CHAPTER 7

ENGLAND

Nick Heather, Deborah Hutchings, Emma Dallolio, Catherine Lock, Mark Girvan, Paul Cassidy & Eileen Kaner

7.1. Introduction

7.1.1. Country description

England is the largest of the four countries making up the United Kingdom of Great Britain and Northern Ireland (UK). England covers an area of approximately 129,720 sq km.

In a 2001 census, the population of England was 49,138,831 (83.6% of the UK population). The UK population has grown by 17% overall since 1951 but, compared with many other developed countries over the same period, is growing more slowly. For the first time, people 60 and over form a larger part of the population than children under 16 (21% compared to 20%). There has also been a big increase in the number of people aged 85 and over- now more than 1.1 million or 1.9% of the population.

In 2002, life expectancy at birth for females born in the UK was 81 years, compared with 76 years for males. This contrasts with 49 and 45 years respectively at the turn of the last century in 1901. In recent years, the increase in life expectancy among older adults has been dramatic, particularly for men.

7.1.2. Health care services

The National Health Service (NHS) in the UK has recently undergone radical changes in the way health care services are organised and financed.

The NHS plan published in July 2000 set out proposals for modernising and reforming the NHS over 10 years. At the heart of the plan are patients and primary care, with Primary Care Trusts (PCTs} the organisations responsible for making it happen. PCTs presently have 3 core functions. First is a public health function - to improve the health of the local community and reduce inequalities in health. This involves health needs assessment and the active engagement of patients.

Secondly, PCTs help develop primary and community health services, including the independent practitioner services of general practice, dentistry, pharmacy and optometry, as well as directly providing some of these services themselves. From 2008 however the intention is that PCT's will cease providing any such direct primary and community services. This will help PCT's to focus on their main third role of commissioning secondary and tertiary care services, and supporting general practices in performing their own practice-based commissioning.

In tandem with the changes to PCT's, the independent practitioner services are all having new contracts to help them modernise. The first of these contracts to be finalised was with general practice, the new General Medical Services contract [nGMS] implemented from 1

April 2004. It is the greatest change to how GPs work within the NHS since the NHS was founded in 1948. Firstly, it gives GPs the ability to control and manage their workload through a more flexible provision of services, giving them the ability to choose the services they provide. This is achieved through a categorisation of services. All GMS practices provide *essential services* and a range of *additional services* which they can opt out of if experiencing difficulties, such as recruitment. They then have the opportunity to increase income further by providing a wider range of *enhanced services*. PCT's can commission these enhanced services from other providers, thereby introducing competition into primary care and helping to drive up quality. The nGMS contract also allows GPs to drop all their out-of-hours care to further help their work/life balance.

The nGMS contract also provides a major focus on quality and outcomes. The new quality framework rewards practices for delivering quality care with extra incentives to encourage even higher standards. The 4 components focus on clinical standards, organisational standards, experiences of patients and additional services. The framework is supported by new *Information Management and Technology* (IM&T) systems to collect national data and will create one of the best chronic disease data sets world-wide.

Finally the nGMS contract is associated with the largest sustained investment in primary care the NHS has ever made. Practice infrastructure is being modernised in premises and IM&T, and a new allocation formula provides equity and recognises practice circumstances so that money flows according to patient need. The intended final outcomes are better services for patients. They will be empowered to use primary care more effectively and will have greater access to services which are shaped around their own needs.

7.1.3. Alcohol consumption and alcohol-related harm

Total alcohol consumption in the UK rose steadily during the last century; in 2001 per capita consumption calculated at 8.6 litres of ethanol represented a 121% increase since 1951. Compared with other countries in the European region, the UK has been classified as having a "middle level of consumption", defined as between 5 and 10 litres per person per year[1]. However, in contrast to other European countries, notably the wine-producing countries of southern Europe, consumption in the UK is still rising[2]. An *Interim Analytical Report*[3] prepared by the Prime Minister's Strategy Unit in 2003 stated that, "If present trends continue, the UK would rise to near the top of the consumption league within the next ten years" (p.13).

From the General Household Survey 2001[4], 12% of adults (16+ years) in England are abstainers (M=8.5%; F= 15.2%), 67.1% are moderate drinkers (M=64.4%; F=69.6%), 16.3% are heavy drinkers (M=20.7%; F=12.3%); and 4.6% are very heavy drinkers (M=6.4%; F=2.9%). Thus 27.1% of adult males, 15.2% of adult females and 20.9% in all drink above recommended weekly guidelines (21 units/week men, 14 units/week women). This represents an increase since 1988 when roughly 25% of men and 10% of women exceeded these weekly guidelines.

Within the general trend of increasing consumption, there has been a particularly marked increase among young people in the UK. Among school pupils who admit drinking during the previous week, consumption has nearly doubled from 5.3 units in 1990 to 10.5 in 2002[5]. British teenagers are now among the heaviest drinkers in Europe, being more likely to

report drinking, getting drunk and suffering from alcohol-related problems than teenagers from nearly all other European countries[6].

As in other countries, the age-group with the highest level of consumption is 16-24, with 14% of men and 7% of women reporting drinking at very heavy levels, i.e., 50+ and 35+ units per week respectively[3]. As well as being heavier, drinking among younger adults also tends to be concentrated in fewer days of the week than that of older members of the community. Thus 16-24 year-olds are more likely to report "binge drinking" than older age-groups; only one-sixth of men and one-quarter of women report never having drunk more than 8 or 6 units respectively in a day[3]. Binge drinking is by no means confined to the younger age-group, however, since one-third of men and one-fifth of women between 45-64 years report doing so at least once a week. In marked contrast to some other European countries, in the UK 40% of all drinking occasions by men and 22% by women involve consumption of at least a bottle of wine or equivalent[3].

It is clear that England, in common with the other countries of the UK, is currently experiencing a marked increase in alcohol consumption, both in terms of per capita consumption and of hazardous and harmful drinking patterns. This increase is especially marked among women and among young people of both genders, including those under 16 years of age. Although it is by no means confined to young people, the tendency to binge drink appears to be increasing more sharply among those under 24 years of age.

Associated with this increase in consumption, there has, of course, been a significant increase in alcohol-related harm of all kinds. Adding together costs in the areas of health, crime/public disorder, workplace productivity and family/social networks, the *Interim Analytical Report*[3] estimated that the total cost of harm due to alcohol in England is about £20 billion. This is a higher figure than has ever been advanced before.

7.1.4. Responses to alcohol-related harm

The modern evolution of treatment services for problem drinking in the UK began with the establishment of specialised, self-contained inpatient units following the work of Glatt in the early 1950s[7]. These were controlled by psychiatrists, and had a strong emphasis on group therapy, close links with Alcoholics Anonymous and a commitment to total abstinence as a goal of treatment for all patients.

More recently, and following the publication of a report commissioned by the Department of Health and Social Security in 1978[8], there has been a move towards a community-based response to alcohol problems. This involves an attempt to integrate previously disparate services, such as psychiatric treatment, local non-statutory councils and hostel accommodation, to form a multi-disciplinary approach including psychiatrists, nurses, clinical psychologists and social workers, and the provision of training and support for professional groups in direct contact with problem drinkers, such as general medical practitioners and other primary health care staff.

The latest statement of Government policy in the field of alcohol problems is contained in the Alcohol Harm Reduction Strategy for England (AHRSE) published in 2004[9]. The measures discussed in the strategy framework fall into four categories: Education and Communication; Identification and Treatment; Alcohol-related Crime and Disorder; and Supply and Industry Responsibility. The AHRSE accepts that there is a clear association

between price, availability and consumption but nevertheless rejects measures to control price and availability as policy levers, mainly because "the majority of those who drink do so sensibly the majority of the time" and "policies need to be publicly acceptable if they are to succeed" (p.23).

In the chapter on Identification and Treatment, the Government considers the best way of identifying and treating those who have established alcohol problems that may be affecting their health or their social functioning and recognises that people with alcohol problems may not be picked up in the public services with which they come into contact because of the absence of a clear identification process and also because of lack of staff training to enable identification of an underlying problem or how to refer. It states that: "Following screening, individuals may benefit from a brief intervention….. Brief interventions are usually 'opportunistic' – that is, they are administered to patients who have not attended a consultation to discuss their drinking" (p.37). Such brief intervention may be effective for patients whose problems are not yet too severe. A number of action points in the chapter are relevant to research and implementation of screening and brief intervention (SBI) and to the need to train health care staff to deliver it.

7.1.5. Research on alcohol brief interventions

Studies of the effects of brief interventions in medical settings were pioneered in the UK[10,11]. Randomised controlled trials by Wallace and colleagues[12] and by Anderson and Scott[13] provided the first scientific evidence that SBI delivered in general medical practice was effective in reducing alcohol consumption among hazardous and harmful drinkers who received it.

Subsequently, research on SBI in the UK has turned to studies of how it can be implemented in PHC and how GPs and other primary care staff can be persuaded to adopt it in routine practice. For example, as part of the WHO Phase III Strand 1 project, Kaner and colleagues[14] reported findings from a questionnaire survey of GPs in the English Midlands. Results showed that GPs did not to make routine enquiries about alcohol and may be missing as many as 98% of the excessive drinkers presenting to their practices. Kaner *et al.* also identified a range of obstacles and incentives to the routine implementation of SBI based on questionnaire responses.

Further research by this group in Newcastle, this time as part of the WHO Phase III Strand 3 study, showed that telemarketing is the most cost-effective means of disseminating brief intervention programmes in primary health care[15]. In a related study[16], it was shown that trained and supported GPs implemented a screening and brief intervention programme more extensively and systematically than those who received training alone or a control group and that this was a cost-effective strategy for encouraging GPs to use the programme on a longer-term basis. The Newcastle group has also conducted studies of the effectiveness of SBI delivered by nurses[17] and of methods for increasing implementation of nurse-led SBI in primary health care[18].

7.2. Customisation

The customisation strand of the Phase IV study in England was funded by the *Alcohol Education and Research Council*. The task of customising materials and services was approached using two methods - focus groups and a Delphi survey. Focus groups were carried out both with primary health care professionals and with patients or prospective

patients of primary health care services to obtain their perspectives on the contents and delivery of an SBI programme. It was hoped that these perspectives could inform the adaptation of the programme so that it would be appropriate and acceptable for use in primary health care in England. Specific objectives were:

- To provide information about the appropriate customisation of materials for SBI in primary health care;
- To provide information about the most effective delivery of SBI in primary health care.

The aim of the Delphi survey was to obtain a consensus of expert views on how best to implement SBI in a routine and enduring fashion in primary health care throughout England.

7.2.1. Focus groups with primary health care professionals

The first round of the focus group study was conducted with a purposive sample of primary health care teams within Newcastle and North Tyneside Health Authority (n=75), stratified into two groups based on their previous experience of using the Drink-less package in Phase III of the WHO study in order to explore both user and non-user responses to the programme. Teams were also allocated to one of two focus group discussion topics:

- To explore responses to the Drink-less package
- To explore issues surrounding the achievement of widespread, routine and enduring implementation of SBI in primary health care, including training and support.

Four practice teams were recruited in this round. Groups were heterogeneous in nature in that they consisted of a number of different health care professionals (practice managers, GPs, practice nurses, receptionists etc) within existing teams. This was done to explore the team response to the screening and brief intervention programme and how it might be implemented within 'real' practice situations.

The findings of the first round were used to inform a further 4 professionally-homogeneous groups with GPs and practice nurses. The aim of these homogeneous groups was to explore professional differences in knowledge, attitudes to and experiences of discussing alcohol issues with patients and to derive different options for screening and brief alcohol intervention work. GPs were recruited from practices in the Gateshead area (n=30) and practice nurses from practices in the South Tyneside area (n=30).

Full details of sampling method, recruitment of practices, procedures and data analysis will be found in a report to the funding body[19].

Findings

Full details of the findings from these focus groups, including verbatim quotations from participants, will be found in the report to the funding body[19]. Some of the most important findings were as follows.

a) The majority of both nurses and GPs said that they had received little or no specific training on alcohol and what little information had been imparted had mostly come through more general training on health promotion and lifestyle issues.
b) This low level of training was presumably responsible for the considerable confusion regarding recommended levels for low-risk alcohol consumption[20].
c) A potentially useful grouping made by participants was the distinction between patients whom they felt they might be able to help and those they felt they could not.

Much of what was said on this topic was consistent with the "stages of change" model developed by Prochaska and DiClemente[22-24].

d) Shorter and simplified versions of the AUDIT[25-29] might be used to save time in the busy general practice setting.
e) GPs were opposed to routine screening for excessive drinking unless it was part of a general health or blood pressure check.
f) New patient checks, diabetic or hypertension clinics, well man/woman clinics and general health screening were all mentioned as being appropriate circumstances in which to ask about drinking.
g) Most of the health professionals felt that patients would find it easier to discuss alcohol issues with a practice nurse, who was regarded more as a 'people's person', less formal than a GP and with more time to spend with patients.
h) There was a lack of support among participants for the idea of receptionists handing out screening questionnaires to all patients.
i) Participants emphasised the need for support to health professionals care if widespread implementation is to be achieved[30].

7.2.2. Focus groups with patients

These groups were conducted with a purposive sample of patients registered with practices within Newcastle and North Tyneside Health Authority. All practices within the study area (n=75) were invited to participate. Ten practices contacted the study centre regarding participation.

Participating practices were asked to select a random sample of 60 patients from their records, stratified by age (16-18, 19-25, 26-45 and 46+) and gender (male and female), to be invited to attend a focus group. A total of 43 patients (21 male and 22 female) returned their consent forms agreeing to take part in the study. Of these, 35 (81%) were over 40 years of age.

Due to the low response from patients aged under 40 years, a second recruitment strategy was developed. Market research methods were used to recruit participants aged between 18 and 30 years from the general public. Subjects were approached in Newcastle city centre, the research was explained to them and they were given an information sheet. To ensure that each focus group was as homogenous as possible and had a similar number of potential participants, patients who agreed to participate in the study were placed into groups determined by their age and gender. This gave a total of six groups with the following characteristics: female 18-30; male 18-30; female 40-55; male 40-55; female 56+ and male 56+. (No patients aged between 30 and 40 years agreed to participate).

Again, full details of methods and data analysis will be found in the report to the *Alcohol Education and Research Council*[19].

Findings

a) In general, participants did not resent being asked or advised about lifestyle issues, particularly if these issues were raised at certain clinics (e.g., patient registration, general check-ups, well man/woman clinics) where they expected them to be raised.
b) When asked what "excessive drinking" meant to them, participants gave a variety of replies but none appeared to use the concept of alcohol units to measure drinking level and define what was excessive.

c) Given the popularity of the AUDIT questionnaire, it is surprising that participants reported they would have difficulties in completing it. But most agreed that being asked to complete the AUDIT would be acceptable as part of general health screening, new patient registrations or while waiting to see a health professional, provided in the latter instance that privacy could be ensured.

d) The suggestion that screening alcohol consumption should be "layered" to avoid giving offence to patients could be met by the use of the FAST version of the AUDIT questions[29].

e) Apart from some small degree of confusion over the contents, the Drink-less intervention package was regarded positively be participants. It did emerge, however, that the materials should probably be specially adapted to suit the needs and concerns of younger drinkers.

f) When participants were asked to rank-order 5 types of health professional in terms of their preference for discussion of alcohol issues, the resulting order was: GP, practice nurse, counsellor, alcohol worker and lifestyle worker. However, a range of factors affected the interpretation of this order[19].

g) There was general agreement among participants about the need for more information to the general public on alcohol and its associated problems. A number of suggestions were made as to how this information could best be conveyed.

Combined findings from focus groups

When findings from both types of focus groups (i.e., with health professionals and with patients) were combined[31], the following were the main conclusions.

I Discussions about alcohol are acceptable within specific contexts in primary care. 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. However, there is still uncertainty among professionals as to the effectiveness of brief interventions and disagreement between professionals and patients as to who should carry them out.

II 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.

7.2.3. Delphi survey

The survey was conducted in 3 rounds. The first questionnaire consisted of 7 open-ended questions and was sent with an accompanying letter and guidelines for completing the study to all individuals (n=79) who had agreed to take part. Preparation of the second questionnaire began shortly after Round One questionnaires had been received. A total of 264 items were listed by respondents and a content analysis was conducted to establish the main themes and corresponding items. This number was culled to 157 after removing similar and redundant answers. The second questionnaire consisted of 8 sections:

- The best way to identify risky drinkers in primary health care without offending patients is by … (17 items)
- Patients can be encouraged to talk about their drinking by … (20 items).

- The most effective types of brief intervention for risky drinkers in primary health are … (18 items)
- Which PHC professionals should be involved in screening and brief interventions for excessive drinking and what should their respective roles be? (13 items)
- Primary health care professionals can be encouraged to routinely deliver screening and brief intervention by … (26 items)
- The concept of risky drinking can best be communicated to the general public via … (23 items)
- The concept of risky drinking can best be communicated to PHC professionals via … (13 items)
- The most important issues concerning screening and brief intervention in PHC are … (27 items)

Respondents were asked to agree or disagree with each item using a 5-point Likert scale The response categories ranged from '1' (Strongly Disagree) to '5' (Strongly Agree). After piloting, the second questionnaire was again sent to all individuals (n=79) who had initially agreed to participate.

Amendments were made to the third and final questionnaire which consisted of the same overall set of items as the second. This was sent to all individuals (n=68) who had completed the second round of the study. Using a mail merge facility, the median response and the individual's responses to each item were included on each questionnaire and the panel was asked to re-rate each item in light of the group's response. If new ratings differed by more than one point from the median, respondents were encouraged to comment on their reasons for this at the end of the questionnaire

The median and the inter-quartile range were calculated for the panel as a whole. The same statistics were also calculated separately for three sub-groups of the panel (see below). In analysing findings from Round 3, consensus was defined in terms of the inter-quartile range. Items with an inter-quartile range of =<1 were defined as having achieved group *consensus*; an inter-quartile range of 0 was taken to indicate *high consensus*.

The composition of the sample for each of the three rounds and for each category of experts is shown in Table 7.1. Fuller details of the method and analysis are given in the report to the funding body[19] and in a journal publication[32].

Findings

Details of findings and a discussion of their implications for practice will be found in the report to the funding body[19] and in Heather *et al.*[32]. Some of the main findings may be summarised as follows:

a) 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[33]. 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.

b) 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.

c) The findings suggested a model involving screening by other PHC staff, possibly in addition to screening by the specialist, followed by brief intervention, support and monitoring and onward referral to alcohol or addictions agencies where appropriate by the specialist worker.

d) In circumstances where the employment of a specialist alcohol worker is not feasible, the findings suggested a model of inter-professional co-operation in the delivery of SBI: (i) screening for excessive drinking is carried out in appropriate circumstances by the GP, practice nurse, district nurse and counsellor; (ii) referral of positive cases for brief intervention is made to the practice nurse, the counsellor or the dietician, with additional involvement by the GP or the health visitor given time and interest; (iii) support and monitoring of the patient is carried out by the PHC staff member who gave the brief intervention; (iv) onward referral is made by the same staff member, perhaps in consultation with the GP.

TABLE 7.1

Composition of sample for Delphi survey

Subgroup	Recruitment	Round One	Round Two	Round Three
Academic	26	20	18	11
Researcher	28	21	24	12
G.P.	14	11	9	7
Nurse	15	7	7	6
Alcohol Service Worker	39	28	25	17
Director/Chief Exec. of Alcohol Service	5	5	5	5
Other	7	7	7	6

Numbers do not sum to totals in text as some individuals fall into more than one category.

e) The 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.

f) Experts showed broad agreement on the importance of principles bearing on the interaction between helper and patient derived from the motivational interviewing perspective[33] and the idea that behaviour change should be negotiated with the patient rather than prescribed or imposed.

The findings of the Delphi survey, together with those of the focus groups, were used to inform the development of the Demonstration Project (see below).

7.3. Reframing Understandings of Alcohol Issues

The aim of this component of the study was to develop a *Communications Strategy* to promote an understanding among the target audiences of the concept of "risky drinking", i.e., drinking above medically recommended levels with an increased risk of alcohol-related harm. The basic assumption of the strategy was that this should be seen as primarily a lifestyle issue and needs therefore to be distanced from concepts of "alcoholism" or severe dependence. Positive messages in relation to moderate drinking and healthy lifestyles were also to be communicated in the strategy. It was further assumed that, without such an improved understanding of the rationale behind SBI, no attempt at widespread dissemination could be expected to succeed in the long term. Three separate target groups were identified: health care professionals; the general public; stakeholders in SBI.

The development of the strategy was undertaken by a *Communications Strategy Working Group*, with the remit to advise and produce recommendations for a Communications Strategy on two levels:

a) on a national level for widespread dissemination throughout England;

b) on a local level for use in conjunction with the Demonstration Project component of this study.

As part of its output, the Working Group produced a document entitled, *Marketing Strategy for Screening and Brief Intervention in Primary Health Care*. This was intended to meet the objective of producing recommendations for promoting implementation of SBI throughout England. Included within this document was the Communications Strategy concerned specifically with the task of reframing understandings of alcohol-related issues among target groups. It was published by the charity, Alcohol Concern[34] and was widely distributed throughout England. It was also posted on the project web site **www.alcohol-phaseivproject.org.uk** and sent to the Cabinet Office Strategy Unit concerned with developing the Alcohol Harm Reduction Strategy for England.

As an illustration of the contents of the Communication Strategy, Table 7.2 summarises recommendations for communicating SBI among primary health care professionals.

7.4. Lead Organisation and Strategic Alliance

At the inception of the study, the lead organisation was the Centre for Alcohol and Drug Studies at Newcastle, North Tyneside and Northumberland Mental Health NHS Trust in collaboration with the Department of Primary Health Care at the University of Newcastle. Later and in the Demonstration Project, the lead was taken by the Division of Psychology at Northumbria University in collaboration with the Centre for Health Services Research, University of Newcastle upon Tyne and Gateshead Primary Care Trust. A Project Management Team was formed to run the Phase IV study and this met regularly on a monthly basis throughout the study.

7.4.1. Local alliance

A local Steering Group was formed to advise and co-ordinate research activities in the local area. This contained representatives of a range of local institutions and organisations, including universities, health care organisations, local government and public relations. The members of the Steering Group were influential in publicising and advancing the aims of the project on a local basis.

Another group of experts formed locally as part of the Phase IV study was a Policy Working Group. This had the remit of reviewing general policy on health in England and advising on what facets of health policy could be used to further the routine implementation of SBI. The group produced a document entitled, *Overview of Reforms and Developments in Health Policy: Implications for the Implementation of Brief Interventions in Primary Care* and this was included in the report to the funding body and posted on the project website.

7.4.2. National strategic alliance

To develop a Strategic Alliance on a nation-wide basis, a meeting was held at the Department of Health in London in May, 2000 which was attended by representatives of leading national organisations with a potential interest in promoting the implementation of SBI in England, including Alcohol Concern, the Royal College of General Practitioners, the Royal College of Nursing and the All-Party Parliamentary Group on Alcohol of the House of Commons.

Using contacts established at this meeting, publicity in various media and, following completion of the survey, the panel formed in the Delphi survey, a national Strategic Alliance was formed of organisations and individuals interested in promoting the widespread and routine implementation of SBI in PHC in England. Those joining the alliance were asked to sign a statement endorsing the aims of the Phase IV project. The membership of the Strategic Alliance contained 47 organisations and 92 individuals, including several Members of Parliament or Members of the European Parliament. The organisations in the Strategic Alliance are listed Appendix 7.1.

As part of the activities of the Strategic Alliance, a national one-day conference was held at the *International Centre for Life* in Newcastle upon Tune in June 2002. The conference was organised by a local public relations company, *Benchmark Communications Ltd* with the help of grant from *Pfizer Ltd*. The conference was titled, *Action on Alcohol: the Role of Primary Care* and was attended by over 300 delegates. Invited keynote addresses in the morning sessions were by Professor Sir Liam Donaldson, the Chief Medical Officer and Professors Griffith Edwards, Paul Wallace, Hazel Watson and Mike Kelly. In the afternoon there was a presentation of the latest findings from the Phase IV study by the project team, followed by another keynote address by Dr. Stephen Rollnick. The meeting concluded with a discussion among the members of the Phase IV Strategic Alliance of the best ways to take forward the alliance and the aims of the project.

7.5. Demonstration Project

Following completion of Strand 1 of the Phase IV study (customisation, reframing and strategic alliance), three attempts were made over a period of two years to obtain funding for a Demonstration Project but without success. Reasons for this failure to attract funding are unclear but it may be that funding bodies in the UK are not sufficiently familiar with the need for "translational research", i.e., research aimed at translating findings from efficacy and effectiveness research into routine practice.

Eventually, in 2004, the Tyne and Wear Health Action Zone (HAZ) invited tenders for a one-year project entitled, *Implementing Screening and Brief Alcohol Interventions into Pilot GP Practices* and our Phase IV team of investigators was successful in obtaining this grant. The application for funding specifically mentioned the opportunity to build on the research

conducted in the WHO Phase III study, what had so far been accomplished in the Phase IV study and other research by our group. The project was described as an example of action research in which the participants in the project are invited to join researchers in meeting the project aims and an iterative process is used to make progress towards those aims. The project began in August 2004 and data collection has recently been completed.

The aims of the project were:

i) To pilot the routine implementation of alcohol SBI in at least one general medical practice in each of the five areas of the Tyne & Wear HAZ (Sunderland, Newcastle, South Tyneside, Gateshead, North Tyneside)

TABLE 7.2

Summary of Communications Strategy for Primary Health Care Professionals

Objective	Channel	Content	Format
Raising awareness	▪ Professional (GP/Practice Nurse) education/training group meetings ▪ Individual practice team meetings	▪ Alcohol-related problems (health and social) ▪ Size of problems (nationally and locally) ▪ Public health/primary care issue ▪ Recommended levels ▪ 'Risky' drinking vs alcoholism ▪ What is SBI ▪ Evidence of effectiveness of SBI	▪ Presentation and discussion ▪ Overhead slides ▪ Handouts ▪ Printed SBI materials for demonstration ▪ Web site
Dissemination	▪ Telemarketing by GP or nurse ▪ Follow-up from awareness-raising meetings	▪ 'Risky' drinking and primary care ▪ SBI programme details ▪ Training programme details	▪ Telephone call and 'script'
Provision of SBI tools / materials	▪ Published screening tools ▪ Intervention materials ▪ Clinical guidelines	▪ Clinical guidelines for SBI and appropriate referrals ▪ Screening questions and scoring ▪ Information on units, sensible, hazardous and harmful levels, benefits of cutting down, strategies for cutting down etc for patients ▪ Available support services	▪ Written guidelines and decision making diagram/flow chart ▪ Screening tool and scoring template ▪ Unit calculator ▪ BI materials (advice card, handy card, booklet) ▪ CD ROM version ▪ Posters and leaflets for waiting room ▪ Directory of support services ▪ Web site
Training	▪ Practice team based training sessions (accredited)	▪ Recap of session for raising awareness (see above) ▪ Use of screening tools ▪ Stages of change (Helping people change) ▪ Brief interventions ▪ Motivational interviewing ▪ Diagnosis and treatment of dependence	▪ Overhead slides ▪ Handouts ▪ SBI Materials ▪ Interactive exercises ▪ Video ▪ Role play

		▪ Available support services and referrals ▪ Audit and feedback mechanisms	

ii) On that basis, to develop Clinical Guidelines to assist primary health care professionals to deliver SBI in their everyday practices

iii) At the same time, to develop a Training Programme for the routine delivery of SBI in primary health care

iv) To roll out tried and tested Clinical Guidelines and a Training Programme to general practices across the HAZ and beyond.

7.5.1. Methods

The research protocol specified that at least one general practice from each of the 5 PCTs covered by the Tyne & Wear HAZ be included in the project. Selection of these practices began with a letter to each surgery within the HAZ with 3 or more partners introducing the research and asking for expressions of interest. A total of 118 letters were sent out. Sixteen (16) practices replied to this initial letter.

A second letter was sent to all 16 practices together with a "research contract", a brief description of the project and a questionnaire asking for a practice profile, previous experience of research and other relevant information. Practices were asked to review the information and, if they still wished to be considered, to complete and return the questionnaire. Twelve practices applied to undertake the research and 5 were chosen, one from each HAZ area, on the basis of achieving socio-demographic representativeness of practice populations and perceived ability to complete the project.

A payment of £1,000 was made to all participating practices in each of the 6 months of the active pilot phase of the project (i.e., £6,000 in total to each practice). This was done to compensate practices for the time and resources spent on the project and also to anticipate conditions under the nGMS contract in which practices would be paid to implement SBI.

The main method used to achieve the project aims was a series of meetings between practice staff and the research team. There were three *plenary* meetings attended by representatives from all participating practices at the beginning, middle and end of 6-month implementation phase. In addition to this, research staff attended monthly in-practice meetings to monitor progress and respond to queries. Continuous contact with practices was maintained via telephone, email and informal practice visits and this was regarded as key to sustaining involvement and ensuring that the project remained a priority in busy work schedules.

The agendas for the 3 plenary meetings were as follows:

1st meeting – 5/10/04

- Introduction to the project
- Previous research by the Newcastle group (including WHO Phases III and IV)
- Options for the SBI package, with emphasis on screening tools and delivery of screening
- Questions and general discussion

2nd meeting – 1/2/05

- Screening experiences – feedback from all practices and discussion

- Options for brief intervention
- General discussion and plans for intervention phase
- Plans for writing final report on research, including contributions of practice staff

3rd meeting – 26/5/05

- Experience of delivering brief interventions – feedback and discussion
- Project overview – screening conclusions, computer template, incentivising SBI
- Plans for final report and future work

Between plenary meetings practices used the PDSA cycle (Plan-Do-Study-Act) to adjust screening and brief intervention to their preferences and requirements. This method is popular in general practice research for testing and refining innovations in practice[35]. Practice staff were also asked to complete the shortened *Alcohol and Alcohol Problems Perception Questionnaire*[36] before and after the implementation phase of the project. As a way of monitoring changes in practice during the project, an audit of SBI activity was carried out from practice computer records before and after the implementation phase. Data collected were:

- Number of patients on the practice list
- Number of patients with recorded alcohol consumption levels, broken down by age and gender
- Number of patients with an updated consumption level within the last 6 months
- Number of patients with a read code for alcohol dependence syndrome

7.5.2. Findings

Although data collection has been completed, a report to the funding agency and articles for publication arising from this research have not yet been submitted, so the findings below should be regarded as preliminary.

Initial screening decisions

Screening tool(s). After trying various alternatives, practices opted for the following screening preferences: full AUDIT (1 practice); AUDIT PC (2 practices); AUDIT C (3 practices); FAST (2 practices). Three practices chose two different tools for use in different circumstances.

Screening delivery. All practices chose joint delivery by both practice GP's and nurses.

Consultations. Overall, the following types of consultation were chosen for the delivery of screening: New patient registrations; CHD clinics; Emergency contraception; Smear clinics; IHD clinics; almost universal screening (1 practice).

Levels of intervention and training

Two levels of brief intervention were eventually agreed by participants:

Level 1: simple structured advice. Based on research evidence for the effectiveness of brief intervention, this first level of intervention is aimed primarily at hazardous drinkers, although some practices opted to offer advice to all patients screening positive. The intervention was scheduled to last only 2-3 minutes.

Training for this level of intervention was agreed to comprise two 30 minute sessions and it was emphasised that training in screening and the intervention itself should be delivered together. Participants felt the need for specific "bridging techniques" to make the step from a positive screen to the offer of simple structured advice. A "training the trainers" approach, in which one member of a practice team would be trained to teach his or her colleagues in the practice setting, was thought to be suitable for this level of intervention

In addition to development of the training programme in the form of PowerPoint slides and accompanying notes, an existing version of the Drink-less pack, with the new title of "How Much Is Too Much?", is being developed to assist the delivery of simple structured advice. This will be accompanied by clinical guidelines, both in a long form based on the guidelines produced by the PHEPA project and a short "how-to-do-it" form for use in routine practice.

Level 2: Behaviour Change Counselling: This 2nd level of intervention is aimed at harmful drinkers, those who have not benefited from brief advice and those patients who request a longer discussion of their drinking. It is scheduled to last for 10-15 minutes plus follow-up consultations when necessary. Counselling techniques are based on those described by Rollnick, Mason and Butler[36] for the negotiation of behaviour change in health care settings

The development of the training programme for the Level 2 brief intervention was carried out by an independent company with considerable experience in training clinical communications skills (*Effective Professional Interactions*: Dr. Malcolm Thomas, Director; <www.effectivepi.co.uk>). Training takes place during a half-day session and includes an introduction to the stages of change model, motivational interviewing techniques and practical exercises in motivational techniques using role-play. The training has been piloted with practice teams and is now being developed into a formal training programme.

IT issues

A data entry template was designed and created which could be installed on the clinical system of each of the 5 research practices. This template consisted of a list of on-screen prompts relating to alcohol which an individual clinician could access and run through within a consultation where alcohol appears to be an issue. The first problem encountered was that not all of the practices used the same clinical computer system interface. It was therefore necessary to create two systems, one for the EMIS computer system used by most practices and one for the slightly older EXETER system.

An initial task was to identify what information needed to be asked for and collected within the template. While we wanted to gather a maximum amount of data, if too many questions were included clinicians would be deterred from using it. Choosing which information to include involved selecting a number of read-codes from a predetermined national list which any EMIS-based practice in the country is able to access. In total there were 139 alcohol-related read codes from which to choose. The research team initially selected 15 read-codes from the total that it was felt would capture the main information required. This list was then presented to the 5 practices for their feedback and, after consultation, was reduced to a final list of 9:

Alcohol consumption screen**(68S)**
Alcohol consumption **(136)**
Alcohol use **(ZV4KC)**

Alcohol dependence syndrome NOS**(E23z)**
Nondependent alcohol abuse**(E250)**
Patient advised about alcohol **(8CAM)**
Contemplation stage**(67K1)**
Not Interested In Reducing Alcohol**(EMISQNO6)**
Alcohol leaflet given**(8CE1)**

Within this design stage, the main obstacle was the lack of suitable codes for 'hazardous', 'harmful' and 'dependence' - the terminology used by the WHO to define different types of consumption levels and drinkers; as such we were keen to promote the use of these definitions within this study. It was therefore unanimously decided by all practices that new read codes specifically for *Hazardous alcohol consumption* and *Harmful alcohol consumption* would be beneficial. Importantly, this would encourage consistency in the terminology health practitioners used. The *National Health Information Authority* agreed to the creation of the above codes (136S and 136T), both of which can now be accessed by any GP in the UK.

The majority of the practices successfully incorporated the new template into all other templates in which there is an existing read code for alcohol. It can now therefore be called up from within templates such as diabetes, epilepsy, and depression. If an entry is made to indicate a patient has been screened, the computer automatically takes the clinician into the full alcohol consumption template.

Implementation model
A best-practice implementation model derived from the findings of the Demonstration Project will be found in Figure 7.1.

FIGURE 7.1 ABOUT HERE

7.4. Conclusions: Obstacles and Opportunities

In addition to the usual difficulties concerning lack of interest in alcohol SBI among health professionals and policy-makers, the main obstacle to progress in the Phase IV study in England was the failure to attract funding for the Demonstration Project and thus to ensure continuity in research activity. Staff who had been trained in SBI research and had become skilled and knowledgeable in this area were lost to other fields of study. Moreover, the impetus for widespread implementation of SBI that had been built up by the formation of the Strategic Alliance and strengthened by the national conference in Newcastle in 2002 was to a large extent dissipated and will have to be rebuilt.

Ironically, however, the hiatus caused by the delay in carrying out a Demonstration Project may have had unintended benefits for the effort to implement SBI in England. This is because the delay allowed time for several important developments to occur that have now provided a unique opportunity to make progress in the Phase IV study's central aim. These developments are:

- the Government's *Alcohol Harm Reduction Strategy for England* (AHRSE)[9], implemented in March 2004. The AHRSE document includes reference to alcohol SBI in general and SBI in PHC in particular in Chapter 5 on *Treatment and Identification* and summarises the Government's intentions with regard to SBI in

England. While there are flaws in the discussion of SBI in the AHRSE, particular its neglect of the hazardous drinkers as opposed to patients with established alcohol problems, the prominence given to SBI in the document, especially in PHC, gives grounds for optimism that the Government now recognises its potential in the effort to reduce alcohol-related harm in England;

- the *New General Medical Services Contract* (nGMS) which came into effect at the beginning of April 2004. A specification for the treatment of "Patients who are alcohol misusers" is provided in the Contract as a *National Enhanced Service* (NES) and this includes SBI for hazardous and harmful drinkers. It is clear that the nGMS needs reform if it is to assist the widespread implementation of SBI but the opportunity to effect such reforms does exist.
- a White Paper published by the Department of Health in November 2004 entitled *Choosing Health: Making Healthy Choices Easier*[37]. This includes alcohol consumption among the other health behaviours it addresses and proposed a new profession of "Health Trainers" to work in PHC to give advice to patients showing health-related risk behaviours.

In the light of these developments, the line of research initiated by the Phase IV study in England is clearly still of obvious relevance to implementing SBI routinely in PHC and is possibly more in line now with declared national priorities and government thinking than when the study began. More specifically, as promised in the AHRSE[9], in May 2005 the government invited tenders for research to carry out a number of pilot schemes to test how best to use a variety of models of targeted screening and brief intervention in primary and secondary healthcare settings, focusing particularly on value for money and mainstreaming. The main questions that were to be addressed were:

a) Can it be demonstrated within the UK context and in a real-life environment that screening and brief intervention are clinically effective and cost effective in changing individual drinking behaviour?

b) What forms of screening and intervention for alcohol misuse are acceptable and reasonable to be implemented GPs, primary care staff, healthcare staff in other settings (A&E, outpatient clinics, inpatient wards) as well as staff in other settings such as criminal justice settings?

Our Newcastle team is part of a consortium that was successful in bidding for this research grant and will take particular responsibility for a cluster randomised trial in the PHC segment of the project. While some answers to the questions above have been provided, at least in PHC, by the Tyne and Wear HAZ project (see above), the new project will investigate these questions on a much wider scale and in a more formal, quantitative fashion.

Acknowledgements
This research could not have been carried out without the support of the *Alcohol Education & Research Council* in the earlier stages of the study or the *Tyne & Wear Health Action Zone* in the Demonstration Project. We are also grateful to Pfizer Ltd for its contribution to staging the one-day conference, *Action on Alcohol: the Role of Primary Care* in June 2002

7.7. References

1. World Health Organisation. *Global Status Report on Alcohol.* Geneva: WHO, Substance Abuse Department, 1999.
2. Rehn N, Room R, Edwards G. *Alcohol in the European Region: Consumption, Harm and Policies.* Copenhagen: WHO Regional Office for Europe, 2001.
3. Prime Minister's Strategy Unit. *Interim Analytical Report.* http://www.number10.gov.uk/files/pdf/SU%20interim_report2.pdf.
4. Office for National Statistics. *Living in Britain: Results from the General Household Survey 2001.* London: the Stationery Office, 2002.
5. Department of Health. *School Survey 2001.* London: Author, 2001.
6. Hibell B, Andersson B, Ahlström S, Balakireva O, Bjarnasson T, Kokkevi A, Morgan M. *The 1999 ESPAD Report (European School Survey Project on Alcohol and Other Drugs): Alcohol and Other Drug Use Among Students in 30 European Countries.* Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (Pompidou Group), 2000.
7. Ettore EM. A study of Alcoholism Treatment Units: treatment activities and the institutional response. *Alcohol & Alcoholism* 1984;19: 243-255.
8. Department of Health & Social Security. *The Pattern and Range of Services for Problem Drinkers.* London: HMSO, 1978.
9. Prime Minister's Strategy Unit. *Alcohol Harm Reduction Strategy for England.* London: Cabinet Office, 2004.
10. Chick J, Lloyd G, Crombie E. Counselling problem drinkers in medical wards: a controlled study. *British Medical Journal* 1985; 290: 965-967.
11. Heather N, Campion P, Neville R, MacCabe D. Evaluation of a controlled drinking minimal intervention for problem drinkers in general practice (the DRAMS Scheme). *Journal of the Royal College of General Practitioners* 1987; 7: 358- 363.
12. Wallace P, Cutler S, Haines A. Randomized controlled trial of general practitioner intervention with excessive alcohol consumption. *British Medical Journal* 1988; 297: 663-668.
13. Anderson P, Scott E. The effect of general practitioners' advice to heavy drinking men. *British Journal of Addiction* 1992; 87: 891-900.
14. Kaner EF, Heather N, McAvoy BR, Lock CA, Gilvarry E. Intervention for excessive alcohol consumption in primary health care: attitudes and practices of English general practitioners. *Alcohol & Alcoholism* 1999; 34: 559-566.
15. Lock C, Kaner E, Heather N, McAcoy B, Gilvarry E. A randomised trial of three marketing strategies to disseminate screening and brief alcohol intervention programme to general practitioners. *British Journal of General Practice* 1999; 49: 699-703.
16. Kaner E, Lock C, McAvoy B, Heather N, Gilvarry E. A RCT of three training and support strategies to encourage implementation of screening and brief alcohol intervention by general practitioners. *British Journal of General Practice* 1999; 49: 699-703.
17. Lock C, Kaner E, Heather N, Doughty J, Cranshaw A, McNaamee P, Purdy S, Pearson P. The effectiveness and cost-effectiveness of nurse-led screening and brief alcohol intervention in primary health care: a cluster randomised controlled trial. *Journal of Advanced Nursing*; in press.
18. Lock C, Kaner E, Lamont S, Bond S. A qualitative study of nurses' attitudes and practices regarding brief alcohol intervention in primary health care. *Journal of Advanced Nursing* 2002; 39: 333-342.

19. Heather N, Hutchings D, Dallolio E, Kaner E, McAvoy B. *Strategy for Implementing Screening and Brief Alcohol Interventions in England. Report to the Alcohol Education & Research Council on work carried out under Action Project Grant R3/99.* Newcastle upon Tyne: Division of Psychology, Northumbria University, 2005.
20. Webster-Harrison P, Barton A, Barton S, Anderson S. General practitioners' and practice nurses' knowledge of how much patients should and do drink. *British Journal of General Practice* 2001: 51: 218-220.
21. Kaner EFS, Heather N, Brodie J, Lock CA, McAvoy BR. Patient and practitioner characteristics predict brief alcohol intervention in primary care. *British Journal of General Practice* 2001; 51: 822-827.
22. Prochaska JO, DiClemente CC. Stages of change in the modification of problem behaviors. In: Hersen M, Eisler RM, Miller PM (Eds.) *Progress in Behavior Modification.* Newbury Park CA: Sage,1992.
23. Heather N. Brief intervention strategies. In: Hester RK, Miller WR, eds. *Handbook of Alcoholism Treatment Approaches: Effective Alternatives* (2nd edition). Needham Heights MA:Allyn & Bacon,1995.
24. UK Alcohol Forum. *Guidelines for the Management of Alcohol Problems in Primary Care and General Psychiatry* (2nd edition). Edinburgh: Department of Psychiatry, University of Edinburgh, 2001.
25. Bush K, Kivlahan DR, McDonell MB, Fihn SD, Bradley KA. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. *Archives of Internal Medicine*1998; 158: 1789-1795.
26. Seppa K, Lepisto J, Sillanaukee P. Five-shot questionnaire on heavy drinking. *Alcoholism: Clinical & Experimental Research* 1998; 22: 1788-1791.
27. Gordon AJ, Maisto SA, McNeil M, Kraemer KL, Conigliaro RL, Kelley ME, *et al*. Three questions can detect hazardous drinkers. *Journal of Family Practice* 2001; 50: 313-320.
28. Gual A, Segura L, Contel M, Heather N, Colom J. AUDIT-3 and AUDIT-4: effectiveness of two short forms of the Alcohol Use Disorders Identification Test. *Alcohol & Alcoholism* 2002; 37: 591-596.
29. Hodgson R, Alwyn T, John B, Thom B, Smith A. The FAST Alcohol Screening Test. *Alcohol & Alcoholism* 2002: 37: 61-66.
30. Anderson P. Managing alcohol problems in general practice. *British Medical Journal* 1985; 290: 1873-1875.
31. Hutchings D, Cassidy P, Kaner E, Dallolio E, Pearson P, Heather N. Implementing screening and brief alcohol interventions in primary care: views from both sides of the desk. Unpublished ms. Newcastle upon Tyne: Centre for Health Services Research, University of Newcastle upon Tyne, 2005.
32. Heather N, Dallolio E, Hutchings D, Kaner E, White M. Implementing routine screening and brief alcohol intervention in primary health care: a Delphi survey of expert opinion. *Journal of Substance Use* 2004; 9: 68-85.
33. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People for Change*. 2nd ed. New York: Guilford, 2002.
34. Hutchings D, Cassidy P, Lock C, Lowry R., Ness M, Reay S, Heather N. *Marketing Strategy for Screening and Brief Intervention in Primary Health Care.* London: Alcohol Concern, 2003.
35. Langley GJ, et al. *The Improvement Guide: A Practical Approach to Enhancing Organisation Performance.* National Primary Care Development Team http://www.npdteducation.org/scripts/default.asp?site_id=15&id=428

36. Anderson P, Clement S. The AAPPQ revisited: The measurement of general practitioners attitudes to alcohol problems. *British Journal of Addiction* 1987; 82: 753-759.
37. Rollnick S, Mason P, Butler C. *Health Behavior Change: A Guide for Practitioners*. Edinburgh: Churchill Livingstone, 1999.
38. Department of Health (2004). *Choosing Health: Making Healthy Choices Easier.* http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor.

APPENDIX 7.1.

Membership of the Strategic Alliance (Organisations)

- Addiction Prevention in Primary Health Care, London
- ADS (North West), Manchester
- Alcohol Concern
- Alcohol Counselling and Prevention Services, London
- Alcohol Education and Research Council
- Alcohol Problems Advisory Service, Nottingham
- Alcohol Recovery Project, London
- Alcohol Services for the Community
- Appleby Solutions Ltd
- C.A.I.S. Ltd
- City and Hackney Alcohol Service, London
- Clapham Family Practice, London
- Community Alcohol & Drugs Service, Kings Lynn
- Community Mentors Ltd
- Department of Nursing & Community Health, Glasgow
- Department of Pubic Health & Family Health APU, Chelmsford
- Drinksense
- Health Development Agency
- Heath Promotional Research Group University of Newcastle
- Hereford and Worcester Advisory Service on Alcohol
- Leeds Addiction Unit
- Manchester Community Alcohol Team
- Medical Council on Alcoholism
- National Association of Primary Care
- Newcastle & North Tyneside Drugs & Alcohol Service
- Newcastle & North Tyneside Health Promotions Department
- NORCAS
- North Lambeth Primary Care Group, London
- North Wales Drug & Alcohol Forum
- Northumberland CSMT
- Nursing Council on Alcohol
- Options
- Royal College of General Practitioners
- Royal College of Nursing Practice Nurses Association
- South Tyneside Drug & Alcohol Service, Tyne & Wear
- South Tyneside PCT
- Specialist Community Alcohol Team, Crewe
- Sunderland Community Health Council
- Swanswell Charitable Trust : Coventry Community Alcohol Service
  - Leamington Community Alcohol Service
  - Nuneaton Community Alcohol Service
  - Rugby Community Alcohol Service
- The Albert Centre
- The Department of Nursing & Community Health, Glasgow Caledonian University
- Trafford Alcohol Service, Manchester
- Trafford SMS, Manchester