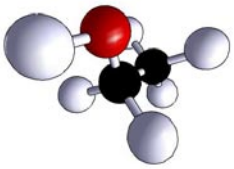
41 ALCOHOL INSIGHT



Strategy for Implementing Screening and Brief Alcohol Interventions in Primary Health Care in England

Introduction

There is abundant evidence that screening for hazardous and harmful drinking in the primary health care setting and offering brief advice to patients drinking over recommended levels for "safe" alcohol consumption is an effective and cost-effective means of reducing alcohol-related harm. It is estimated that, if screening and brief intervention (SBI) were routinely offered to such patients by general practitioners, practices nurses and other primary health care (PHC) staff, the benefits for public health would be considerable. Unfortunately, however, for a variety of reasons, PHC staff have been slow to incorporate SBI into their daily working practices and an opportunity significantly to reduce alcohol-related harm is being lost. The study funded by AERC was aimed at making a contribution to solving this problem.

The study formed part of Phase IV of a long-standing WHO Collaborative Project on *Identification and Management of Alcohol-related Problems in Primary Health Care*. In previous phases of the WHO Collaborative Project:

a) a reliable and valid screening instrument for detecting hazardous and harmful drinkers in PHC settings (the AUDIT questionnaire) had been developed (Phase I);
b) the effectiveness of SBI in PHC had been demonstrated in a cross-national clinical trial (Phase II);
c) the current practices and perceptions of SBI among general practitioners had been assessed, and barriers and incentives to implementation had been identified, together with an evaluation of methods for encouraging the uptake and utilization of a SBI in PHC (Phase III).

Phase IV was entitled *Development of Countrywide Strategies for Implementing Early Identification and Brief Intervention in Primary Health Care* and was carried out in 12 countries (11 European countries plus Australia). The rationale for the study was that, given the achievements of the previous phases of the WHO Collaborative Project, what remained to be done was the *development and application of country-wide strategies for the widespread, routine and enduring implementation early identification and brief intervention throughout the PHC systems of participating countries*.

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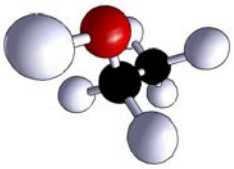


Phase IV was a much more practical and policy-oriented group of studies than had been seen in previous phases of the WHO Collaborative Project. It was in many ways an example of *action research* in which the central aim was to make a significant difference to the "real world" conditions under which brief interventions are disseminated in a particular country and to establish a programme of action leading to the widespread, country-wide implementation of early identification and brief intervention in PHC. In terms of research methods, qualitative approaches assumed equal or greater importance than quantitative methods in Phase IV. While the specific methods used were flexible across participating countries, all adhered to four basic components of the study:

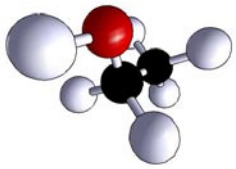
(i) Create Customized Materials and Services
(ii) Reframe Understandings of Alcohol Issues
(iii) Establish Lead Organizations and Build Strategic Alliances
(iv) Establish and Evaluate Demonstrations

Findings

The main findings from the English arm of the Phase IV project, representing the research funded by AERC, will now be described under the first three headings given above.

Customisation

a) Focus groups with PHC professionals and with patients showed that discussions about alcohol are acceptable within specific contexts in primary care.
b) A *targeted* rather than universal approach to alcohol screening and intervention would be more acceptable to patients and professionals and fits naturally with existing practice.
c) Lack of resources and incentives remains a barrier to implementation. General practices that take on alcohol as an enhanced service through the nGMS contract will receive additional training and resources; however, the nGMS contract could become a disincentive if PCTs are financially unable to commission the work.



d) In a Delphi survey of UK experts on SBI, there was strong support for the employment of a specialist alcohol worker to carry the main load of work created by the delivery of SBI. The specialist worker should be an integral member of the PHC team. By contrast, the idea of employing a specialist alcohol worker in PHC was unpopular among professionals and patients in focus groups, mainly because of the stigma that might be created by visiting such a person. The concept of a "lifestyle counsellor" was more acceptable to patients and professionals.

e) UK experts recommended a way of delivering SBI that is intermediate between universal screening for all patients attending a PHC facility and the abandonment of screening. They were agreed that *routine* SBI should be carried out in special circumstances, i.e., new patient registrations, general health check-ups and special clinics where excessive drinkers were likely to be found. These views were consistent with those of patients and professionals in focus groups.

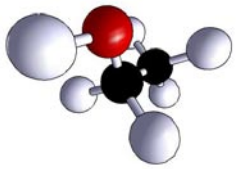
f) In circumstances where the employment of a specialist worker is not feasible, the findings suggested a model of inter-professional co-operation in the delivery of SBI.

g) The Delphi expert panel stressed the need for increased and improved training and education of health care professionals in skills related to SBI, particularly with regard to the recognition of risk and presentational factors, how to encourage patients to talk about their drinking and other brief intervention skills.

Reframing

A *Marketing Strategy* developed during the study indicated that clear information is needed for PHC professionals in the following areas:

a) A consistent message regarding the medically recommended (daily/weekly) levels and information on units;
b) Up-to-date information on the conversion of drinks (bottles, cans etc.) to units, e.g. using a "ready reckoner" unit calculator;



c) The positive as well as negative effects of alcohol, with clear definitions of "risky" or hazardous and harmful levels;
d) The links between alcohol and health/social problems, including links to the national priority areas identified by the Government in 'Saving Lives: Our Healthier Nation';
e) Statistics on the extent of alcohol-related problems both nationally and locally;
f) Information on common alcohol-related problems/conditions likely to present in primary health care;
g) Facts and figures on relative risks;
h) Evidence of the effectiveness of SBI in primary care;
i) The availability of local support services, clear referral procedures and guidelines (developed by the primary care team and local alcohol services);
j) Provision of appropriate leaflets and posters for patients in the waiting room (targeting identified patient groups).

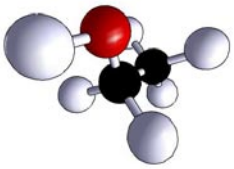
Channels for communicating information about SBI to health professionals should include:

a) Raising awareness of alcohol-related problems and creating interest in SBI via interactive professional group (education and training) meetings and/or in-house practice team meetings;
b) Dissemination of SBI package and training programme to practices via (follow-up) telemarketing;
c) Provision of interactive practice team-based training with ongoing telephone support.

Other recommendations were made for reframing understandings of alcohol issues among relevant stakeholders and among the general public, including preferred channels of information for both these targets.

National Strategic Alliance

A Strategic Alliance of interested organisations and individuals which was formed during the study could be used to help the widespread and routine implementation of SBI in PHC.



Implications

Since the end of this study, several developments have taken place that are relevant to the overall aims of this study:

- the Government's Alcohol Harm Reduction Strategy for England, which recognises the potential of SBI in PHC for reducing alcohol-related harm;
- the New General Medical Services Contract (nGMS) which includes a specification for "Patients who are alcohol misusers", including SBI for hazardous and harmful drinkers;
- the Department of Health White Paper, Choosing Health: Making Healthy Choices Easier which includes alcohol consumption among the other health behaviours it addresses;
- the funding by the Department of Health of a range of pilot schemes to test how best to use a variety of models of targeted SBI in primary and secondary health care settings, focusing particularly on value for money and mainstreaming.

These developments provide a unique opportunity to use the study findings to make significant progress in furthering the aim of widespread, routine and enduring implementation of SBI in PHC in England.

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A copy of the full report can be downloaded from:
http://www.aerc.org.uk/publicationsFinalRep.htm

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