Grampian Alcohol Screening and Brief Intervention Strategy 2018 - 2021

Our vision for success is that in 2021

Alcohol screening part of the day-to-day practice of frontline staff and volunteers who work with people who are at risk of experiencing harm from alcohol. People are offered information, advice and support which help them change their behaviour or address the underlying reasons which contribute to high risk alcohol consumption.

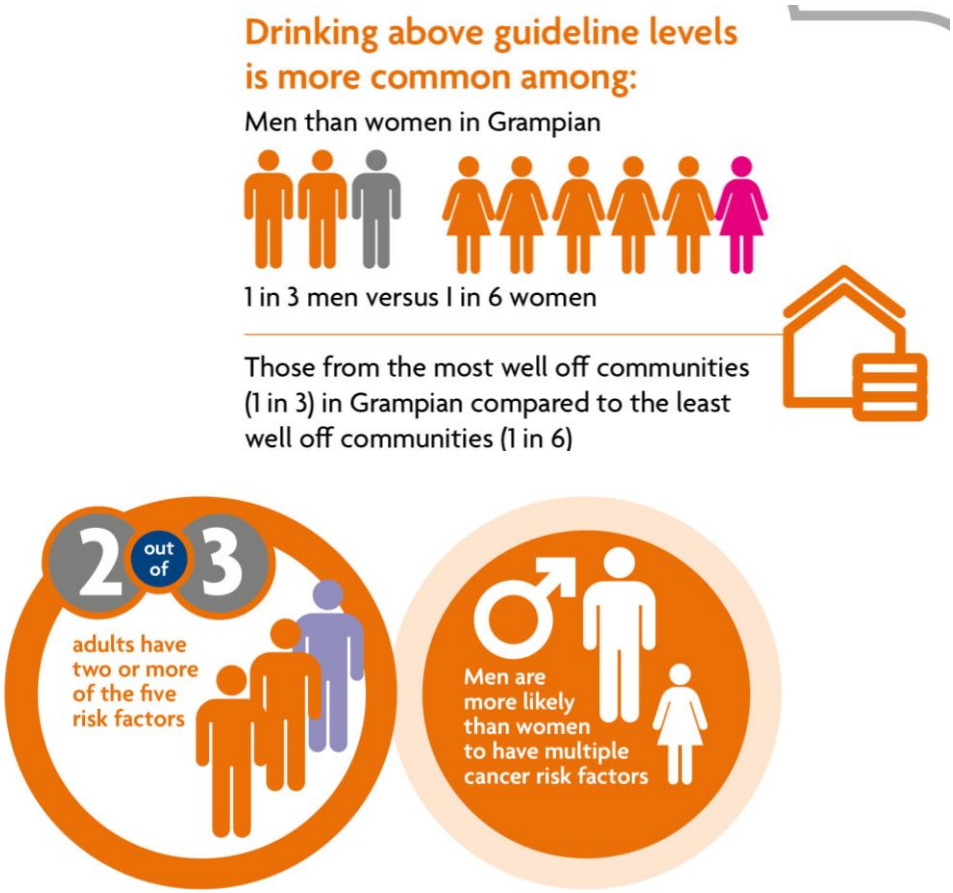
The public health system's role in preventing alcohol harm through screening and brief intervention

- The public who make choices about their lives and are affected, informed and influenced by the social, physical, cultural and political environment around them
- The voluntary and community sector – influences people's choices by providing information, services, volunteering opportunities, employment.
- Health and social care workers, primary care – influence people's choices during planned and unplanned contacts, provide information and services. Responsible for prevention and self-management of chronic disease approaches.
- Criminal justice service providers – influence people's choices during contact, provide information, routes into treatment and care
- Industry – particularly in the context of providing employment and efforts to improve employee wellbeing

Our health today, why we need to improve

The UK Chief Medical Officer published recommendations on low risk alcohol consumption in 2016. High risk alcohol consumption is associated with an increased risk of physical health, mental health, social and economic impacts in the short medium and long term.

Low risk consumption as no more than 14 units of alcohol spread through a week. People with long term conditions and those on regular medication may be recommended to drink less than 14 units. Pregnant women and those planning a pregnancy are recommended to not drink any alcohol at all.



Source: NHS Grampian, DPH annual report 2017

Alcohol is one of five lifestyle behavioural risk factors which contribute to the majority of the burden of chronic and non-communicable disease. Clustering of lifestyle risk factors is associated with higher risk of premature disease development and mortality[1]. Research within Grampian into the clustering of lifestyle risk factors indicates that these are spread unevenly through the population, increased multiple lifestyle risk factors were observed in men and in people from socioeconomically deprived neighbourhoods.

Alcohol screening

Screening is a process that differentiates people who have, or are at risk of having, a condition from those who do not. In the alcohol screening, the objective is to identify:

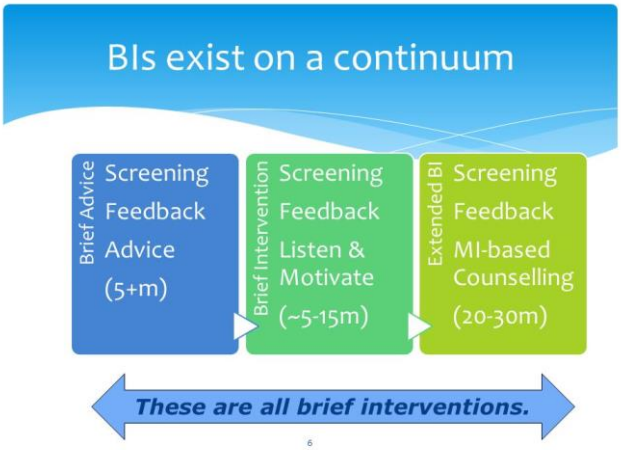
- People whose consumption presents risk of harm to themselves or others
- People who are beginning to experience problems and signs of alcohol dependence.

Alcohol screening should identify both high risk drinking, a pattern of regular excessive or occasional high intensity drinking that increases the risk of alcohol-related harm, and alcohol dependence, or alcoholism. A range of validated screening tools exist which offer professionals and others a systematic way of asking about alcohol.

Alcohol Brief Intervention

There is no formalised definition of an alcohol brief intervention (ABI).It is generally described as:

a short, evidence-based, structured conversation about alcohol consumption with a person that seeks to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and their risk of harm.



Source: Dr Niamh Fitzgerald, http://slideplayer.com/slide/10629505/

Where will the impact of the alcohol screening and brief intervention be seen?

Impact of alcohol screening

Systematic alcohol screening within services and agencies who work directly with people will lead to an improved identification of individuals who are probably alcohol dependent and require additional support. We would expect to see an increase in referrals to alcohol services from partner agencies implementing systematic alcohol screening.

Impact of ABIs

In 2014, NHS Health Scotland recommended ABIs as a prevention best buy[2].

Evidence of effectiveness in primary care

The 2007 Cochrane review by Kaner, individuals who received an ABI consumed an average of four fewer units of alcohol per week one year after the intervention[3]. The evidence base has been challenged by the publication of large pragmatic trials where no or a modest minimal effect was demonstrated[4] suggesting that the efficacy observed in trial environments does not necessarily translate to effectiveness in practice. The pragmatic trials showed that patients in the control group who received screening and usual care had significant reductions in their drinking, suggesting that the active ingredient of ABI programmes might be screening itself rather than the intervention that follows.

Evidence of effectiveness in Emergency Departments and Unscheduled Care Settings

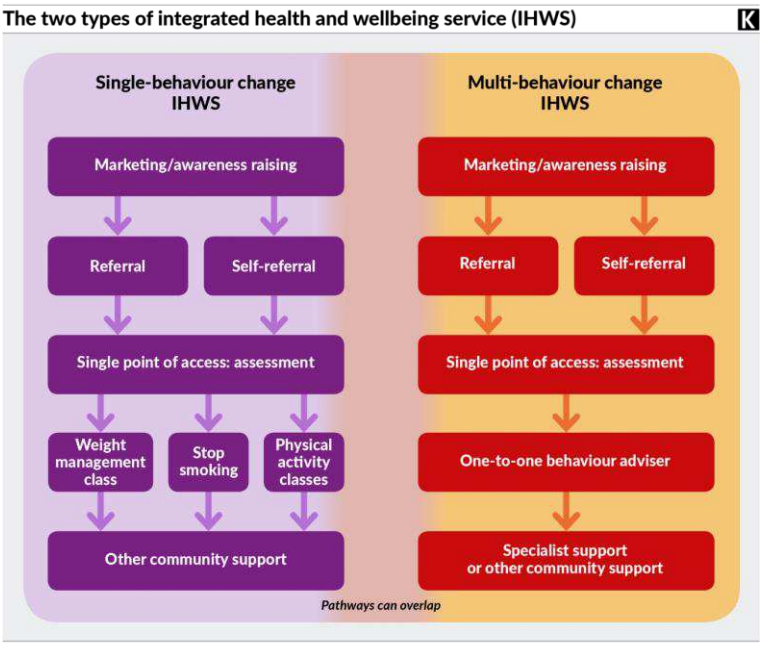
The evidence base for accident and emergency settings is small and includes interventions like personalised mail feedback (rather than structured conversations in the department) which show a small but significant effect associated with reduced consumption at 1 year[5].

Evidence of effectiveness in wider settings

The National Institute for Health and Care Excellence (NICE) recognises the limitations of the evidence base but identifies social care, criminal justice, sexual health and other community or voluntary sectors already engaged with the wider alcohol risk reduction agenda as appropriate settings[6].

Evidence Base on clustered lifestyle risk factors

Clustering has a significant effect on life expectancy and contributes to the inequalities seen. Addressing the clustering of risk factors and, at the same time, addressing their determinants is necessary to reduce inequality and improve population health[7]. Unhealthy behaviours do not respect organisational boundaries, and some of the best partnerships on addressing multiple risk factors occur when local authorities, the NHS and other partners set up formal referral routes between them.



Source: Kings fund (2018)[8]

Intended impacts of ABIs

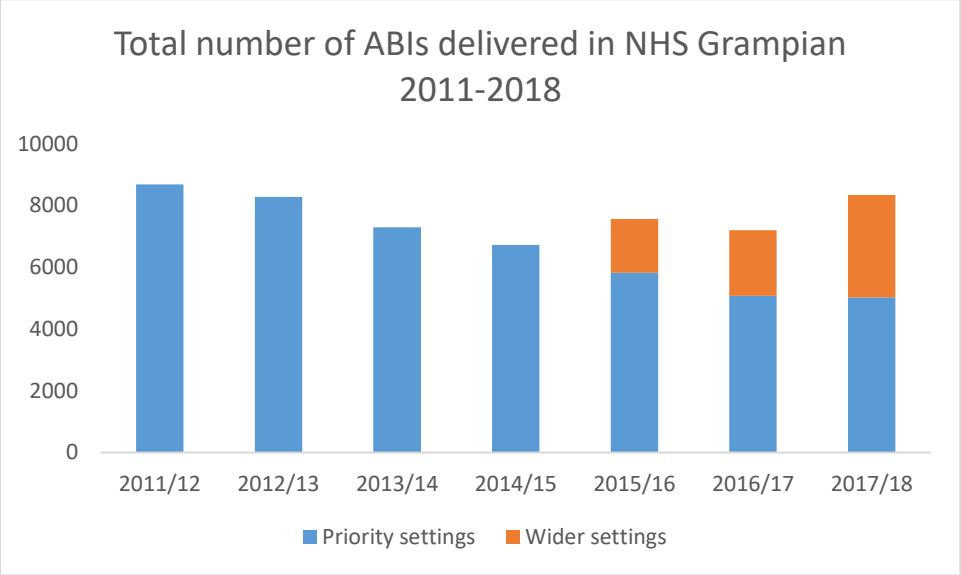
In supporting an individual to reduce their risk of experiencing harm, an ABI is an intervention which contributes to

- Primary prevention (in the prevention of Foetal Alcohol Spectrum Disorder)
- Secondary prevention of the development of health conditions or social impacts associated with high risk alcohol consumption
- Self-management of long term conditions and reduced risk of health complications

Our achievements to date

Scottish Government requirements for ABI delivery are contained within the Local Delivery Plan (LDP) standard (2018/19). NHS Grampian, Aberdeen City, Aberdeenshire and Moray ADP (and by virtue of the partnership link IJBs) are required to continue to embed ABIs into routine practice.

The target number of ABIs allocated to NHS Grampian is 6658. A minimum of 5326 interventions must be delivered in the priority settings of accident and emergency, primary care and antenatal care. The recent growth in ABI numbers is attributable to development of ABI capacity in wider settings.



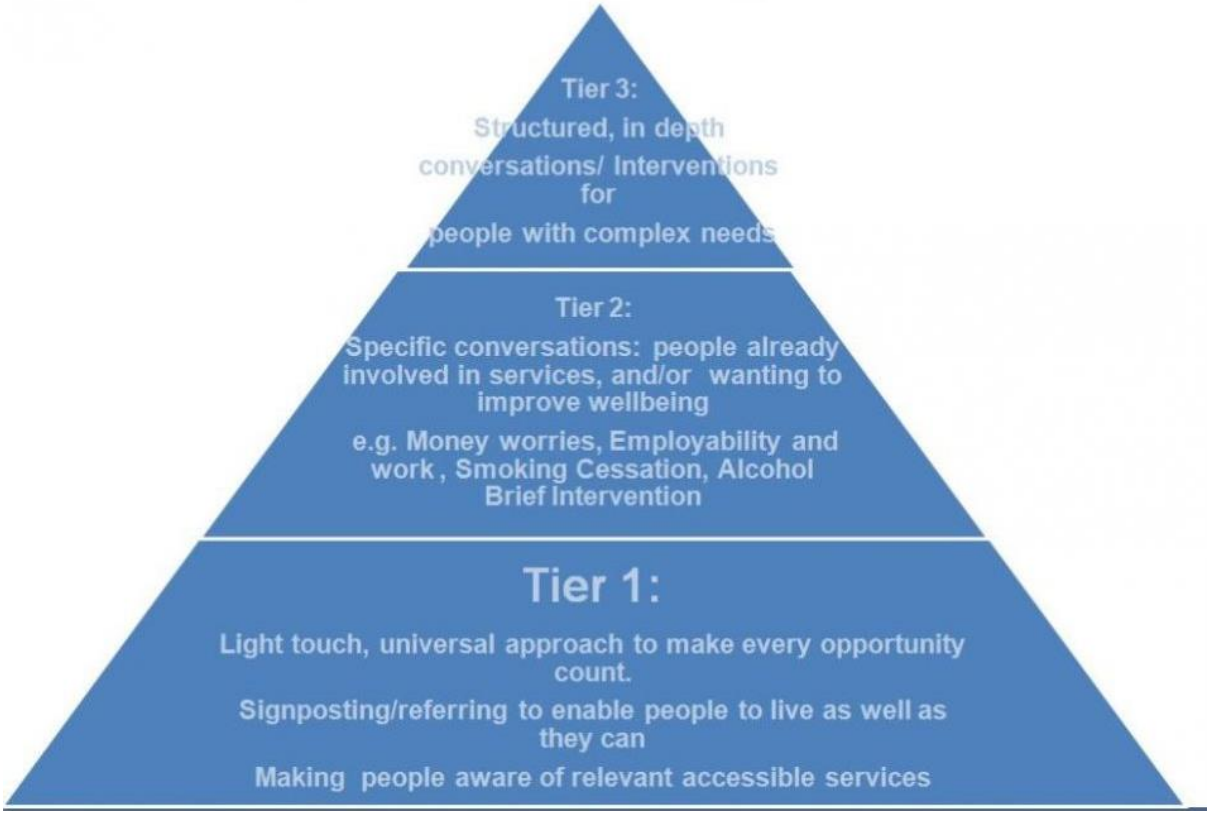
Source: NHS Grampian, ISD return 2017/18

Most ABIs are delivered in primary care, although there is significant variation between practices which does not directly correspond to variation in need or rates of alcohol related deaths or rates of alcohol related hospital admissions. Primary care is the only setting where practitioners are paid for each ABI recorded as delivered under a locally enhanced service.

New and emerging opportunities

Making Every Opportunity Count (MEOC)

NHS Grampian has developed an overarching sustainable and inclusive approach for partnership working that makes real our shared commitment to enabling prevention and self-management. The framework (below) maximises opportunities for people, places, systems and services. It acts as a guide to the nature and scope for conversation and action, creating an environment where it is normal to ask about people's wellbeing. Framing the conversation as an opportunity to raise awareness about risk enables the person using services make an informed choice. It puts people first and starts to take account of the clustering of lifestyle risk factors and the associated socio-economic circumstances which shape them. Alcohol screening and brief interventions are an integral part of this approach which has been adopted by a number of partner agencies.



Source: NHS Grampian, Making Every Opportunity Count (MEOC)

Alcohol Brief interventions are a tier 2 intervention under the NHS Grampian MEOC approach. Alcohol screening can be delivered at tier one followed up by signposting or referral to a service that offers tier 2 interventions or at tier 2.

Tier 3 interventions are those offered by specialist substance misuse services and our commissioned partner providers (ADA, Turning Point and Arrows). This level of intervention is necessary for individuals with high scores on alcohol screening suggestive of alcohol dependence or other problematic alcohol use. ABIs are not clinically indicated in these individuals.

What the MEOC approach permits is recognition of the referral pathways and signposting needs of our partners involved in screening and brief interventions, not just to specialist services but to other organisations which may be able to provide support with some of the issues underlying high risk alcohol consumption.

Recognition of alcohol as a local priority

Alcohol has been identified as a priority by health and social care partnerships in a number of locality plans (health and social care). The issue of alcohol has also been identified by some community planning partnerships as a local outcome improvement priority (LOIP) and as a key improvement indicator for priority local areas. The relationship between alcohol and criminal justice services and settings has been recognised by some community justice partnerships. This recognition should be supported by public health teams to turn into local

ownership and leadership to continue to develop the alcohol screening and brief interventions program via partnerships. The implications for alcohol screening and brief intervention are that we will work with partners from housing, Police Scotland, Criminal Justice Social Work, HMP Grampian, Care providers and others to embed alcohol screening in appropriate assessment tools. We will look to build on the existing work at locality level of MEOC and look at ways of providing more intense support for those requiring level two or three interventions.

General medical services contract 2017

The general medical services (GMS) contract in 2017 set out the future direction and role of general practitioners and the wider primary care support team. The implication for the Alcohol screening and ABI programme as we go forwards is that alcohol should become part of the self-management agenda, consistent with the approach set out in the NHS Grampian and HSCP Clinical Strategies. We will engage with the wider primary care team to identify the relevance of raising the issue of alcohol within the context of their contact with a patient and look to move away from a GP led model of delivery. To ensure systematic approaches to self management, we will work with House of Care and other self-management initiatives to ensure that alcohol is considered and staff are able to support patients improve their wellbeing through changing their relationship with alcohol.

Implementing Alcohol Screening and brief interventions facilitators and barriers

This information was collected by the Grampian Alcohol Brief Intervention Strategic Group. ABI trainers, existing providers were questioned on a one to one basis about facilitators and barriers to alcohol screening and ABI implementation in practice

Barriers to implementing alcohol screening and brief interventions

- Asking about alcohol seen as invasive, fear of offending patient / client and ultimately compromising trust
- The links between alcohol and patient / client presentation are not clear so an ABI perceived as 'additional' and outside of normal business
- Excessive focus on targets
- Poor recording practice, focused on reporting to meet target. Report does not reflecting the reality of delivery and undermines the confidence of the individual or organisation
- Perception that intervention is time intensive in relation to overall workload and other commitments and pressures
- ABI currently 'process heavy', overly complex, 'standalone' and inflexible, a perception reinforced by the current training model.

Facilitators to implementation

- Regular presentation-led opportunities to link condition or situation directly with alcohol consumption in a way that is flexible and amenable to practitioner's professional judgement
- Separate the screening from the rest of the consultation and ask patients to complete themselves
- Creating a climate where patients/ clients are conditioned to expect to be asked, regularly about lifestyle factors
- When practitioners develop the necessary skills, confidence and practice experience to identify and support clients with broader factors that may affect alcohol consumption (e.g. advising a pregnant woman whose partner is not supportive of her not drinking)
- Support and advice from peers who have more experience of screening and delivery
- Integrating alcohol assessment into standard assessment templates
- Identifying situations where patients and professionals find it acceptable to ask about alcohol
- Using recording to drive improvement, rather than respond to a target

- Clarity about which services patients / clients can be signposted or referred to, when and how.
- Framing the conversation as an opportunity to raise awareness about risk and enable the patient / client to make an informed choice.

How are we going to achieve our vision of embedded and sustainable alcohol screening and brief intervention?

The core themes of our strategy are

Create an environment where it is normal to ask about alcohol

Western medical culture is traditionally focused on disease management and "quick fixes" that "medicalise society's problems" rather than adopting a more biopsychosocial approach. Greater awareness of who is at risk (including family and people around the patient) and embedding assessment into routine assessments can help normalise the alcohol question.

Participatory approaches that engage those delivering ABIs may also be helpful in creating a culture of reflection and an environment where asking about alcohol is the norm.

Higher consumption amongst higher paid staff, reluctance to engage maybe be conscious or subconscious. It is important to raise awareness about these barriers and present alcohol screening and brief intervention as an opportunity for a patient to make an informed decision about their health and wellbeing. It is also important to present messages about the normality of low risk drinking to further reinforce this approach and highlight the abnormality and unacceptability of drinking in a high risk way.

Ask more

It is possible that engaging patients in a discussion about their alcohol use, within the context of the specific professional relationship stimulates behaviour change. Numerous validated screening tools exist such FAST, AUDIT, AUDIT-C, PAT etc. Where possible, a formal screening instrument, validated for that particular context, should be used to ensure a systematic approach and consistency. Ideally this should be embedded into routine assessment tools, where appropriate to do so.

In primary care, health professionals have found it difficult to implement screening questionnaires broadly in routine practice. Getting comfortable with asking a question about alcohol consumption is an important first step in addressing the under-detection of high risk alcohol consumption[9]. This approach would be consistent with a level one light touch conversation in the MEOC framework.

Build trust and acceptability with patients / clients

When embedding alcohol screening and brief intervention in any context where professionals are concerned about compromising the patient/ client relationship, a possible

solution is to initially target presentations where alcohol assessment is widely known to be acceptable to the general public. In primary care, these scenarios include new patient registrations, health assessments / checks, chronic disease assessment and care planning, mental health assessment and care planning[9], medication review.

Build on the assets of the professional team

Many roles are linked to health and wellbeing and there are some existing settings where the team structure and dynamic will change. For example, the 2018 Scottish GP contract describes a broad multidisciplinary team supporting primary care, each having a specific but complimentary role to another. Raising professional's awareness about the impact of alcohol consumption on their specific area or role is necessary to achieve buy in. The roles of team members are particularly relevant to the management of multiple clustered lifestyle risk factors and addressing health inequality. The MEOC framework should act as a guide to the nature of conversation and professional action indicated.

Use recording to drive quality improvement.

Understanding the number of ABIs delivered in the context of a system or organisation can be helpful in driving change. This would allow the organisation to assess, the meaning of the number of ABIs delivered, as a percentage of all eligible presentations[9]. This could provide a more effective stimulus for improvement than centrally allocated targets. Quality improvement methodology such as PDSA and others could be used to drive focused efforts of improvement. To support sustainability, the learning generated from improvement cycles should: inform adaptation and evolution of the ABI programme, it should also be shared with others[10], a role that the ABI leads within HSCPs could take on.

Some organisations find tracking individual performance (the number of ABIs delivered by a specific individual) helpful for stimulating discussion and change. It may be helpful in identifying examples of positive deviance that could serve as peer support or a champion in that setting.

Sustainability

The focus of sustainability in this context include concepts such as: 'sustainable programmes', 'sustainable practice', 'sustainable capacity' and 'sustainable outcomes'. Commitment and support from multiple levels of management within the host and its partner organizations is critical for sustainability[10]. A sustainable initiative is one that is responsive to the needs of the community and **evolves** and adapts as evidence emerges[10], this strategy and associated action plan should be reviewed after 3 years.

What are we going to do over the next three years

2018-2019

Seek endorsement of the alcohol screening and brief intervention strategy from management and leadership groups

Undertake tests of change with wider primary care team members, housing services, care providers, emergency department practitioners

Provide one to one support to general practice to make the links between long term condition self-management, alcohol screening and brief intervention.

Provide support to partners developing alcohol screening and brief intervention approaches in their organisations or groups

Increase trainer capacity

2019-2020

Undertake a test of change for embedding systematic alcohol screening within the acute health care sector

Scale up tests of change undertaken in previous years

Provide support to partners developing alcohol screening and brief intervention approaches in their organisations or groups

Embed alcohol screening and brief intervention across criminal justice social work and improve coverage within police custody

Plan evaluation of sustainability of current approach

2020-2021

Conduct evaluation of sustainability

Develop revised strategy

[1] Buck D Clustering of unhealthy behavioural risk factors over time. Kings Fund (2012)

[2] *Best Preventative Investments for Scotland – what the evidence and experts* say, NHS Health Scotland, 2014

[3] Kaner, Eileen FS, et al. "Effectiveness of brief alcohol interventions in primary care populations." *The Cochrane Library* (2007).

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Kaner EF, Bland M, Cassidy P, et al. Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): Pragmatic cluster randomised controlled trial. BMJ 2013;346:e8501.

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Hilbink M, Voerman G, van Beurden I, Penninx B, Laurant M. A randomized controlled trial of a tailored primary care program to reverse excessive alcohol consumption. J Am Board Fam Med 2012;25(5):712–22. Search

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[6] National Institute for Health and Care Excellence. Alcohol use disorders: preventing harmful drinking. London: National Institute for Health and Care Excellence, 2010.

[7] https://www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners

[8] https://www.kingsfund.org.uk/publications/tackling-multiple-unhealthy-risk-factors

[9] Tam, CWMichael, Andrew Knight, and Siaw-Teng Liaw. "Alcohol screening and brief interventions in primary care-evidence and a pragmatic practice-based approach." Australian family physician 45.10 (2016): 767.

[10] Whelan, Jillian, et al. "Cochrane update: predicting sustainability of intervention effects in public health evidence: identifying key elements to provide guidance." Journal of Public Health 36.2 (2014): 347-351.