013). Predicted substantial health service cost-savings and low-cost health benefits from alcohol screening and brief advice in primary care, but some key assumptions which generated these estimates were questionable or are now outdated. Review of similar studies below.

K No demonstrable reductions in patients' drinking after training Welsh GPs in multi-issue lifestyle counselling (2013). Integrated training for GPs on counselling for drinking, smoking, diet and exercise meant more patients were talked to about these behaviours, but behaviour-change success rates generally and specifically in respect of drinking were not significantly improved. For discussion click and scroll down to highlighted heading.

K Small per-screening payments not shown to increase primary care screening rate in England (2019). The clearest impact of a national programme of financial incentives to screen primary care patients in England was the plummeting screening rate after the incentives were withdrawn. For discussion click and scroll down to highlighted heading.

K Large payments can dramatically raise screening rate in UK primary care (2017). From 2011 the main system (the QOF) for financially incentivising quality in UK primary care promoted screening for risky drinking among seriously mentally ill patients. The effect was to quadruple the screening rate relative to other patients. Similar findings in respect of bipolar disorder. For discussion click and scroll down to highlighted heading.

K Pay primary care to screen and advise – and keep paying (2016). EU-funded ODHIN trial tested strategies to promote screening and brief interventions for risky drinking in primary care in five European countries including England. Payments per patient boosted screening and intervention rates especially when combined with training and support, but rates fell back after payments ended. Also from the same study, a cost-effectiveness analysis (2018) and clinicians' views (2016) on what aided or impeded implementation. For discussion click and scroll down to highlighted heading.

K US national programme achieves unprecedented quantity; quality and impact uncertain (2006). Processes and results of the implementation strategy of the US health service for ex-military personnel – in coverage, the most successful large-scale programme to date. However, drinking reductions were minor (2010) or absent (2010; 2014) and screening missed most (2011) risky-drinking patients. For discussion click and scroll down to highlighted heading.

K Dutch programme fails to engage primary care and may have been counterproductive (2012; free source at time of

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writing). Just 3% of invited practices joined the study, half those offered training did not complete even a minimal programme, and the result was that patients were slightly *less* likely (2012) to remit to non-risky drinking. Practice engagement levels "reflect the effects of such a programme when conducted in a naturalistic setting" and training and support "did, in fact, increase the odds that patients would continue with hazardous or harmful drinking". For related discussion click and scroll down to highlighted heading.

R Unclear whether health improvements justify screening and intervention costs (2014). Simulation studies estimate that these programmes are cost-effective health improvers, but evaluations which actually measured health gains "do not allow any firm conclusions to be drawn". UK simulation study above. For related discussion click and scroll down to highlighted heading.

R Abandon the ambition to achieve population-wide health gains? (2017; free source at time of writing). Achieving health gains across an entire population was the raison d'être of screening and brief intervention programmes, but citing an assessment (2012) from the UK's most eminent brief intervention researcher, this review concluded that "After more than three decades of study in primary care, it now seems unlikely that brief interventions alone confer any population level benefit". For discussion click and scroll down to highlighted heading.

R Maximise implementation by preparing organisation and patient (2015; free source at time of writing). Meta-analysis amalgamating results of relevant studies found that implementation strategies had boosted alcohol screening and brief intervention rates yet not significantly affected drinking. Greatest impacts were seen from multi-strand strategies which went beyond incentivising or training clinicians to adapt the organisation to the programme being implemented (eg: re-allocating tasks; extending consultations) and also prepared patients by for example handing out alcohol education leaflets. Screening benefited from involving staff such as nurses as well as doctors.

R Strategies to implement alcohol screening and brief intervention in primary care (2011). Contextualises implementation strategies at the level of the organisation undertaking the work and of the surrounding economic, political and social environments.

R Real-world implementation in primary care requires flexibility (2010). Case studies of system-wide implementation programmes from England, Spain and New Zealand highlight the need for pragmatic flexibility in response to the local context. Related study above. For related discussions click here and here and scroll down to highlighted headings.

G In guidance on alcohol problem prevention (NICE, 2010) and treatment (NICE, 2011), the UK's official health technology advisor stresses that evidence-based alcohol screening and brief intervention must be resourced as integral parts of health and social care practice. For discussions click here, here and here, and scroll down to highlighted headings.

G Commissioning integrated alcohol prevention and treatment systems in in England (Public Health England, 2018). National health body responsible for supporting substance use work offers advice on commissioning alcohol services, including "large scale delivery of identification and brief advice (IBA) to people who are most at risk of alcohol-related ill health".

G Scottish guidance on embedding screening and intervention in routine practice (Scottish Government, 2017). Instructs local health and social care commissioning and planning bodies to plan for routine alcohol screening and brief intervention and stipulates what this should mean in practice. More on practice models and required staff competencies in "competency framework" (NHS Health Scotland, 2010). For discussions click here, here and here, and scroll down to highlighted headings.

G 'Toolkit' for commissioning (2016). From south London's Health Innovation Network, an online resource bringing together the evidence base and guidance for alcohol identification and brief advice plus tips for commissioning across a range of settings, a framework for incorporating quality in the commissioning process, and case studies. For related discussion click and scroll down to highlighted heading.

G Supported among others by Public Health England, guides from the charity Alcohol Concern (now absorbed in Alcohol Change UK) for: community health settings (2015) such as primary care, pharmacy, midwifery, health visiting, drug services, and sexual and mental health services; hospitals (2015) including emergency departments; and criminal justice services (2015). Will help commissioners set expectations and standards for the services they commission.

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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 aims to spot drinkers at risk of or already experiencing alcohol-related harm 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 to 30 minutes 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'. A broader term for this type of activity is "identification and brief advice", which includes structured screening and brief intervention of the type typically studied, but extends to less structured activities with the same objectives. 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 how implementation and impact are affected by commissioning, contracting and purchasing decisions across an administrative area. These are crucial, because screening and intervention are usually implemented by staff and organisations who may see drinking which modestly exceeds guidelines as 'normal' and not seriously threatening the individual's health, and for whom the public health consequences of such drinking spread across an entire population are not a core concern. Without explicit, hard-to-ignore encouragement, mandate or incentives, implementation rates are usually poor, undermining the realisation of potential public health gains.

Much of this commentary also explores another related problem for system planners and commissioners – how to make screening and brief intervention widespread and routine, while at the same time maintaining quality.

Where should I start? For service managers and commissioners in the UK the most authoritative advice – which publicly funded health services cannot (or should not) ignore – comes from Britain's National Institute for Health and Care Excellence (NICE). In 2010 it insisted (see documents listed above) that commissioners and managers of NHS-commissioned services "must" generate a system which provides the training, resources and time needed for staff to conduct evidence-based screening and brief intervention as a routine and integral part of practice. Finding and allocating these resources (above all, time), persuading staff to screen even when they have no reason to suspect excessive drinking, and enabling them to screen and offer advice in ways which meet quality criteria (see section highlighted below), are the tasks set by the guidance.

Half a decade later, a clue to how far there still was to go emerged from a population survey in England conducted between 2014 and 2016. It showed that well over 9 in 10 risky drinkers who had visited their GPs in the past year did not recall their drinking being addressed. In the absence of incentives to promote systematic screening, talking about alcohol was largely restricted to potentially dependent drinkers; more on the critical role of incentives later in this commentary.

Further evidence of the need–intervention gap and the continuing focus on heavier drinkers came from general population surveys (free source at time of writing) conducted in England between 2014 and 2017. In the past 12 months just 2% of the largest category of risky drinkers – those in the lowest risk range – said they had been "offered advice about cutting down on my drinking" in their GP's surgery. At 12%, the proportion of probably dependent drinkers was greater and 14% had been directed to specialist help, but still fewer than 1 in 5 recalled being asked about their drinking. In 2013 the focusing of intervention on heavier drinkers also emerged from a survey of alcohol health workers in English hospitals; 71% of the patients they saw were dependent on alcohol, yet their hospitals will have seen twice as many 'harmful' but non-dependent drinkers. In emergency departments, things seem to have improved. In 2015, 64% of departments routinely asked adult patients about their drinking compared to 48% in 2011. However, these figures were based not on the recollections of patients or direct observation, but on the survey responses of the departments themselves.

In 2015 attendees at a conference in England warned that "Achieving the vision for high quality routine delivery may still be some way off" and might not happen "without sustained national and local leadership". With national programmes, Wales and Scotland (see section below) are probably doing better,

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but quality is uncertain, an issue addressed later in this commentary. The original motivating vision of widespread, routine screening and brief intervention at every opportunity – and with it the promise of population-wide health gains – has receded as the limitations on implementation and effectiveness have become more apparent, a journey explored in the final section of this commentary.

Highlighted study A major strand in its drive to tackle UK-topping alcohol problems, Scotland is the only UK nation to have a national target for the number of brief alcohol interventions, initially set at 149,449 over the three years from April 2008. Our highlighted study (listed above) evaluated this trailblazing initiative, focusing on implementation in primary care.

The aim was to identify patients whose drinking warranted intervention through 'targeted' screening of those known to have possibly alcohol-related conditions, an approach (see cell C1's "Highlighted study" section) more natural and feasible for practitioners than simply screening everyone. Of the services in the three priority settings, only primary care practices really accepted the challenge. Head-count financial incentives, the ability to seamlessly advise after screening, and more of a feeling that this was an appropriate activity, lifted their performance way above emergency departments and antenatal care, the other two priority settings. Despite this, in one of three case-study areas only an estimated 41% of hazardous or harmful drinkers visiting GP practices during a year were screened, and in the other two, about 30%, suggesting that nationally most risky drinkers were missed.

From 2015/16 local health boards were to make plans (document listed above) to embed this work in routine practice. Priority settings remained the same and in each health board area at least 80% of the targeted number of brief interventions were to be conducted in those settings. By 2018/19 the number of recorded brief interventions had fallen from a peak of 104,356 in 2013/14 to 80,575 – well above target, but continuing a steady decline. Primary care accounted for just under half and accident and emergency departments for 14%. Remaining very patchy was performance in antenatal clinics; in half of the 14 health board areas fewer than 10 interventions were recorded, and in the whole of the Glasgow area, just 85. Nevertheless, between 2008/09 and 2014/15 it was estimated that 43% of harmful and hazardous drinkers in the whole of Scotland had been reached by the brief interventions programme. Assumptions underlying this estimate mean it is probably an upper-bound figure, but it does illustrate how the coverage of a programme can accumulate over the years, even if in each of the those years only a small minority of the intended population are reached.

As businesses with an established incentive payment structure, financial rewards were key (study listed above) to achieving the numbers in primary care practices, but the other services had to rely more on leadership and support. In many areas this was not enough to overcome the barriers described by midwives and by staff (document listed above) involved in implementing the programme in antenatal care and emergency departments.

What emerged from these studies were the structural barriers to talking about drinking to distressed and perhaps seriously injured patients in a busy emergency department, and to discussing alcohol with women likely to deny drinking while pregnant. In emergency departments, the typical solution (seen also in England) was to arrange a later appointment – which many patients will not attend – while midwives sometimes took the less threatening route of asking about the patient's pre-pregnancy drinking and discussing their post-pregnancy intentions.

The findings exemplified a lesson from across the Scottish national programme – the need to tailor approaches to the local context, an issue explored more fully in cell D1. That in turn creates a dilemma exposed in a review listed above of implementation case studies from England, New Zealand and Spain. Guidance stresses interventions must be "evidence-based", but researchers have generally tested pre-set interventions rather than general principles. The moment such an intervention is adapted to make it more feasible in the local context, it ceases to be evidence-based. What effect these adaptations have on impacts is unclear, perhaps one reason why NICE says (1, 2; listed above) commissioners should incorporate cost-effectiveness evaluations into their screening and brief intervention plans.

Issues to consider and discuss

Commission for quality as well as quantity – but what *is* quality? This section's title alludes to a major concern among practitioners, commissioners and researchers involved in alcohol screening and brief intervention in the UK. In 2015 they could identify almost no data on the degree to which practitioners do what they are meant to, but cited "anecdotal reports" of poor practice, especially by

untrained primary care staff. Similarly, a toolkit for commissioners (listed above) developed in London queried "the extent to which reported [alcohol identification and brief advice] activity is actually reflective of genuine brief intervention". Developing systematic ways to ensure quality was seen as "crucial", a point made also in UK guidance (1, 2; listed above), which called on commissioners to integrate evaluation into their systems to "ensure adherence to evidence-based practice". Reflecting these concerns, in some areas the Scottish brief interventions programme made payments to primary care practices only if staff (study listed above) had received the required training, and in at least one area clinicians had to record why they had decided *not* to intervene. Sharpening these concerns, a Dutch study (reports listed above) suggests that poorly implemented training and support can actually be counterproductive.

But to assure quality, first we have to have to pin down what 'quality' is. The UK's health technology advisory authority says screening must be "systematic" and use a scientifically validated method (1, 2; listed above). As a minimum, interventions should consist of "structured" advice lasting five to 15 minutes from trained staff using recognised research-validated resources based on FRAMES principles, entailing style and content well beyond a brief health warning and advice to cut down. In turn, these understandings have been reflected in national practice requirements and guidance; unfold the supplementary text for examples.

> Close supplementary text
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> In its brief to local health and social care commissioning and planning bodies, the Scottish government explains (document listed above) that even a five-minute brief intervention is a "structured conversation" distinct from "simply advising a person to drink less", one which features assessment of the degree of risk in order to decide between brief intervention only or referral for specialist help. For this work, required competencies (document listed above) include a "supportive, non-confrontational and motivational … style. The goal is to motivate the individual to decide to change their behaviour, but not to tell them what to do or to direct them." Typical elements include motivational enhancement techniques, analysis of high-risk situations for drinking, coping strategies, and the development of a personal plan to reduce consumption. In the Welsh national programme it seems FRAMES-based advice was also considered good practice. Similar guidance has been disseminated to criminal justice services in England and Wales.
>
> Close supplementary text

In respect of the brief intervention element, these recommendations appear comprehensively contradicted by the findings of research funded by England's Department of Health precisely in order to establish what effective and cost-effective practice really is in typical settings. As detailed in cell A1, the SIPS trials listed above failed to show that interventions of the kind recommended in guidance were any more effective than blunt feedback on screening results plus a health warning and an alcohol information leaflet – a response easily completed in under 30 seconds. On the health service's primary yardstick – quality-adjusted life years – in both probation and primary care, this minimal intervention also seems to have gained most for each £ of social costs associated with the participants' drinking. The implications were not lost on the Department of Health's Director of Health and Wellbeing: "Less is more," she told a conference on the study's results.

However, extrapolating from the SIPS results to the conclusion that only the very briefest and most basic contact is needed is not entirely justified; in SIPS, even the most basic advice was embedded in extensive research assessments and follow-ups which could themselves have affected drinking. It could also be that SIPS's mid-level intervention was sub-optimal, failing to use a motivational interviewing style to centre on the patient's reasons for drinking. Rather than doing less, perhaps *more* was needed – more training, and more expertise.

But overriding the 'maybes' is one unequivocal and perhaps not unwelcome fact – that the results of the SIPS trials offered no convincing reason to spend more money and time than is needed for the most basic, inexpert intervention. Hard-pressed staff and austerity-hit commissioners may be tempted to do the least seemingly justified by trials on which the UK government itself said it would base its policy. That decision would not necessarily be a mistake; basic interventions could reach more risky drinkers than costlier programmes requiring trained staff, and as a result might make a greater contribution to public health.

How would you judge the pros and cons – go for quick and unsophisticated, or aim higher and risk greater implementation shortfalls? How would you recognise quality? Content and style of the intervention? Patient satisfaction? The bottom-line measures seem to be impacts on drinking and through those on health, but perhaps quality consists of prompting someone to seriously *consider* their drinking, even if they decide that for them the balance of pros and cons weighs towards no change. Are resultant referrals

for treatment a relevant indicator? And how would you measure these indicators? Before you answer, take a look at this further evidence that impact is not necessarily linked to quality as defined by guidance and in research, and that sacrificing adherence to ideal interventions can help spread at least some kind of intervention to a greater proportion of risky drinkers.

Close supplementary text

A classic emergency department study from London published in 2004 offers further evidence that (if the yardstick is impact on drinking) extended and expert interventions do not always constitute 'quality'. All the patients received something like the most minimal of the SIPS interventions described above – a warning from an emergency department doctor that their drinking was harmful, reinforced by an alcohol advice leaflet. A randomly selected half were also referred for about half an hour's counselling from an experienced alcohol specialist.

On the face of it, this added intervention also had the intended added impact; on some measures patients referred for counselling drank significantly less six and 12 months later than those not referred. But there was an unexpected twist to the findings: it made no difference whether patients *actually attended* the counselling. Just under a third did, and they averaged just over 60 UK units of alcohol per week at six and 12 months. Across all the referred patients, the averages were just *under* 60 units. On average, patients referred for counselling, but who *did not* attend, must later have been drinking slightly less than those who *did* attend. It seems that what caused the referred patients to drink less was not the counselling, but being *referred* for counselling. As the researchers speculated, perhaps it signified to the patient that the doctor was treating their drinking as a serious problem.

In case you think this and the SIPS trials were isolated examples, a review of studies of brief alcohol interventions in primary care did not find longer (and generally more psychosocially rich) interventions significantly more effective than lesser efforts, and another listed above which focused on cost-effectiveness found "no clear evidence that the duration of intervention delivered has a substantial impact".

None of this necessarily means quality is irrelevant. It might instead mean that indicators of quality lie not along the dimensions of intensity, extensity or sophistication, but along dimensions more to do with the interpersonal style and social skills of the interventionist – the message from cell B1. And even if these have not been shown to affect drinking, it is hard to argue against basic good practice like offering sources of further help, assessing severity, referring those at greatest risk to specialist treatment, following up patients to see if they want and need more help, and informing their GPs about their drinking and the intervention you offered.

Perhaps too, high quality interventions really do further reduce drinking, but we have not yet been able to show this through research. Even if that were the case, there would remain the issue of whether these are also better *in public health terms*. A major advantage of minimal and basic interventions is that relatively untrained staff can do this work in a matter of minutes, making large-scale programmes more feasible. Implementation barriers are correspondingly lower, meaning that a higher proportion of the intended intervention targets will actually be screened and advised about their drinking. This in turn means that, even if they were less effective *per patient* than fully fledged brief interventions, by reaching more drinkers, minimal interventions could still generate greater public health gains.

In practice, programme planners have had to risk sacrificing conventional ideas of quality in order to extend the coverage of screening and brief interventions. To maximise implementation in Scotland, some officials pragmatically departed (study listed above) from theoretically 'ideal' interventions in order to build on existing practices and adjust to the context and resources available – as one official put it, they abandoned the "10 commandments" and instead met staff half way. A similar example comes from Wales, where a nationwide implementation drive had to replace a poorly attended two-day training programme with a much more popular two-hour course. Such adaptations move real-world interventions away from some of the models trialled in research, leaving it unclear whether impacts seen in that research will be replicated. But without these adaptations, implementation will suffer, and with it the numbers of risky drinkers reached.

Close supplementary text

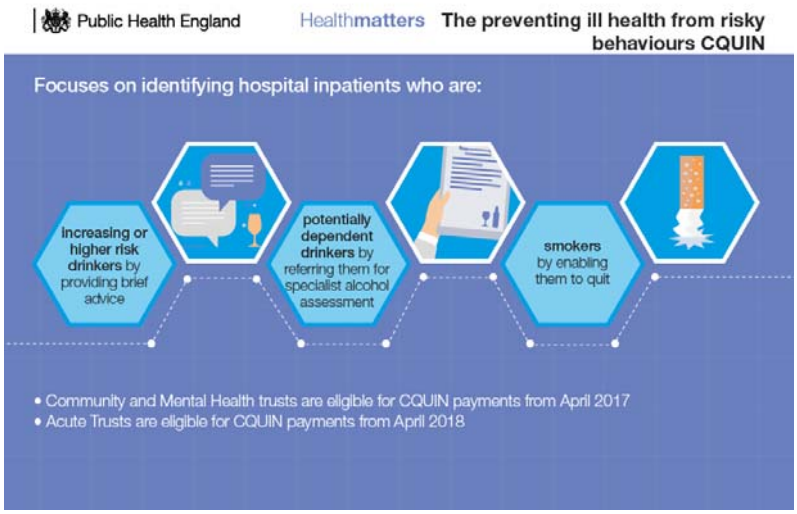
▸ **Are incentives essential?** Do we have to accept that unless staff are paid extra per screened/advised patient or held to account for meeting standards or targets, little will happen which would not have happened anyway? Professionals committed to public health might be expected to promote that without needing carrots or sticks. But firstly, the evidence is not that convincing that

screening and brief intervention do promote public health – among the reasons why in 2017 the UK National Screening Committee rejected a universal alcohol screening programme after a review found a "lack of evidence" that it "would improve morbidity and mortality or would reduce social harm". Secondly, even if the evidence *were* convincing, the possibility that incentives would nevertheless be needed arises from the nature of screening and brief interventions: that they take advantage of encounters in which sub-dependent drinking is not naturally on the agenda; one way or another, it has to be inserted. Often this is because the *individual's* health is the main concern for the staff involved, not the grand scheme of public health, for which small and patchy individual improvements lower down the severity scale can cumulate to a worthwhile effect.

In practice, per-head payments and targets for which staff are held accountable have been critical in implementation programmes in Scotland (document listed above) and in England, where between 2008 and 2015 the Directed Enhanced Services scheme offered general practices the chance to earn a small sum for each newly registered patient screened for risky drinking. More recently, instead the UK has moved towards embedding alcohol screening and brief intervention in routine practice, though a notable exception was the introduction in 2017/18 in England of payments to encourage hospitals to screen adult inpatients for smoking and risky drinking. For more on these developments, unfold the supplementary text.

Close supplementary text

Incentives at the level of an entire provider organisation were introduced in 2017/18 in England to encourage NHS-commissioned community, mental health and acute services (other than maternity and emergency services) to screen adult inpatients for smoking and risky drinking. Providers are under no obligation to accept the deal on offer. If they do, it commits them to keep records enabling a calculation of the proportion of patients screened for smoking and/or risky drinking, and the proportion who screen positive for these behaviours who are given brief advice, or for possibly dependent drinkers, are offered referral to specialist services. Payments depend on the screening rate the service records in the range 40% to 80%, and the brief advice rate in the range between 50% and 90%.



Commissioning for Quality and Innovation (CQUIN): The "preventing ill health" indicator

Screening for risky drinking is to be done using the three questions of the AUDIT-C screening questionnaire, which assesses the respondent's typical current drinking pattern. Depending on the patient's score, brief advice might consist simply of feeding back to the patient what this suggests about their health risk and encouraging reduced consumption, backed up by a leaflet with information about harm from drinking, the benefits of cutting down, and ways to achieve this. Complementing this work are free e-learning courses from Health Education England on alcohol identification and brief advice, and "very brief advice" on smoking.

Moving away from special schemes, targets and incentives, across the UK attempts have been made to position alcohol screening and brief intervention as usual practice. Published in 2017, among them are instructions (document listed above) to Scottish health service planners to embed this work in routine practice.

Sharing the same objective, the Welsh "Have a word!" campaign was an attempt to win hearts and minds through exhortation, information and training. Launched in May 2012, by August 2016, 13,308 individuals from a wide range of organisations had been trained, but after that the campaign ended as Public Health Wales decided to deliver brief alcohol interventions within an

approach to multiple lifestyle risks such as smoking and inactivity.

These interventions were to be embedded in practice through the Making Every Contact Count programme. In England as well as Wales, the programme aims to extend the delivery of public health advice by (at minimal cost) training non-specialist staff from a wide range of services in the basic skills of health promotion and disease prevention, including the prevention of risky drinking through brief lifestyle behaviour change techniques, a form of brief intervention. As described in the Yorkshire and Humber region of England, the focus is on training non-professionally qualified staff.

In England, screening newly registered patients for risky drinking and providing follow-on brief interventions or referral to specialist services were from April 2015 bundled into the core contract for primary care services, replacing the national scheme enabling per-patient incentive payments. However, the programme's planners are not entirely leaving practices to their own devices. Each step of the contracted process is to be recorded by practices, and the records are intended to be audited by local commissioners. In theory this could identify practices which fail to screen or record an abnormally high proportion of patients as not needing further testing or advice.

Close supplementary text

Payments are not sufficient in themselves to ensure implementation and quality, but interviewed in 2015, GPs in Scotland saw them as a key component. More was needed, in particular the well organised and well resourced training and support found important in the multi-national 'ODHIN' trial described below, and the frequently cited need for sufficient time, for which there is some relatively strong evidence from England (free source at time of writing). Such resources can enhance quality, but in primary care, experience shows that the public health bedrock of quantity will be lacking unless there are strong incentives.

In England the main national incentives schemes for primary care are the Quality and Outcomes Framework (QOF) and the Directed Enhanced Services scheme. It is the latter – an optional scheme targeting newly registered patients which practices can choose whether or not to contract into – which has mainly been used to extend screening and brief intervention. Though practices which do opt into the scheme can substantially increase their screening rates, its small per-screening payments and requirement to audit subsequent interventions have been insufficient to greatly affect practice among surgeries overall, including those which did not join the scheme. The upshot was that the scheme was unable to ensure that more than a small minority of risky drinkers attending surgeries were advised about their drinking. Perversely, its withdrawal in 2015 left screening rates lower than they had been before the scheme started.

Researchers on these studies speculated that the higher payments and the embeddedness in primary care of the Quality and Outcomes Framework would be more effective. In London and also nationally, that proposition has been investigated among patients suffering from or at risk of cardiovascular conditions and/or diagnosed with serious mental illness. The researchers' expectations were validated. Both studies found that from just a small minority of patients being recorded as screened or whose drinking was documented, with the QOF incentives, this became the norm. Payments may have allied with a greater appreciation on the part of clinicians of the clinical importance of limiting drinking in these particularly vulnerable patients. For more on these studies in England, unfold the supplementary text.

Close supplementary text

The importance of adequate payments was apparent in England where between 2014 and 2016 well over 9 in 10 risky drinkers seen by their GPs in the past year did not recall being advised about their drinking. It was not that the clinicians were reluctant to address any lifestyle issue; smokers were eight times more likely than risky drinkers to recall their consumption being addressed. The reason may have been that then and now, the major incentives system for primary care – the Quality and Outcomes Framework (QOF) – financially rewarded practices for documenting and responding to smoking but not drinking. In the absence of these incentives, talking about alcohol was largely reserved for very heavy and potentially dependent drinkers, contrary to the intention that screening programmes would ensure *non*-obvious risks were not overlooked.

In part that was the message also to emerge from comparing the records of primary care practices in northern England which in 2010–2011 were or were not incentivised to screen for risky drinking under local schemes and/or the national Directed Enhanced Services scheme. The national scheme concerned only newly registered patients. Incentives appeared to substantially raise the proportion of newly registered patients recorded as screened (often by practice nurses) in a year from under 1% in non-incentivised practices to about 48%.

However, even when incentivised by the local scheme, payments did little or nothing to induce practices to more generally undertake screening, not just of newly registered patients. Without incentives the recorded screening rate among all patients registered with the practices was virtually zero. With them it rose to about 4%, but nearly all these were newly registered patients. Interviews with GPs suggested that the more lucrative and embedded QOF system would have been more effective, but would still run up against reluctance to depart from patient-centred practice and scepticism about the effectiveness of brief alcohol interventions. In this study the risk could not be eliminated that practices *already* committed to alcohol screening chose to get paid for this by opting into the incentives schemes, giving the false impression that the schemes had caused more extensive screening.

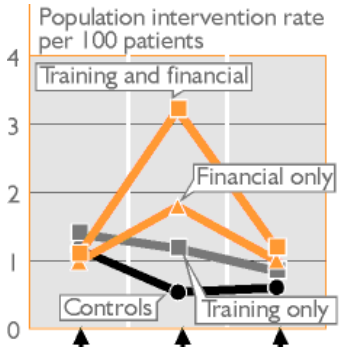
The above study contrasted practices which had taken up the option of being paid for screening newly registered patients under the Directed Enhanced Services scheme with those which had not. In contrast, an important national study in England (listed above) investigated the impact of making this scheme available in 2008 and its withdrawal in 2015, without narrowing in on practices which actually joined it. Across a sample of over 500 practices, introducing these provisions seemed to have had no effect on the proportion of patients screened, but might have increased the (still small) proportion then advised about their drinking. The clearest impacts came when payments ended, after which the proportion of patients screened fell steeply to below pre-incentive levels, and fewer patients drinking risky amounts were advised. At no time were more than a small minority of patients screened each month and of those showing evidence of risky drinking, few received brief advice. However, if not screened in one month a patient might be screened in another, meaning that while the incentives were in place, within 12 months of registering about 65% of patients had at some time been screened. Again, the researchers raised the possibility that the more lucrative QOF would work better at incentivising alcohol screening and intervention.

Between 2008 and 2011 that proposition had been investigated in London, where a borough had implemented an extension to the QOF scheme which allowed it to pay general practices for alcohol screening and intervention for mental health patients or those at risk of or experiencing cardiovascular conditions. The effect was dramatic, raising the previously negligible screening rate to the point where nearly two-thirds of targeted patients were screened, compared to just 15% (itself an improvement on past performance) of patients whose screening did not attract extra payments. Also, a greater proportion (87% v. 74%) of targeted patients who had screened positive then received a brief intervention, but as in the 'ODHIN' trial (below), by far the greatest impact was on the screening rate. Payments here may have allied with a greater appreciation on the part of clinicians of the clinical importance of limiting drinking in these particularly vulnerable patients as opposed to patients in general.

That alignment of influences also possibly accounts for the impact of a national version of the scheme described in the previous paragraph. Though withdrawn from 2019/20, in 2011 the QOF incentive system was amended nationally to specifically incentivise screening for risky drinking (previously merged with other lifestyle issues) among primary care patients suffering from serious mental illness, including schizophrenia and psychoses. Across the UK, the effect (study listed above) was similar to that seen in London. Before any incentives, the proportion of patients whose drinking was recorded had been about the same for those with and without the relevant mental health diagnoses. After 2011, for those with the targeted diagnoses the annual rate jumped to reach 723 out of 1000 while it lagged at 184 among other patients. By far the greatest effect was seen when alcohol was specified rather than merged with other lifestyle issues. Though among patients with the targeted diagnoses, recording of drinking was now the norm, just 5% were known to have been identified by a recognised screening test, raising concerns over the quality of the identifications. The same research team observed a similar pattern among people with bipolar disorder.

Close supplementary text

None of the studies in England were randomised trials capable of demonstrating the impact of financial incentives by eliminating alternative explanations for the findings. However, further evidence of the influence of incentives comes from the multi-national 'ODHIN' European implementation trial listed above. Findings from this randomised trial (chart right) suggested that continuing financial incentives for clinicians and/or their workplaces help extend any benefits of screening and brief intervention to the greatest number of patients, though still a small minority because clinicians preferred to raise



drinking only when it seems relevant. Though critical, payments were not all there was to boosting implementation; they worked best with training and support for clinicians, and interventions which they felt appropriate – specifically, not 'merely' referring patients to a website. Unfold the supplementary text for more on this important trial.

Incentives are intended to and – as the studies describe above show – certainly can divert clinical practice in the desired directions, but with that comes the risk of unwelcome distortion in both recording and practice. Without professional commitment, the figures may be manipulated to record phantom interventions, believed to have happened at some primary care practices paid for intervening in England, and in Scotland among health staff working in non-primary care settings. Their accounts (study listed above) suggested that targets created "perverse incentives to maximise reporting of [alcohol brief intervention] delivery". Some GPs in Scotland also acknowledged (study listed above) that payments might divert them from what they felt was their proper role and could led to 'box-ticking', though they doubted this had been widespread.

The GPs were alluding to the possibility that when screening and intervention *are* conducted, staff may do the minimum to attract payments or meet targets. Resulting quality may be so poor that little impact can be expected. Just such a scenario was suggested (see studies listed above) by initial results from primary care clinics in the US health system for ex-military personnel, where managers lose out financially if their services do not meet numerical targets ▸ more in cell C1. More anecdotally, among general practices incentivised by payments, quality deficits have been observed in England (1 2) and in Scotland, where some practitioners were said to have adopted a relatively "perfunctory" approach to advising patients. From the borough of Haringey in London, take a look at this revealing account of what can happen.

> Close supplementary text
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> The example dates from a time when alcohol screening and advice were something general practices could contract into locally as a 'Directed Enhanced Service'. Under the scheme they were paid for each newly registered patient they screened, but were also required to conduct and record further assessment of positive-screen patients and resulting brief interventions or referrals.
>
> Though the borough was not known for its low levels of drinking, across the 29 practices in the scheme, only 2% of patients screened positive, wildly below 25–30% expectations. Some practices screened all newly registering patients, others just a quarter. One which screened all found every one of them to be a risky drinker, while most found none at all. In 2009/10, as a result of the scheme just 10 patients were referred for specialist treatment.
>
> Surprised at how few problem drinkers were identified, the area's drug and alcohol treatment service initiated an on-site audit of four GP practices, visits which revealed some of the reasons for the shortfalls. Most practices had done no training to support the scheme, and most too used the wrong versions of standard screening questions or in effect substituted their own. Two of the four did not respond to risky drinkers with face-to-face advice, and those which did neither systematised the advice nor provided a leaflet for patients to take away. One practice offered no intervention at all to patients unless they scored as probable dependent drinkers. Across all the practices, even these patients were rarely referred for treatment.
>
> On close inspection, the 'system' could not really be termed a system at all. This was just one area, but it shows what *can* happen, and what can be uncovered by a close, on-the-ground look behind the statistics.
>
> Close supplementary text

If you were planning a national system to promote screening and brief intervention, what role would incentives and targets play, and would this differ in different settings or different categories of staff? One risk is that financial incentives and sticks and carrots attached to targets might confirm to staff that alcohol screening and brief interventions are not their core business. Incentivising screening tempts practitioners to screen but find no need for further assessment or intervention. Incentivising intervention tempts them to intervene only up to the minimum needed to qualify for payments or meet targets. However, incentivising neither usually means few patients are reached. Look back at the previous section and consider too how the carrots and sticks of your preferred system would ensure quality as well as quantity. Or instead of targets and incentives, would you focus on winning hearts and minds over to the view that this work is integral and essential to routine practice? Rather than suggesting a peripheral add-on, perhaps incentives and targets can signal to services that this work is important, helping to move hearts and minds away from a focus on dependent drinking?

▸ Commission programmes for alcohol, alcohol plus drugs, or lifestyle issues in general?

A question which readily throws up possible pros and cons, possibilities largely untested by rigorous, directly relevant research. Merging alcohol into a broader lifestyle programme may spread screening and advice wider by defusing discomfort at focusing on drinking, or result in fewer patients being screened because of the added burden of screening for several lifestyle-related risks. Given some discomfort about addressing non-dependent drinking, alcohol may get missed in the mix. For such interventions as do occur, spreading the focus might detract from impacts on drinking, or augment these because of links with smoking, drugs, diet, stress and exercise.

In the UK these concerns have been high on the agenda for practitioners and researchers in alcohol brief interventions. At a meeting in 2011 they saw multi-behaviour approaches as offering "real opportunities for the further integration of alcohol" into contacts between patients and practitioners, but recognised "there may be some risk of 'diluting' alcohol messages". In the end the feeling was that "alcohol-specific brief intervention approaches must still be prioritised".

At meeting in 2015 the concerns were similar, but were focused on the Making Every Contact Count (MECC) campaign. This aims to encourage and equip health professionals to take every appropriate opportunity to prompt clients, patients or customers to consider improving their health by modifying lifestyle, including smoking, drinking, diet and exercise. For the 2015 gathering, the positive side was that "Alcohol use and motivations are also often closely entwined with other health behaviours – capitalising and supporting the MECC agenda therefore clearly makes sense." Concerns were that quality might suffer and that the "common reluctance to talk about alcohol could leave the alcohol part of MECC conversations being overlooked".

For the UK the most rigorous evidence we have comes from Wales (study listed above), though even this study did not directly test whether focusing on alcohol was more likely to generate effective screening and intervention than integrating alcohol with other health-affecting behaviours. In 2007, 29 general practices were allocated at random to be trained or not in behaviour-change counselling on drinking, diet, smoking and exercise. The training was substantial, including feedback on simulated patient consultations. At issue was whether the training would improve the practices' ability to engage patients in changing these behaviours, leading to actual change to a healthier lifestyle. In brief, the answers were respectively 'Yes' and 'No' – more engagement, but not significantly more change. Specifically in respect of drinking, relative to untrained practices there was no significant increase in the proportion of patients who after seeing their doctors said they were likely to change their consumption, and no significantly greater change in consumption three and 12 months later. For more on this study unfold the supplementary text.

Close supplementary text

Screening questionnaires administered by the research team revealed that all but 5% of patients in the study were risking their health by one of the four behaviours, including nearly 38% drinking at risky levels as indicated by their answers to the three questions of the AUDIT-C screening questionnaire. Multiple risks were the norm: at least two of the four behaviours possibly risked the health of over 70% of patients. The remaining analyses were conducted on patients who scored as risking their health; only among these patients could risks be addressed and reduced.

At first things looked promising. Clinicians participated well in the training. Compared to just over half in untrained practices, immediately after consultations at trained practices over 9 in 10 patients said one of the four lifestyle health risks had been addressed, and there was a similar a differential specifically for drinking. At this stage too, on most measures significantly more patients at trained practices said they were likely to change their behaviour. Drinking was the exception; though slightly favouring trained practices, the difference between 37% and 33% likely to change their drinking was not statistically significant, so could have been a chance finding.

The study's main yardstick of ultimate success was intended to reflect clinically beneficial change in respect of one or more of the lifestyle-related risks three months after the patient's visit to the surgery. For alcohol, this was set at a 20% reduction in risky-drinking screening scores. At both three and 12 months after the visit, across all the behaviours the slight advantage for patients at trained practices was not statistically significant, and at 12 months it was negligible – 40.6% v 39.8%, a difference of less than 1%. Neither did significant differences emerge when the analysis was restricted to patients at trained practices who were actually spoken to about their risky behaviours, or from whom data was able to be gathered at the three-month follow-up. For alcohol in particular, among risky drinkers average reductions in the severity of their drinking was about the same whether they had attended trained practices or not, and at the 12-month follow-up such slight and statistically insignificant differences as there were favoured the untrained practices.

> Across all the behaviours the researchers concluded that training primary care clinicians in behaviour-change counselling did generate more conversations on these topics, and led more patients to say they intended to change and to attempt to do so, but in the end did not generate extra beneficial behaviour change. They speculated that patients found it difficult to follow through on their good intentions, and a single primary care consultation was often not enough to sufficiently reinforce their ability or resolve. However, for drinking the obstacles went deeper: not just actual change, but signs of extra resolve or attempts to change were lacking from the statistically significant findings.
>
> Close supplementary text

The Welsh study described above conducted a randomised trial in selected practices. In this context, numbers of patients talked to about their drinking may not reflect what would happen in routine practice, leaving open the question of whether drinking really is more likely to be neglected than other health-affecting behaviours when a programme tries to cover multiple risks. On this issue we do, however, have patchy evidence from the NHS health-check for older adults; it suggests this is just what can happen. In studies (1 2 3) around half – sometimes more – of patients did not recall drinking being addressed; unfold the supplementary text for more on these studies.

> Close supplementary text
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> The five-yearly NHS health check for older adults incorporates alcohol screening and advice alongside checks for other lifestyle-related behaviours which may be elevating risk of heart disease, strokes, kidney disease or diabetes. Data collected in 2011/12 from Gloucestershire primary care practices showed that 54% of patients who attended a health check were screened for risky drinking, the lowest proportion of all the lifestyle risk factors. Based on the local population, in respect of risky drinking there should have been about 840 referrals for further intervention; there were just 17.
>
> In 2011 in Stoke-on-Trent, nearly half the respondents to a survey of patients at risk of cardiovascular disease who had been through the NHS health check did not recall drinking being addressed, though nearly 8 in 10 did drink. Of those spoken to about their drinking, 36% said they had as a result cut down.
>
> In north-east England, between 2009 and 2012 interviews with 29 patients who had attended an NHS health check revealed that 24 could not recall their drinking being discussed.
>
> Close supplementary text

We also have some data from New Zealand, where in response to trainee feedback what started as a programme to train primary health care workers in screening and brief motivational interventions for risky substance use broadened into (see review listed above) one “enabling patients to discuss the lifestyle issues that most matter to them”. In practice, “The most common issues for which brief intervention was used … were weight, smoking, diabetes, exercise and stress”.

Given this admittedly inadequate evidence, how would you assess the balance of pros and cons: focus on drinking, on substance use in general, or incorporate in broader lifestyle checks and interventions? Would your assessment differ for different situations or patient groups? Who should decide the focus for a health-promoting brief intervention? Should it be the clinician based on which change in behaviour promises the greatest health benefits, or the patient based on what matters most to them or the risk they feel most ready to address? Or should it be determined by national or local priorities operationalised in funding, performance measures, and targets?

Abandon the ambition to achieve population-wide health gains? Over recent years the policy and practice profile of alcohol screening and brief interventions has increased, but at the same time doubts have been building over whether their initial promise will be realised. The doubts broadly fall into two categories: whether real-world screening/brief intervention really does reduce consumption sufficiently to affect alcohol-related harm; and whether even if it did, these programmes can be implemented widely and well enough to dent harm across an entire population.

Of these issues, the most fundamental is whether in routine practice brief interventions generate reductions in drinking of the size and persistence to lead to improved health. If this was considered proven, it might be worth continuing the struggle to find ways to implement the widespread screening needed to find the patients to target, and to persuade practitioners to deliver the interventions. After all, the ideal of near-100% coverage of contacts at each service is not required; given multiple attendances at a service or services, incomplete implementation can cumulate to most individuals being reached. But however reluctantly, expert opinion has become pessimistic about the prospects, most notably in the form

of the journey taken by Professor Nick Heather, whose work forms a thread from the first trial in Dundee in 1985 of a brief intervention in general medical practice to the SIPS trials listed above, whose results released in 2012 were intended to guide government policy.

We approach this journey via its culmination in 2017 in the downbeat verdict of two prominent UK and US researchers. Contrasting with the faith placed in brief interventions in national UK policy , they summed up (free source at time of writing; listed above) the evidence as they saw it: "After more than three decades of study in primary care, it now seems unlikely that brief interventions alone confer any population level benefit, and their ultimate public health impact will derive from working in concert with other effective alcohol policy measures." What prompted this conclusion was the lack of convincing evidence that in real-world circumstances, brief interventions do reduce alcohol-related ill-health (evidence reviewed in cell A1), coupled with the difficulty of persuading GPs to focus on not-very-heavy drinking when patients often have multiple lifestyle risk factors, and they and their doctors may be more concerned with here-and-now problems rather than those drinking might cause in the future.

The citation offered by the researchers for their prediction that impacts "will derive from working in concert with other effective alcohol policy" was a paper by Professor Nick Heather published in 2012. Six years earlier, his views had been different. Though appreciating the difficulties, in 2006 he had optimistically referred to the "steadily gathering momentum" of an "international movement dedicated to reducing alcohol-related harm by achieving the widespread, routine and enduring implementation of screening and brief intervention". In contrast, by 2012, the year the unexpectedly negative SIPS findings emerged, he was arguing that "Widespread dissemination of [screening and brief intervention] without the implementation of alcohol control measures … would be unlikely on its own to result in public health benefits".

In 2012 Professor Heather had identified four requirements for such benefits to be generated, of which he judged only one to have been satisfied – evidence that brief intervention "reduces consumption to low-risk levels in some of those who receive it". If "some" means enough to register significant findings, even that requirement has arguably not been satisfied in real-world circumstances. Meeting the remaining three requirements was, he wrote, "currently unlikely, either because they are difficult to achieve or because there is no evidence to support them". A major gap was that "public health potential … is unlikely to be realized without the widespread deployment of universal screening," something no national health care system had yet been able to achieve. The (for alcohol harm reduction) ideal scenario of drinking being asked about at every contact with a health professional, followed if indicated by help or advice to cut down, "might not be tolerated by the general public, not to mention the health professionals asked to deliver it, and might therefore be an electoral liability to any political party supporting it".

To a degree these doubts are inherent in the nature of brief interventions. Such minimal interventions, not very different from the normal practice against which they are compared, and conducted with unmotivated patients, could not be expected to produce large, easy-to-detect effects on drinking, and even more so on health outcomes only marginally affected (if at all) by small drinking reductions. The point about them is that they are undertaken 'opportunistically' during contacts made for other reasons and when clinicians and patients have more immediate priorities, inherent barriers to implementation. Demonstrating effectiveness in a widely implemented programme was always going to be difficult, and 'not proven' the likely verdict.

After optimism fuelled by some success in controlled trials, a rethink has been happening, which can be understood as the emergence of these inherent limitations as the evidence base expands into more real-world trials. Yet there have been demonstrably effective brief interventions, and with sufficient incentives, even screening rates – the weak link in widespread implementation – can be greatly raised. Would admitting defeat in respect of the original public health ambitions be premature, is a further push needed in implementation and research, or should we cut our cloth and retreat to less ambitious objectives?

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