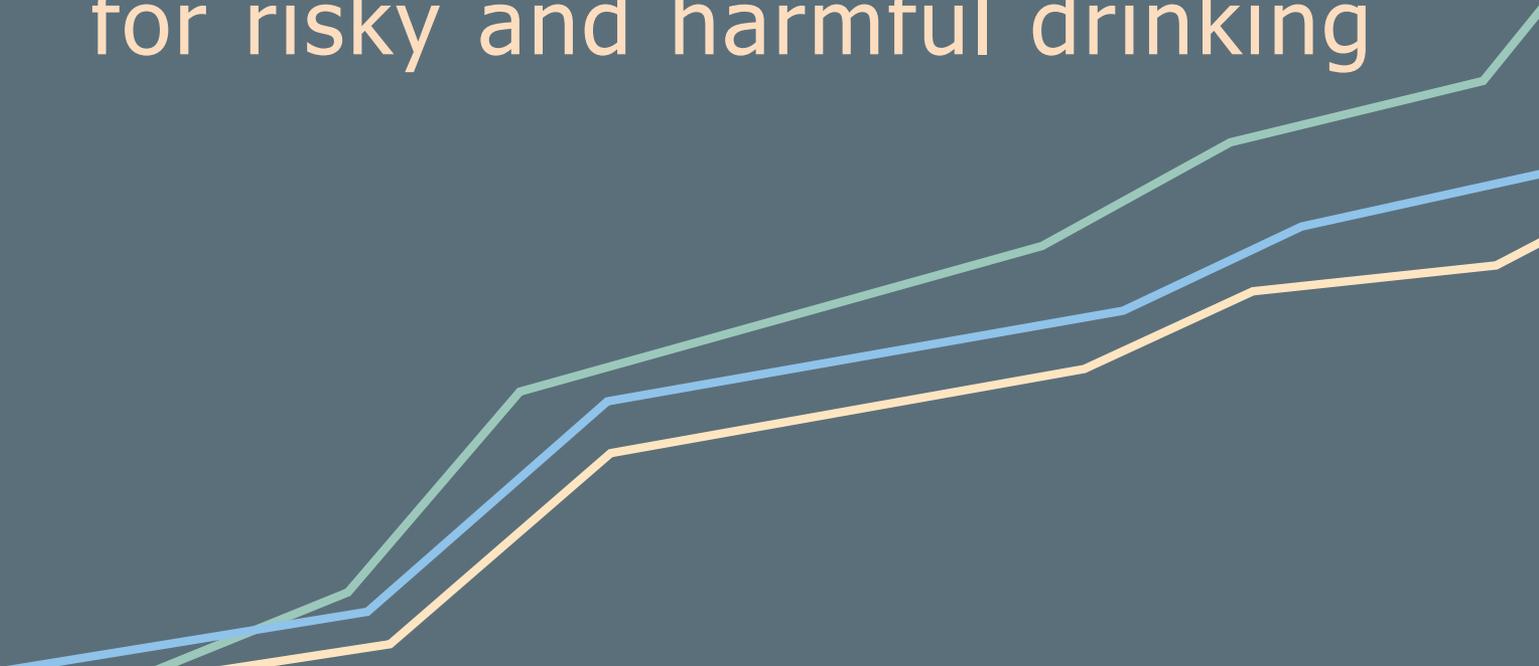


Screening and brief interventions

for risky and harmful drinking



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Introduction

This briefing paper has been produced by SHAAP (Scottish Health Action on Alcohol Problems) following a conference held at the Royal College of Physicians in Edinburgh on 7th February 2008.¹ The aim of the conference was to identify barriers to the delivery of brief interventions in the Scottish Health Service and to pinpoint action required to overcome them.

This briefing provides an overview of what is considered as best practice for screening for alcohol problems and delivery of briefing interventions (SBI), based on current research evidence and learning from roll-out and implementation at the local level. It also outlines current policy and practice in Scotland; in particular, the steps that are being taken to address barriers to implementation.

The scale of the problem

Tackling problem alcohol use has been highlighted as a public health priority for Scotland. Over the past few decades, alcohol-related morbidity and mortality in the country has risen considerably as alcohol consumption has steadily increased. From having had one of the lowest cirrhosis mortality rates in Western Europe in the 1950s, Scotland now has the one of the highest.² Treatment for alcohol-related problems is estimated to cost the NHS in Scotland £405 million a year – more than £1 million every day.³

An extensive body of research evidence shows that brief interventions are one of the most effective means of reducing hazardous and harmful alcohol use and consequently alcohol-related harm.

Categories of problem alcohol use

Hazardous drinking

Also termed “risky drinking”, refers to people consistently drinking over recommended limits, but without alcohol-related problems. Recommended limits are 21 units a week for men and 14 units a week for women (Royal Colleges, 1995) and not more than 3-4 units a day for men or 2-3 units a day for women (UK Government). Hazardous drinking also includes people who “binge” drink (men drinking 8 units or more a day and women drinking 6 units or more a day) even though they may not exceed weekly limits. A hazardous drinking pattern puts the user at increased risk of harmful consequences in the short- and longer-term.

Harmful drinking

Refers to people consuming more than the daily and weekly recommended limits, at higher levels than hazardous drinkers. They will exhibit clear evidence of alcohol-related problems but often without this having resulted in their seeking treatment.⁴

Identifying hazardous and harmful drinkers

Before carrying out a brief intervention, hazardous and harmful drinkers first have to be identified, and this is done by screening.

The main screening methods used are self-report questionnaires, laboratory tests / biological markers, and clinical indicators. Screening questionnaires include the AUDIT (*Alcohol Use Disorders Identification Test, consisting of 10 questions*) and a shortened version of AUDIT, the FAST (*the Fast Alcohol Screening Test, consisting of 4 questions*). There are other screening questionnaires available, some developed for specific settings such as ante-natal care.⁵ The evidence shows that self-report screening tools are reliable and valid under most clinical conditions and cost very little to administer and score.⁶ By contrast, biological tests are more expensive to carry out.

A number of clinical indicators may be suggestive of hazardous / harmful alcohol use. SIGN Guideline 74 – *The management of harmful drinking and alcohol dependence in primary care*⁷ - lists 34 social, occupational, psychiatric and physical indicators. However, a reliance solely on this method of identification will fail to pick up the majority of hazardous drinkers who have no obvious alcohol problems.

A key question in relation to screening for alcohol misuse is whether to screen everyone, or target specific populations or people attending special types of consultation – e.g., a diabetic clinic. To be a truly preventative approach, universal screening is the optimum, but this has obvious resource implications. At present, current guidance in Scotland SIGN 74 recommends screening based on clinical presentation, plus new patient registration.

In terms of screening tools, SIGN 74 recommends the FAST for use in primary care and A&E, with the PAT (*Paddington Alcohol Test*) as an alternative in A&E. Specially designed questionnaires (*TWEAK and T-ACE*) are recommended in antenatal care settings.

What is a brief intervention?

A brief intervention is a time-limited (between approximately 5 and 30 minutes) interaction/conversation between a practitioner and patient focused on addressing hazardous and harmful alcohol use. The guided nature of the conversation, which is delivered in a motivational style, distinguishes a brief intervention from basic information provision, although providing information and written self-help materials for an individual to take away may form part of a brief intervention.

A brief intervention is aimed at motivating hazardous or harmful drinkers to reflect on their drinking behaviour and reduce their alcohol consumption to lower risk levels. There is no evidence that brief interventions are effective among dependent drinkers who are likely to require more intensive, specialist treatment services.⁸

The delivery of a brief intervention will often occur in an opportunistic way, meaning that the patient will not specifically be seeking help for an alcohol problem; although clinical factors or screening may suggest alcohol to be a contributory factor in their presentation.

Studies suggest that extensive training is not required to carry out a simple brief intervention.⁹ One or two sessions of instructive and practical training should be sufficient for a practitioner experienced in managing consultations, with a good level of knowledge of the risks of hazardous/harmful consumption. Other groups of staff may need more training. Training methods and the competencies acquired through training need to be carefully evaluated.

A brief intervention may include some or all of the following components:¹⁰

Feedback on an individual's alcohol use and the risk of harm from their current rate of consumption or drinking pattern

Information on the benefits of reducing intake and what constitutes low risk alcohol consumption

An attempt to increase the individual's belief and confidence in their ability to change their drinking behaviour (self-efficacy)

Identification of high risk situations for drinking and coping strategies

Goal-setting (targets for daily/weekly limits), development of a personal plan to reduce consumption

Arrangements for follow-up monitoring

The evidence

There is more research support for screening and brief interventions than for any other treatment for alcohol problems. This evidence is reviewed in *SIGN 74* and the *Review of the effectiveness of treatment for alcohol problems*, NTA, 2006.¹¹

Settings

Brief interventions can be carried in a range of settings (primary care, general hospital wards, A&E, educational establishments, in the criminal justice system - police stations and prisons - and the workplace) and by a range of personnel, such as general medical practitioners, practice nurses, other primary healthcare staff, general hospital staff, Keep Well workers, social workers, police, and probation officers. Evidence is strongest for the efficacy of SBI delivered in primary health care and A&E. Further research and evaluation is required in settings such as community pharmacies, mental health services, and community justice services.

How long do the effects last?

The evidence is mixed on the longer-term effects of brief interventions. Some studies have shown the effects to last up to two years.¹² There is no evidence of benefit from structured follow-up, but raising the issue of alcohol opportunistically during subsequent consultations with patients who have previously screened positive is likely to be beneficial in maintaining the effect.

Extended or simple brief interventions?

At the present time, it is unclear whether an extended brief intervention (20 to 30 minutes) offers anything more than a simple brief intervention taking 5 to 10 minutes. Some research suggests that there is no increased benefit from delivering a longer brief intervention.¹³ More research is needed to clarify the additional benefits of a longer brief intervention. In practice, the length and content of a brief intervention is likely to vary according to the context in which it is delivered, and will depend to varying degrees on the wishes of the client and their readiness to change; the skills and confidence of the

practitioner; the level of alcohol problem; and the time available to both. Three case examples included at the end of this paper illustrate how SBI can be implemented in different healthcare settings. Brief structured advice delivered in an empathic way is probably the most acceptable and achievable method in a primary care setting.

Cost-effectiveness?

Brief interventions delivered to hazardous drinkers who are not seeking treatment for an alcohol problem have the potential to save the health service money in the longer-term, as well as providing benefit to the individual by reducing their risk of alcohol-related harm. Recent research published in the American Journal of Preventive Medicine (2008) found that alcohol screening and brief intervention in primary care is one of the highest-ranking preventive services in terms of effectiveness and cost-effectiveness.¹⁴

In hazardous drinkers, brief intervention reduces average weekly drinking by 41g (about 4-5 units a week) compared to controls.¹⁵

Eight patients need to be advised for one patient to benefit. This compares favourably with advice to stop smoking where the ratio is twenty to one.¹⁶

There is some evidence of effectiveness in reducing alcohol-related mortality. On average, 282 patients need to receive brief advice to prevent one death within one year.¹⁷

Barriers to implementing brief interventions

Lack of time

Within healthcare settings, particularly general practice, there are a lot of competing priorities and pressures on time. Alcohol is one of a number of risk factors.

Lack of reimbursement

Until recently there was no resource attached to the delivery of brief interventions in primary care or other healthcare settings, except in the case of some specially funded projects.

Scepticism of the benefits of screening

The effect of preventative measures is often not evident to staff who will be more aware of patients with existing medical conditions.

Fear of offending patients

There is common perception that patients will react badly or be offended if asked about their alcohol consumption.

Lack of training and guidance

A need for training, especially in motivational interviewing techniques has been identified, as well as user-friendly assessment tools, toolkits, and information resources for patients.

Lack of access to specialist services

Work carried out in the UK has shown a lack of capacity in specialist alcohol services.¹⁸ Concerns about opening 'Pandora's Box' without having the necessary back-up resources, are likely to act as a disincentive to the identification of alcohol problems in primary care and other settings.

Overcoming the barriers

Despite the evidence supporting the effectiveness and cost-effectiveness of SBI, they have not routinely been carried out in Scotland. A number of barriers to implementation of SBI have been identified. Some of these barriers could be fairly easily overcome. The evidence base supporting the effectiveness of SBI could be better communicated to health professionals. For example, several research studies have shown that a majority of patients consider it important for their physicians to know about their alcohol consumption and were not embarrassed to be asked about it.¹⁹ Training and resource materials for practitioners and patients should be easily available, assuming that staff can be released from their workplace to attend training.

Alongside these practical measures, support for the delivery of brief interventions at a strategic level is key to successful implementation in Scotland. Similarly, if alcohol screening identifies people requiring more than a minimal intervention, specialist services need to be in place to provide more intensive treatment and support. Clearly mapped local care pathways need to be identified between service providers.

Alcohol screening and brief interventions have been implemented in some parts of Scotland over a number of years and experience has shown that many potential barriers can be overcome with careful planning.

Policy and practice in Scotland

A number of policy measures have been introduced over the past few years to promote the implementation of screening and brief interventions in the Scottish Health Service, but to date delivery of SBI across Scotland remains limited and patchy. Only six out of 14 health board areas in Scotland have prioritised alcohol as an enhanced service in primary care, and a recent audit of A&E departments across Scotland revealed that staff in emergency departments have not had a clearly designated role in opportunistic alcohol screening despite a high level of alcohol-related admissions.²⁰

In recognition of this and the growing problem of alcohol misuse, the Scottish Government has introduced a new health improvement target relating to alcohol (HEAT 4) which requires all Health Boards to deliver a given number of SBIs over the next three years. This initiative is being supported by funding of £85 million for alcohol misuse, which also covers the provision of additional treatment and prevention services.

The HEAT target on brief interventions is a developmental target in year one and it is envisaged that considerable work will be needed in the first year to build capacity and establish delivery arrangements within Health Boards. At the national level, several capacity building initiatives are underway to support Health Boards in meeting their targets. These include:

- Ongoing work by the Scottish Alcohol and Drugs Workforce Development (SADW) group to co-ordinate a training and development strategy to support the workforce (see Resources).
- Development of practitioner and client/patient resources.
- Development of service/quality standards.
- Development and evaluation of brief intervention projects within the Scottish Prison Service and with general dentistry.
- Development and evaluation of a telephone brief intervention delivered by NHS 24.

Key policy developments

- 2002 [Plan for Action on Alcohol Problems and Alcohol Services Framework](#)
First Scottish Plan for Action advocated the development of screening and brief interventions in health settings.²¹
- 2003 [SIGN 74: The management of harmful drinking and alcohol dependence in primary care](#)
SIGN 74 is a clinical guideline for Scotland with best practice recommendations and guidance on screening and the delivery of brief interventions in primary care.
- 2007-2009 [Scottish Enhanced Services Programme for Primary Care](#)
Alcohol screening and brief interventions is one of nine nationally identified services that Health Boards can choose to prioritise for delivery in primary care. Participation in the enhanced service within a health board area is voluntary, with practices “signing-up” to deliver a service for which they receive an additional payment. Health Boards who have prioritised alcohol as an enhanced service are: Dumfries & Galloway, Fife, Forth Valley, Glasgow, Tayside, Orkney and Shetland.
- 2008-2010/11 [HEAT \(Health, Efficiency, Access, Treatment\) Target on Brief Intervention](#)²²
The Scottish Government has set a number of health improvement targets for the NHS in Scotland. HEAT target H4 states: *“Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guideline by 2010/11.”* 149,449 screening/brief interventions is the cumulative total for the whole of Scotland, with each health board area set a specific target for delivery across the priority settings of primary care, A&E, ante-natal care and acute care.

Implementing brief interventions in practice: 3 Scottish examples

Alcohol screening and brief interventions have already been successfully implemented in parts of Scotland through some specially funded projects and, more recently, through the Enhanced Services Programme for Primary Care.

The following case examples provide a brief sketch of SBIs delivered in three separate geographical and clinical areas in Scotland. The case studies serve to illustrate what SBI might look like in different healthcare settings, underlining the point that a SBI is likely to vary in length and content according to the context in which it is delivered. The examples also demonstrate that SBI can be effective in reducing hazardous/harmful alcohol consumption in some individuals and therefore lowering their risk of experiencing alcohol-related harm.

General Practice - NHS Tayside

- Tackling problem alcohol use was identified as the highest priority by local GPs. NHS Tayside opted to deliver alcohol screening and brief interventions as part of the Enhanced Services Programme for primary and community care 2007 to 2009.
- 89% (around 60) of Tayside practices have signed up to offer screening for specific presentations and brief interventions for hazardous/harmful drinkers.
- Practices receive £500 on signing up and £20 per BI delivered following a positive FAST screen.
- SBI is located in an integrated care pathway.
- It is expected that approximately 2000 brief interventions will be carried out across Tayside per year. The number of patients referred to specialist alcohol treatment services is already 15 to 20 per year. This number is expected to increase following implementation of SBI.

Tayside Enhanced Alcohol Service Specification

- Prepare staff – at least one member trained.
- Opportunistically screen patients using FAST.
- Develop a register of patients with a positive FAST screen.
- Deliver brief interventions on behaviour change.
- Provide patient information on support services.
- Refer to specialist services where appropriate.
- Use standardised health promotion material.
- Record all related information using agreed Read codes.
- Participate in audit.

Accident and Emergency - NHS Ayrshire & Arran

- Alcohol-related ill-health in Ayrshire & Arran is above the national average.
- An Alcohol Liaison Nurse was appointed in 2005 to provide specialist consultancy and support to acute services, in particular A&E, with the objective of improving identification of alcohol problems and facilitating referral to secondary community services. Initial funding was provided by the Scottish Government.
- There are many challenges to providing an alcohol service in A&E. Patients can be intoxicated and often don't want help. In a busy A&E, staff are under pressure to move patients on as soon as possible.
- An Alcohol Awareness Clinic was set up at Crosshouse Hospital. The clinic opens one afternoon a week and is only open to referrals from A&E. Patients are opportunistically screened within A&E using AUDIT PC (a shortened form the AUDIT screening questionnaire). Those with a

positive score are referred to the clinic within seven days of presentation.

- Patients are given a 30 minutes appointment at the clinic where they are offered a brief intervention and signposting to other support services.
- To date, 143 people have been referred to the clinic. Fifty per cent have attended. People recalled back after six months have been found to have lower AUDIT scores.
- A similar service is planned for Ayr Hospital.

For more information see Case study 14 at: www.healthscotland.com/documents/1948.aspx

Specialist clinic - Maxillofacial surgery in the West of Scotland

- In 2006 18,473 Scottish in-patients were discharged from hospital following a facial injury. 21.8% of these injuries were associated with alcohol. Potential cost £4.66M, not including surgery.
- A study was designed to look at the feasibility of delivering a brief motivational interview package for patients with alcohol-related facial injuries.
- A nurse-led alcohol screening and intervention programme was set up at the Maxillofacial Clinic in Glasgow.
- AUDIT was used as an initial screening tool. Patients with AUDIT score of 8 or over were allocated to one of two treatment groups: (a) motivational interview with a nurse and (b) a control group who were provided with a leaflet - "Alcohol: Know the facts".

- 25 minutes was the median interview time. This was found to be short enough not to significantly impact on the running of a maxillofacial clinic.
- The results of the study showed that at 12 months there was a statistically significant 'change in drinking days' between the leaflet and interview group for those subjects who initial AUDIT scores were high. The motivational interview was found to be more effective in this setting for patients with high AUDIT scores. These patients are more likely to have recurrent facial injuries.

For more information see:

www.shaap.org.uk

Resources

Information on SBI

Review of the effectiveness of treatment for alcohol problems, National Treatment Agency for Substance Misuse, November 2006

A comprehensive resource which reviews evidence on the effectiveness of screening tools and brief interventions in range of settings. Available to download from www.nta.nhs.uk.

SIGN 74 The management of harmful drinking and alcohol dependence in primary care, Scottish Intercollegiate Guidelines Network, 2003.

Includes best practice guidance on the delivery of alcohol screening and brief interventions in primary care. The guideline includes copies of the FAST and PAT screening questionnaires. See: www.sign.ac.uk

General alcohol information

www.infoscotland.com/alcohol

Scottish Government website which brings together a range of information and

resources on alcohol, including facts and figures, a directory of local and national services, and leaflets and factsheets to download.

Training

SBI Training for Trainers Course

NHS Health Scotland initiative to support the delivery of brief interventions in Scotland. See: www.alcoholtraining.co.uk
For information on NHS Health Scotland trainers available to provide training on SBI to practitioners in your area contact: Catriona.loots@health.scot.nhs.uk

STRADA training courses

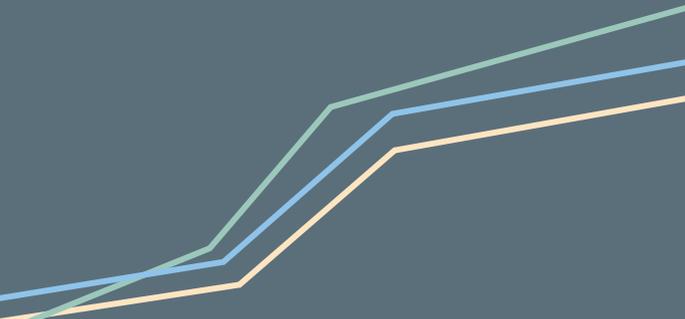
STRADA provides training to staff working in the substance misuse field. A range of courses are on offer including one on motivational interviewing techniques. See: www.projectstrada.org

Royal College of General Practitioners (RCGP) Training on SBI

A practical training course for GPs, nurses and pharmacists is currently under development by RCGP Scotland.

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SHAAP (Scottish Health Action on Alcohol Problems) has been established by the Scottish Medical Royal Colleges and Faculties to raise awareness about alcohol-related harm and to promote solutions based on the best available evidence. A key function of SHAAP is to provide a coherent and authoritative medical voice on reducing the impact of alcohol on the health and well-being of the people of Scotland and to promote measures that can be adopted to reduce this harm.