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pull-out digest

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## Alcohol Concern's Quarterly Information and Research Bulletin

### **Putting brief interventions into practice**

#### **Introduction**

Discussion on the usefulness of brief interventions to halt or reverse harmful drinking patterns has been on-going for nearly 20 years. A recent report from the Primary Health Care European Project on Alcohol (PHEPA) identified 56 controlled trials on the effectiveness of brief interventions and a further 13 meta-analyses or systematic reviews. Of these meta-analyses, 5 specifically focussed on their use within primary care. (Heather, 2006)

Yet the question of their usefulness in practice has been a contentious issue much debated in academic journals such as the British Medical Journal, and the implementation of brief alcohol intervention programmes remains the exception rather than the general rule within primary health care (PHC).

The purpose of this article is to examine five screening and brief intervention programmes currently operating in England looking at the various methods employed and identifying common themes such as the difficulties faced implementing the projects and pointers for success. These projects show the situation on the ground and how, of necessity, practice often diverges from theory. (NB For the purpose of this paper A&E departments will be defined as a primary health care setting).

There is large body of research on the efficacy of trials of brief interventions in controlled environments. Some of the headline figures will be given as background but for more detailed information please refer to Alcohol Concern's factsheets on Brief Interventions and Screening tools for healthcare settings.

#### **The current situation**

Plans to introduce brief interventions across the board in England are at a pivotal stage.

The Government's Alcohol Harm Reduction Strategy for England (AHRSE) in 2004 acknowledged the "efficacy of trials of brief interventions conducted under optimal research conditions" but argued the need to supplement these with "effectiveness studies conducted in real-world conditions of primary health care". The Strategy included two action points for the Department of Health to communicate with health

professionals on the importance of early identification of alcohol problems and to set up a "number of pilot schemes by Q1/2005 to test how best to use a variety of models of targeted screening and brief intervention in primary and secondary healthcare settings". Evidence from these pilots will provide much needed guidance on how to implement brief interventions in PHC. Although the pilot studies have been formally agreed at the time of writing they had yet to be set up. (Prime Minister's Strategy Unit, 2004)

There is also increased pressure to introduce structured screening and brief intervention models within PHC, following the introduction of specification for treatment for "patients who misuse alcohol" within the new GMS contracts for GPs as a National Enhanced Service (NES).

In addition, the Government White Paper "Choosing Health" highlights the need for health professionals to identify alcohol problems at an early stage and the importance of training in enabling them to do this. (Department of Health, 2004)

### **Section 1: The push for early alcohol interventions**

#### **Why is there a need for brief interventions?**

Alcohol consumption in the UK has risen by 121% since 1951 with per capita consumption currently estimated to be around 8.6 litres of 100% alcohol per year. (Prime Minister's Strategy Unit, 2003) Around 90% of the adult population drink and a significant proportion misuse alcohol by regularly drinking over recommended guidelines:

- 38.2% of adult men and 22.1% of adult women drink over daily recommended levels (4 units of alcohol for men and 3 units of alcohol for women) at least once a week. (Office for National Statistics (ONS), 2002)
- Drinking frequency has increased with 38% of men and 25% of women drinking on 3 or more days in the week. (Prime Minister's Strategy Unit, 2003)
- 40% of all drinking occasions by men and 22% by women involve drinking at least a bottle of wine or over 4 pints of standard beer or lager. (Prime Minister's Strategy Unit, 2003)
- An estimated 1.8 million adults drink at harmful

levels - over 35 units per week for women and over 50 units a week for men. (Prime Minister's Strategy Unit, 2003)

- An estimated 1.1 million adults are dependent upon alcohol. (Department of Health, Programme of Assessment , 2005)

Alcohol misuse creates a huge burden for the health service. The Government's 2003 Interim Analytical Report calculated that alcohol misuse costs the NHS £1.7 billion per year. In particular:

- 35% of all accident and emergency and ambulance costs are alcohol related. (Prime Minister's Strategy Unit, 2003)
- up to 150,000 hospital admissions per year are linked to excess drinking. (Prime Minister's Strategy Unit, 2003)
- there are an estimated 15,000-22,000 alcohol-related deaths per year. (Prime Minister's Strategy Unit, 2003)
- around 10% of deaths from hypertension are caused by alcohol misuse
- alcohol is a factor in an estimated 3.5% of all cancer deaths. (Heather, 2006)
- annual expenditure on alcohol services is c£217,000,000 per year with the NHS as the dominant funder. (Drummond et al., 2005)

Alcohol misuse should be seen as a continuum. People can be drinking at excess levels (above recommended guidelines) for a while before they start to experience problems. Early intervention strategies are needed to prevent the onset of alcohol-related health problems or alcohol dependency.

**What is a brief Intervention?**

The WHO manual for the use of brief interventions in primary care defines brief interventions as:

"Those practices that aim to identify a real or potential problem and motivate an individual to do something about it"  
(Babor and Biggins-Hiddle, 2001)

In the view of the authors, brief interventions fill a gap between "primary prevention efforts" and "more intensive treatment for people with serious alcohol problems" and also provide a referral framework for severe cases of alcohol dependence. In addition it is also argued that screening and brief advice could have a positive effect on attitudes that underline hazardous drinking patterns. The definition in both this manual and the AHRSE are reasonably flexible and therefore open to interpretation by practitioners. However, studies identify several key elements common to brief intervention:

- A brief intervention (BI) can range from 5-10 minutes of information and advice to a number of sessions of motivational interviewing or counselling.

- BIs involve the giving of information and advice, encouragement to consider the negative and positive aspects of their drinking and support if the patient does decide to cut back on their drinking.
- They are targeted at hazardous or harmful drinkers rather than dependent drinkers (See figure 1 for definitions)
- BIs are usually opportunistic. The person has not complained about a problem with alcohol but is seeking help for other reasons. However, they can be used for people expressing concern about their drinking
- Targets for an intervention are usually identified through the application of a screening tool such as FAST or AUDIT.
- BIs can be given by non-alcohol specialists such as GPs, other primary care staff such as hospital physicians, nurses, social workers, or probation officers.

(Alcohol Concern, 2001, and Babor and Biggins-Hiddle, 2001)

The WHO manual outlines a very structured approach to brief interventions based on the AUDIT screening tool. In this system different bands of scores equate to different levels of risk that should elicit a specific level of response. (Babor and Biggins-Hiddle, 2001 (see Figure 2)) However, as there are a range of screening tools currently in use in the UK it would not possible to adopt this approach as a standard in the current situation.

**Figure 1 Definitions of drinking patterns (Biggins-Hiddle and Babor, 2001)**

- Hazardous drinking - is a pattern of alcohol consumption carrying with it the risk of harmful consequences - physical and mental health problems and social difficulties for the drinker or others.
- Harmful drinking - is a pattern of alcohol consumption that is already causing damage to health.
- Alcohol dependence syndrome - is a cluster of cognitive, behavioural and physiological symptoms - three of which need to have been experienced in the last year.

**Figure 2 Drinking risk levels and related interventions (Biggins-Hiddle and Babor, 2001)**

AUDIT score	Risk level	Intervention
0-7	Zone I	Alcohol education
8-15	Zone II	Simple advice
16-19	Zone III	Simple advice, brief counselling and continued monitoring
20-40	Zone IV	Referral for diagnostic evaluation and treatment

**Efficacy of brief intervention trials**

Given the large number of international studies on the use of brief interventions, there is clearly a wide variation in the findings. More well-known and recent evidence on the efficacy of BIs are as follows:

- A 2003 WHO sponsored review of policies aimed at reducing alcohol-related harm judged that BIs are of moderate effectiveness, have a high breadth of research support, high level of cross cultural testing and moderate cost to implement. (Heather, 2006)
- Freemantle, in a meta-analysis of 6 RCT trials, found that overall "the effect of brief intervention is estimated to be a 24% reduction in alcohol consumption". (Freemantle et al., 1993)
- Wilk et al estimated that heavy drinkers who received a brief intervention were twice as likely to moderate their drinking in six to 12 months after intervention as heavy drinkers who received no intervention. (Wilk, Jensen and Havighurst, 1997)
- The Number Needed to Treat (NNT) for brief interventions in PHC has been estimated at 8 - ie approximately eight patients would need to receive a BI in order for one to succeed in reducing their drinking below recommended levels. Note that this compares with an NNT of 20 for advice on smoking cessation. (Heather, 2006)
- Fleming and colleagues four-year study on the use of brief intervention in PHC in Wisconsin calculated that every \$10,000 invested in a screening and brief intervention, resulted in a saving in health care costs of \$43,000. (Heather, 2006)

**Primary health care as a setting for brief interventions**

Primary care professionals are seen to be in a unique position to identify and intervene with patients whose drinking is putting their health at risk. Some of the advantages of tackling excess drinking in PHC include the following factors:

- Each year 70% of the population visit their GP so there are numerous opportunities for GPs and practice nurses to ask about a patient's drinking, for example at registration or in relation to conditions such as hypertension. (Alcohol Concern, 2001)
- Problem drinkers are known to consult their GP twice as often as average patients; the most common complaints are gastrointestinal or psychiatric problems and accidents. (Alcohol Concern, 2001)

- PHC professionals are trusted by patients, PHC is an appropriate setting for continuous monitoring and repeated interventions and advice given in this setting are taken seriously. (Babor and Biggins-Hiddle, 2001)
- A large proportion of attendees at A&E departments (up to 70% at peak times) present with alcohol-related injuries. (Prime Minister's Strategy Unit, 2003)

However, surveys of staff in GP practices and A&E indicate that screening and brief intervention is not the norm. A 1999 survey of GPs in the Midlands indicated that 67% of GPs asked about drinking "some of the time". The recent General Practice Research Database (GPRD) found very low levels of formal identification, treatment and referral of patients with alcohol misuse disorders by GPs. Overall GPs identified in their database entries around 1 in 67 male and 1 in 82 female hazardous drinkers and 1 in 28 and 1 in 20 male and female dependent drinkers. (Drummond et al., 2005)

The situation in A&E departments is similar. A 1998 survey of 216 A&E departments showed that only 12% of nurses and 7% of doctors routinely asked about alcohol consumption. (Waller 1998). A survey of 256 acute hospital trusts in 1999/2000 showed that only 6 of the 138 trusts that returned the questionnaire employed alcohol specialist nurses. (Owens, Gilmore and Pirmohamed, 1999)

**Barriers and incentives to implementing brief interventions**

Despite research the efficacy of BIs and the pressing need for evidence of a workable model for intervention within PHC, it seems that plans to implement brief interventions across the board have stalled. The delay in setting up the Department of Health pilot projects is obviously a factor in this. However, previously identified barriers and incentives for generalist medical professionals also play a part and it is useful to reconsider these in the context of the five case studies under examination (See figure 3)

**Section 2 Case studies of brief intervention programmes for alcohol**

This section contains five case studies of screening and brief intervention in practice. Two programmes are based in GP practices and two in A&E departments. The fifth is a new community based initiative. The case studies are based on

**Figure 3: Barriers and incentives to implementing brief interventions (Alcohol Concern 2001)**

Barriers	Incentives
Lack of knowledge and skills Lack of time Financial disincentives Organisation of the health care system Lack of professional reward Lack of diagnostic aids for alcohol-related problems Too busy dealing with the presenting problems of patients Lack of training on counselling for reducing alcohol consumption Lack of Government policies supportive of preventative medicine	More readily available support services to refer people to If early interventions were proven to be successful Patients requested advice about alcohol The provision of training Dissemination of information about the success of brief interventions Government support for alcohol work Funding for alcohol support agencies.

interviews with workers involved in the projects. The case studies show how the programmes worked in practice and in each case the worker has provided their professional judgement on what worked or what hindered the project. Findings from the projects have been included where they exist.

Note that a number of different screening tools are used in these programmes. Refer to Alcohol Concern's factsheet Screening tools for health-care settings for a description of various screening tools and scoring methods.

**Common themes**

- Where did the impetus come from?
- Ways of working
- Problems encountered
- Pointers for success.

**Case study one  
Screening and brief interventions at St Mary's Paddington Hospital, London**

The A&E department at St Mary's runs a screening and brief intervention programme which begins in its A&E department but now covers the whole hospital. The alcohol health work (AHW) draws on the skills and experience of its medical staff and the support of a full time alcohol nurse specialist (ANS).

**Background**

The introduction of a screening and brief interventions programme in 1994 followed the successful trialling of the Paddington Alcohol Test (PAT) at the hospital in the early 1990s. The PAT was found to be fast and effective at identifying patients with alcohol problems. It provided patients with a factual and non-judgemental assessment of their drinking problem. It can be administered without specialist substance misuse knowledge by medical and nursing staff in the course of their routine work. Earlier studies of patients presenting at A&E have shown attendance

at A&E to be a 'teachable moment' in which individuals can acknowledge and address any problems they have with alcohol.

**How it works**

Doctors within the A&E department are given guidance on how to administer the PAT. They are also provided with a number of standard questions and statements to enable them to raise the issue of excess drinking with patients in a non-judgemental manner without stigmatising the patient's drinking behaviour. The training is provided by the lead consultant and the ANS as part of the routine induction for all new medical teams. Each new A&E doctor is given an incentive figure of five screenings and brief interventions to complete during their first two weeks.

**Care pathway**

- Each patient presenting at A&E is routinely assessed by the triage nurse. If the nurse suspects that alcohol is a contributory factor, a note is made on the file but does not intervene at this stage unless no further A&E assessment is required.
- Screening is carried out at the end of a medical assessment by a doctor using the PAT; assuming the doctor thinks it appropriate. Screening filters out the majority of patients that might have been thought to have a problem with alcohol. This is because the majority do not report drinking above twice the recommended limits regularly.
- Once the PAT has been administered the doctor administers brief advice - recommending reduction in drinking and an appointment with the ANS. If appropriate the doctor can refer the patient to ANS, either as an outpatient or in-patient if they are admitted to hospital.
- The ANS brief intervention is a motivational assessment, lasting between 15-45 minutes - if the patient is thought unlikely to engage with further counselling or does not require such a referral, then the intervention is slightly longer

during which the ANS discusses some of the risks attached to heavy drinking and gives practical tips for cutting back.

- The ANS sends a standard letter to the patients GP giving the reason for attendance at A&E and stating that a screening and brief intervention was made, plus any further outcome.

#### Problems in running the programme

- Regular staff turnover (SHOs change every six months) means that continual training programmes have to be carried out
- Earlier trial studies of the PAT suggested that medical staff needed regular follow-up to check that they were routinely screening and without this the numbers of screenings dropped (reference)

#### Criteria for success

- Reduction in alcohol consumption after PAT screening, and after ANS session.
- Reduction in the numbers of patients re-attending with alcohol-related problems.
- Reduced numbers of patients being referred for treatment for alcohol problems in the future.

#### Recorded successes

- In a trial of the PAT, 202 patients were assessed by an AHW. 71 of the patients were followed up after 6 months, 65% of these reported a reduction in alcohol consumption and the mean reduction was 43% (Wright et al. 1998)

Recent studies have indicated the continuing success of this programme:

- In a 12-week randomised controlled trial in 2001, around 23% of patients were screened for alcohol problems at St Mary's. Senior house officers were given training to provide feedback on the potential health consequences of heavy drinking. In the control period of the trial during the first 6 weeks of the trial no feedback was provided, but was provided in the second 6-week phase. In the first phase 52.1% of patients were willing to accept brief advice and this increased to 64% in the second phase (23% increase). The researchers estimated that this increase could lead to an additional 350 patients per year accepting help and advice to reduce their drinking. (Crawford et al., 2004)
- 599 patients were randomised over a 12-month period. At 6 months, those referred to an alcohol health worker were consuming a mean of 59.7 units of alcohol per week compared with 83.1 units in the control group. At 12 months those referred were drinking 57.2 units per week compared with 70.8 in controls. Those referred to the alcohol health worker had a mean of 0.5 fewer visits to the emergency department over the following 12 months. (Patton, Crawford and Tourquet, 2003)

#### Pointers for good practice

- Use of a fast workable screening tool that gives medical staff the confidence to intervene.
- An evidence base showing the effectiveness of the intervention.
- Provision of training as a routine part of medical staff's induction programme which makes them more ready/willing to accept screening and brief interventions as a standard part of their work.
- Employment of a full-time liaison nurse, and preferably a lead consultant within the department.

*(Based on an interview with Adrian Brown, Alcohol clinical nurse specialist, St Mary's Hospital, Paddington, June 2006)*

#### Case study two Liverpool model for delivering brief interventions in A&E and acute wards

Since 1997/98 The Liverpool Royal Infirmary has employed alcohol nurses within its A&E department and selected acute wards to offer brief interventions to patients presenting with clear or suspected alcohol problems.

#### Background

In 1997 a successful bid for funding was made to The North West Health Authority to enable the hospital to incorporate an alcohol nurse into the assessment and care of patients. The project fund was managed by the University of Liverpool. Earlier studies had shown that around 12.5% of patients attending A&E were either dependent drinkers or their drinking was a contributory factor in the injury they presented.

The aim of the project was to help patients address their drinking problem and also to educate health care professionals to help them develop a different view of these patients that did not stigmatise them as "difficult" or impossible to treat and would assist them in carrying out enforced detoxification in acute wards.

#### How it works

A trained alcohol nurse works within the hospital and can be called on by medical staff as required.

#### Care pathway

Triage nurses routinely carry out a first assessment of a new case presenting at A&E and will make a judgement on whether they suspect alcohol may be a factor in the patient's injury. If this is the case the patient is offered the opportunity of a referral to an alcohol nurse as part of their care plan. During normal working hours the patient will be offered immediate access to the alcohol nurse but out of hours, they are given a card and advised to seek a referral.

The alcohol nurse meets the patient and carries out an assessment of their drinking using a combination of the Alcohol Use Disorders Identification Test (AUDIT), The Severity of Alcohol Dependence

Questionnaire (SADQ) and lifestyle questionnaires. An AUDIT of 8 or above indicates the need for an intervention. A brief intervention, lasting anything from 5 to 45 minutes, is made, depending on the patient. The intervention is based on a FRAMES approach:

- Feedback
- Responsibility
- Advice
- Menu
- Empathy
- Self Efficacy

This is essentially a motivational approach to alcohol counselling. The patient or client is encouraged to make an holistic review of their health and lifestyle - looking at areas such as diet, exercise or lack of it, stress and other personal problems and to identify how alcohol has contributed to their injury or condition. The aim is to get the patient to take responsibility for their health. Follow-up is provided in a primary care setting or an inpatient care plan is drawn up where appropriate.

In addition the Alcohol Specialist Nurse (ASN) also carries training for health professionals which aims to provide an introduction the various types of intervention available for alcohol misuse, outlines the effects of alcohol misuse on the body, and identify any personal subjectivity in definitions of alcohol use.

**Problems in setting up the service model**

- The need to find additional funding for the alcohol nurse.
- The negative attitudes of existing health care professionals towards drinkers as difficult patients with un-resolvable problems.
- Regular staff turnover within A&E meant that new staff were continually needing to be trained to look for alcohol problems and make referrals when necessary.

**Criteria for success**

- The numbers of patients that agreed to the intervention and undertook a follow-up programme.
- A reduction in alcohol consumption.
- Changing attitudes of existing medical staff.
- Cost effectiveness of the intervention.

The initial project proved very successful. Evaluation of the first stage of the project showed:

- 9.8% of patients referred to the alcohol specialist nurse were assessed for alcohol-related problems and of those referred 66.9% received treatment for alcohol withdrawal symptoms (AWS) and 33.1% received a brief intervention. (16% were referred on more than one occasion)
- Among those patients that received a brief

intervention: the average Audit score dropped from a score of 20 to 11.9, the average number of drinking days per week reduced from 5.7 to 3.6 and the number of alcohol units consumed daily reduced from 20 to 11.9. In addition 30.6% of those who received the intervention were abstinent in the following 6 months.

- An evaluation of the training programme showed that training made health professionals more open to assessing patients for alcohol misuse, referring them to the ASN and providing medical care as required.
- Preventing the admission of 23 patients covered the cost of the ASN for the entire project and in the course of 18 months, 258 patient admissions were prevented. (Owens, Gilmore and Pirrmohamed c1999/2000)

Around 75% of patients referred for an intervention took up the option of a follow-up programme. Medical staff received first hand evidence that appropriate care could help to resolve problematic patterns for many patients and make them easier to handle and more inclined to follow care plans.

**Pointers for good practice**

- The immediacy of having professional alcohol nurses to hand to make interventions
- Use of FRAMES to encourage patients/clients to take a more responsible approach to their drinking.
- The use of a specialist alcohol nurse demonstrated that it was possible to handle this group of patients successfully.

**Attached primary care project Background**

Following the successful introduction of brief interventions in a hospital setting, funding was secured in 2004 to introduce a similar scheme within GP surgeries in the Liverpool area.

**How it works**

A team of five alcohol nurses cover the hospital and five primary care clinics in the area and are available for referral every weekday.

**Care pathway**

- When a patient presents with a condition in which excess drinking could be a contributory factor, the GP uses the FRAMES model described above to raise the issue of drinking and its effect on the individual's health.
- Patients with a less serious problem can be supervised by the GP and asked to keep a drinks diary over a period of time to encourage their return to controlled drinking.
- Patients with more advanced drinking problems can be referred to the alcohol nurse either for a supervised detox and a follow-up care plan or a more intensive programme of counselling.

**Problems in setting up the service model**

- The need to find additional funding to employ five alcohol nurses.

- The need to provide a workable model for GPs to give them confidence to broach such a difficult issue with patients.

#### Criteria for success

- Numbers of interventions made by GPs.
- Numbers of referrals to alcohol nurses.
- Numbers of patients that complete a care plan with the alcohol nurse.
- Numbers of patients returning to controlled or moderate drinking.

This project has yet to be evaluated.

#### Pointers for good practice

- Presence of alcohol nurse gives the medical staff confidence to raise the issue of problem drinking.
- Use of FRAMES as a model that has been shown to be successful in dealing with this patient group

*(Based on an interview with Dr Lyn Owens, Nurse Consultant at the Royal Liverpool and Broadgreen University Hospital Trust, June 2006)*

#### Case study three North West primary care service model

Alcohol and Drug Services (ADS), Manchester, is a voluntary sector service provider in the North West that currently operates a primary care service model in a number of districts. Over the past 12 months they have redefined the model to ensure that clients receive the most appropriate intervention, following a stepped care approach. This case study provides an overview of this new model being used and also proposed enhancements under the Local Enhanced Service GP contracts within the borough of Wigan.

#### Background

The impetus for this new service model in the Wigan area came from the local alcohol service providers and the PCT Commissioner. ADS had provided a brief intervention service operating out of local GP practices. The main aim of this service was to take referrals from a range of sources, (primarily GPs and self-referral) and provide brief interventions/brief counselling to patients as appropriate and to refer dependent/complex cases to the NHS service provider which delivered community detoxification, management of complex cases and referral pathways to inpatient detoxification and residential rehabilitation. The NHS provider also received inappropriate referrals from clients through a variety of routes including GPs and self-referral.

#### Problems associated with this model

- Two entry points resulted in clients and referral agents being unsure of which service to refer to and why
- Clients presented for assessment to an inappropriate service

- The NHS provider was over-stretched with 4-6 month waiting times - partly the result of receiving inappropriate referrals

- No after-care provision in the area and as a result clients were being held on the NHS service case list.

As a result of these problems the NHS lists grew, GPs began to "double" refer dependent drinkers to the brief interventions service knowing their patients would be "held" while on a waiting list for the NHS provider. This result resulted in brief interventions becoming overloaded and clients who could benefit from the service having their treatment adversely affected by waiting times and increased gaps between appointments.

As a result of this alcohol service providers met with the PCT to redesign the model. Additional staff resources supplied through Health Improvements funds provided further assistance.

#### How it works

The new model provides a single point of contact with ADS providing a locally agreed triage assessment. Clarity now exists regarding the separate funding of the brief interventions and NHS provision.

#### Care pathway

- As a result of the triage assessment, all clients receive advice and information about their own alcohol use and the help available to them; matched to their current situation. This initial appointment may be the sole intervention required for some clients. As a number of clients suitable for further intervention will not attend, ADS provide all clients with the following information at the end of the triage screening session:
  - Comprehensive information pack - "drinkers' pack"
  - Self-help services (written)
  - On-line support services (written)
  - Services within the Metropolitan Borough (written)
- Dependent drinkers and clients with complex needs are referred direct to the NHS provider and are no longer held by ADS
- Pre-dependent or early dependent drinkers are offered appointments with ADS Brief interventions Workers in their GP practices or local Community Health Centre for a brief interventions/ brief counselling programme of 1-6 sessions depending on their level of need.
- Brief interventions clients and NHS clients are assessed and where appropriate offered group aftercare delivered by ADS. The after care service of 3 group activities per week focusing on Relapse prevention, social support and maintenance. The aftercare service enables the NHS provider to offer ongoing support for many of their clients where individual sessions are not required. Thereby reducing the case load and creating capacity to see new clients

### Creating further capacity

The PCT have entered into discussion with a number of local GP practices who have expressed interest in offering screening and brief interventions services within their practices as part of a local enhanced service contract. As the service provider in the area, ADS have been approached to provide a structured training package. This will enable them to deliver what has previously been ADS service. It will create further capacity, have a positive impact on waiting times and give practice staff confidence in making assessments and interventions for patients around their alcohol use. The training will also include an introduction to transferable skills such as motivational interviewing techniques and helping skills.

### Criteria for success

- Number of clients referred for brief counselling or referred the an NHS provider
- Numbers of clients who complete the counselling programme.

This refined service model has only recently been introduced and is the course of being evaluated.

### Pointers for good practice

- Providing training to GPs and practice nurses that gives them confidence to intervene
- Putting in place practical arrangements such as evening appointments to help clients attend assessment and counselling
- Early engagement with clients to encourage them to attend the initial assessment
- Using the expertise of alcohol workers to ensure that clients are channelled into appropriate care pathways and do not cause blockages in the service delivery model
- Provide clear feedback to clients on their triage assessment and a choice of actions based on the assessment.

### Case Study four

#### North West Community Intervention

A complementary intervention run by ADS in Blackpool provides a community-based short training programme in opportunistic brief interventions. This short training programme started in 2005 and is targeted at a wide range of professionals such as human resource managers, social workers, paramedics and police officers who might be expected to intervene when faced with someone with evident alcohol problems.

The course is funded by the Neighbourhood Renewal Fund. The local authority recognises the high impact of alcohol misuse on the community in an area where levels of heavy drinking exceed the national average. The course aims to equip front line professionals with the skills and confidence to raise the issue of alcohol misuse with individuals in the course of their work.

### How it works

ADS runs a series two day training programme in local community in the region. The training package includes:

- Training in the use of screening tools such as AUDIT and FAST
- Training in administering opportunistic brief interventions based on WHO guidelines
- An introduction to the alcohol service delivery structure/ referral pathways in their area and guidance on where to direct people with alcohol problems of varying severity
- Awareness raising of the health effects and potential risks of excess drinking
- Pointers to key sources of information on alcohol such as the Alcohol Concern website and the Down your Drink website
- An introduction to basic motivational interviewing skills and the skills of helping
- A training reference manual
- Course follow-up questionnaires and the contact details for the 2 trainers who can be called on for future support, including "top up" training.

### Potential problems

For many on the course the question of how to tackle alcohol misuse is a complex area outside their normal professional competence and alcohol misusers. So it's important that the training package provides people on the course with the requisite skills to raise the issue of drinking and support if the intervention proves difficult.

### Criteria for judging success

This project is in its early phases. Criteria for success include:

- Numbers of people attending the courses
- Course feedback indicating whether those who attended feel confident to carry out an opportunistic brief intervention.
- In future the training organisers also plan to carry out an analysis of referral patterns of clients to alcohol services to see if the sources of referral match the range of people attending the course.
- Follow up contact with the training recipients to review confidence and competence in the interventions used

### Pointers for good practice

The course organisers point to the value of a comprehensive back up manual to help once they have completed the course, the usefulness of feedback to shape future courses and the role of the trainers in providing ongoing backup.

*(Based on interview with Tracy Hogan, Director of Clinical Standards and Practice, Alcohol and Drug Services)*

### **Case study five** **Screening and brief interventions in the Richmond and Twickenham Primary Care Trust (PCT)**

The Richmond and Twickenham PCT is working in partnership with Addiction Support Care Agency (ASCA) to provide a screening, brief interventions and referral service for people experiencing problems with drinking.

#### **Background**

The service started in 2001 when ASCA was awarded funding from the Alcohol Concern Primary Care Grant to run a year-long project to recruit GPs in the area to participate in a screening and brief intervention project. Continued funding was provided by the local health authority and primary care group, until 2005 when the local Health Commissioner decided that the service should be funded as a "local enhanced service" provided by 15 GP practices as an additional facility provided over and above the routine care they gave to patients.

The aim of the service is to identify hazardous and harmful drinkers, intervene before their drinking seriously damages their health and refer patients on for more intensive treatment if required.

#### **How it works**

Nine ASCA counsellors are seconded to different GP practices for a set number of days per week. They provided training to GPs in the use of the FAST screening tool and some basic strategies for probing the patients drinking behaviour encouraging the patient to acknowledge a problem where it exists. They also provide a 6-10 week programme of counselling as required.

#### **Care pathway**

- GP carries out an opportunistic screening using FAST for patients presenting with problems the GP suspects could be alcohol-related.
- If the patient tests positive for problem drinking, they are offered a referral to an alcohol counsellor based in the practice.
- A patient can choose not to be referred and less problematic drinkers will be monitored by the GP.
- The ASCA worker will work with the patient/client through a series of 6-10 counselling sessions using mainly motivational interviewing techniques, depending on what seems the most suitable approach for a particular client. The aim of the counselling is to help the client to return to controlled drinking or support them in becoming abstinent.
- If the patient/client has a severe alcohol problem the alcohol worker can take the decision to refer them to the Community Drug and Alcohol Team which can make more intensive psychiatric or drug based interventions and can also fund residential care.

- Regular reports on patients/clients' progress or lack of it are relayed to the GP for their records.

#### **Problems in operating the service**

- Securing long term funding for the service.

#### **Criteria for success**

- ASCA uses an outcome-monitoring tool to measure success based on improvements in the drinking behaviour and health and well-being of the client. It includes treatment goals i.e, abstinence or controlled drinking, number of sessions attended, number of units drunk at the beginning of the programme and number of units consumed at completion.
- Service user survey measuring client satisfaction which included questions on how long they had to wait for an appointment, why they decided to seek help, and their opinion of the interventions programme.

Statistics on client referrals in 2003 - 2004 indicate that 102 clients were referred from GP surgeries in Richmond for brief counselling and a further 95 were referred in Kingston. Of these, 98 clients (50%) completed the programme of counselling. The programme has been running for several years and both alcohol workers and GP practice staff report favourably on the working of the referral and intervention programme so far.

#### **Pointers for good practice**

- Positioning the ASCA worker within the GP practice helps to build a good working relationship between the alcohol workers and the GPs
- Regular meetings where the alcohol workers provide general feedback on the progress of the counselling sessions helps to keep the practice members informed.

*(Based on interviews with Michal Ullman-Harwood Primary Care Alcohol Counsellor, and Phil Moring, Primary Care Team Manager, Addiction Services Care Agency (ASCA) and Sarah Darcy, Contract Manager at Richmond and Twickenham PCT, June and July 2006)*

### **Section 3 common themes**

Analysis of the individual case studies highlights a number of common themes involved in putting brief interventions into practice.

#### **Summary and pointers for further consideration**

Two critical points emerged from the studies that need further investigation.

WHO guidelines for brief interventions state that brief interventions can be given by non-alcohol specialists. However, in these case studies, screening is generally carried out by general medical staff with the intervention being provided by the specialist alcohol worker. This system of working has evolved

**Getting the project/programme off the ground**

- In the earlier projects, such as St Mary's Paddington, the impetus came from committed health professionals with an alcohol specialism, and the existing project follows on from earlier research-based projects.
- Research evidence of the efficacy of screening and brief interventions helped alcohol specialists to present a case for their projects.
- In a number of the case studies funding for initial projects had to be secured from external sources.
- In the two PCT projects, the impetus came from shared interests and the commitment of local PCT commissioners and alcohol services.

**Making the programme work**

In each case the contributory factors link directly back to the barriers and incentives identified with PHC earlier.

Overcoming barriers:

- Providing training to general medical staff to boost confidence.
- Supplying a fast workable screening tool to identify problem drinkers.

Providing incentives:

- Having an expert alcohol worker readily available to refer cases on to.
- Providing empirical evidence that early interventions are successful in managing so-called 'difficult cases'.
- Proven success in helping patients to control their drinking or become abstinent.
- Providing screening and brief intervention as a local enhanced service provides a financial incentive for general medical staff.

**Points for further consideration**

In general, success in running and developing the project depended upon:

- The introduction of working practices that brought general medical staff on-side.
- Proven success in reducing alcohol consumption among patients, and reductions in future referrals for medical care
- Being able to produce concrete evidence of success to secure ongoing funding

to suit each local situation. If screening and brief interventions are to become normal practice, then it is important that both the alcohol workers and the general health professionals are clear and comfortable with their respective roles within individual programmes.

In a number of the programmes attached to GP surgeries, it appears that it is the patients with more advanced alcohol problems that are referred to the alcohol worker and in some cases receive several sessions of brief counselling. While some GPs do provide advice and monitoring for less serious hazardous drinkers, there is a danger that some practices are providing a targeted screening and referral service that identifies and supports the heavy or harmful drinker, but misses a significant proportion of hazardous drinkers who are at an early stage in the continuum towards harmful drinking. This is still a new area of work, but if screening and brief interventions are to become the norm, then more training and more comprehensive data on patient's drinking are needed to make doctors more confident when making interventions with problem drinkers of varying levels.

**The way forward**

This article has focussed on the work of a select number of projects/programmes that make use of screening and brief interventions to prevent or manage problem-drinking within primary health care. These case studies have been used to show how brief interventions can be made to work in practice, and that previously identified barriers to their implementation are surmountable.

The recent PHEPA report on integrating health promotions for problem drinkers within primary health care, (Heather, 2006) shows that much more needs to be done to introduce screening and early interventions throughout the health service. The report lists a number of key principles requiring actions such as:

- The development and dissemination of national training programmes to enable practitioners to feel more confident in the delivery of screening and brief interventions (SBIs).
- The development of tested user-friendly SBI materials and procedures and their dissemination among PHC professionals.
- The availability of more adequate reimbursement to general medical practices for the routine delivery of SBI.
- The availability and promotion of a web-based Alcohol Management Database for use by professionals delivering SBI.

In addition the implementation of the recently published Models of Care for Alcohol Misuse and the establishment of the pilot studies on brief interventions, will have a significant impact on future developments in this area.

However, one common feature in each interview was the positive attitude that each of the alcohol specialists was able to maintain throughout their time on the various programmes. These interviews with key alcohol workers demonstrate that their enthusiasm, commitment and professional approach to working with this patient/client group can help to make screening and brief interventions a workable option.

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## Health Interventions for Problem Drinkers

Integrating Health Promotion Interventions for problem drinkers into primary health care

By Nick Heather



Primary Health Care European Project on Alcohol (PHEPA)



Alcohol Concern  
Making Sense of Alcohol

Alcohol Concern has just published the strategy *Integrating Health Promotion Interventions for Problem Drinkers into Primary Care*. The aim of this strategy is to make brief interventions routine within primary care by creating the nationwide conditions in which PHC professionals will see screening and brief interventions as a worthwhile activity with a high priority for their practices and feel able to implement it on a regular basis. The report was produced as part of the EU-funded Primary Health European Project on Alcohol (PHEPA)

A detailed summary of the report by its author, Professor Nick Heather, was included in the previous issue of *Straight Talk* (21, 2).

A full copy of the report can be obtained from the Information Service at Alcohol Concern. (Cost £7.50 + 10% postage and package).

Please Telephone: 020 395 4000 for copies.

