ALCOHOL DRUG FINDINGS Research analysis

This entry is our analysis of a study added to the Effectiveness Bank. The original study was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text. The Summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

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Screening and brief intervention for alcohol and other drug use in primary care: associations between organizational climate and practice.

Cruvinel E., Richter K.P., Bastos R.R. et al.

Addiction Science and Clinical Practice: 2013 8(4).

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From Brazilian primary care clinics a rare confirmation that a positive organisational climate featuring commitment to staff professional development and good links with the local community is associated with overcoming barriers to widely implementing screening and brief intervention programmes.

SUMMARY In Brazil primary health care professionals have encountered numerous obstacles to incorporating screening and brief intervention into their daily routine, including poor teamwork, low motivation, high turnover, high workload, lack of adequate infrastructure, and bureaucracy.

Some of these obstacles may be related to the health-care work environment and in particular to organisational climate – staff perceptions of organisational policies, practices, and procedures. Climate influences the conduct and effectiveness of people in organisations in general. In mental health services, studies have found climate related to various aspects of job satisfaction and staff turnover, which might in turn be linked to quality of care and outcomes. However, few studies have addressed the relationship between organisational climate and implementation of screening and brief intervention for risky substance use.

In the Brazilian primary care context, the featured study investigated relationships between staff perceptions of organisational climate and implementation of screening and brief intervention among health-care staff who had participated in training in screening and brief intervention. The study was conducted in four cities which agreed to ensure the participation of all their primary care teams in the study and their availability for training and follow-up. Staff from the 30 teams who supplied data for the study had to have completed the training and surveys organised by the study, and to have worked throughout in the same team.

Key points
From summary and commentary

The featured study investigated relationships between staff perceptions of organisational climate and implementation of screening and brief interventions at Brazilian primary health-care clinics after training in these procedures.

The more a clinic was seen to have a good organisational climate – especially in terms of professional development and relationship with the community – the greater the implementation of, and staff confidence in, screening and brief intervention.

Dominance of the findings by the perceptions of community workers and the community focus of the Brazilian teams may limit detailed applicability to areas such as UK, but in any health service organisational features of some kind are likely to be a major influence.

Training consisted of an eight-hour class which included use of the World Health Organization's ASSIST screening questionnaire for risky drug and alcohol use, and how to conduct brief interventions for different severity levels and types of substance use. Brief intervention strategies were based on motivational interviewing and used the FRAMES approach to counselling.

Classroom training was followed by further training and monitoring for three months. Clinicians were asked to complete the ASSIST screening test for all patients and on the screening form to note resulting brief interventions. Each week research staff provided feedback on each clinic's ASSIST and brief intervention performance and led a discussion on how to improve performance.

At the end of the three months of training and monitoring, clinicians completed a questionnaire assessing organisational climate in general – not specifically in relation to substance use – and reported how often they had asked patients about their drinking and provided brief interventions to those who screened positive for risky drinking. They also rated how confident they felt about developing screening and brief intervention activities and about their ability to conduct these procedures. Also asked about were the degree to which they had integrated intervening with drug users into their practice and how often they had helped provide preventive interventions. All this data plus the number of ASSIST forms recording screening and brief interventions was aggregated for each clinic, so that the resulting relationships were not between an *individual's* perceptions of climate and their own level of substance use interventions, but between those of the clinic as a whole.

Clinic teams consisted of physicians, nurses, community health workers, administrators, and other health professionals. Each operated as an independent unit with separate leadership. All these staff were invited to attend training and follow-up and to participate in the study. Initial training was completed by 230 staff of whom 149 completed the study; the remainder had moved on from their initial teams. Nearly 71% of study participants were not working as nurses or doctors but as community health workers and about 1 in 8 were nurses or nursing assistants; just 3% were physicians. The remainder were social workers or other health-related professionals.

Main findings

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Almost uniformly, the more the clinic was seen as characterised by a good organisational climate, the greater the implementation of and confidence in screening and brief interventions. Organisational climate dimensions most consistently and strongly related to implementation and confidence (and the only ones significantly related to activity documented on screening forms) were 'professional development' and 'relationship with the community'. More details below.

The 'professional development' dimension assesses staff perceptions of training opportunities in the organisation, focus on improvement in productivity, investment in the personal and technical development of staff, application of newly acquired skills, and other features of the organisational environment supportive of staff and practice development. The more the clinic was seen as fostering professional development, the more often staff said they conducted screening and brief intervention and the more ASSIST forms they submitted recording these activities. There were similar relationships with intervening with drug users and how often staff participated in preventive interventions. All these relationships were strong and statistically significant. Relationships with confidence in brief intervention work were positive but not statistically significant.

'Relationship with the community' assesses the strength of relationships within a health team, and between the team and its local community and municipal health department. A strong relationship with local residents is vital to Brazilian primary care because of the daily presence of teams in the community and their mission to make preventive care accessible to all. This dimension was strongly and positively related to how often staff said they conducted screening and brief intervention and also to the number of brief interventions recorded and confidence in developing screening and brief intervention activities, but not so strongly and not significantly to the number of times ASSIST had been used in screening. There was also a strong positive relationship with intervening with drug users but not with how often staff participated in preventive interventions.

Also (but less consistently) related to screening and brief intervention activity and confidence levels were staff perceptions of the clinic's leadership (which includes staff supervision and motivating staff) and of the adequacy of staff salaries. In contrast, dimensions of organisational climate to do with team spirit and strategy were generally not significantly related to screening and brief intervention, and perceptions of workplace safety, not at all.

The authors' conclusions

The findings show that a positive organisational climate is related to greater adoption of screening and brief intervention for alcohol and other drug use. However, only dimensions reflecting commitment to professional development and a strong relationship with the local community were significantly related to the more objective implementation measures based on activity documented on screening forms. Perhaps only teams who valued and participated in professional development were motivated to adopt new approaches such as screening and brief intervention. Teams with strong community links might be more aware of the impact of drug and alcohol use on their communities, less willing to judge and/or condemn patients with substance use problems, have caring and trusting relationships with families which enable them to address sensitive issues, and be more willing to adopt new interventions that could benefit their communities.

However, this study did not assess organisational climate until training had ended, leaving the possibility that rather than organisational climate affecting implementation, the training itself or subsequent implementation levels of screening and brief intervention had affected organisational climate. This seems unlikely because the study lasted just three months – a short time for organisational climate to appreciably alter – training was very focused on screening and brief intervention, and even after training and feedback, clinics differed widely in staff perceptions of climate. Results were available only from staff who stayed with their teams for the three months of the study and may not reflect broader staff perceptions.

FINDINGS COMMENTARY As the authors point out, this is a very rare example of a study directly relating organisational features to implementation of screening and brief intervention. Though not commonly researched, such issues are crucial, because these procedures are often implemented by organisations and by staff in professions which do not see non-dependent drinking or drug use, or public health rather than individual treatment, as their core business. Without prioritisation and backing from the organisation, it's likely that screening and brief intervention will be sidelined or of poor quality.

The featured study suggests that certain types of organisations are much more capable and willing than others to make the changes needed, and that this depends on generic features like their commitment to staff development, relationships with and concern about their catchment population, and leadership quality. Those suggestions are strongly supported by the other studies and by the review summarised below.

However, without a randomised controlled trial or the equivalent, any such study remains vulnerable to the results not being due to (in this case) organisational features, but to other influences associated with these features, or to the reverse causality the authors referred to. The distinctive community nature of the Brazilian team's aims, and the dominance of the findings by the perceptions of community workers rather than qualified medical staff, may limit applicability of the findings to areas such as UK.

Along the way the study illustrates what seems a common and serious obstacle to effectively and efficiently embedding new practices – high staff turnover. Within the three months of the study over a third of the staff it trained had moved on, though in some cases to another primary care team. Elsewhere too, high staff turnover and the 'churn' in organisations due to market forces and commissioning cycles have severely limited the addiction treatment sector's capacity for accumulating and implementing learning (1 2 3).

Organisational features seem critical

Though studies are few, they sum to a convincing documentation of the relationship between the degree to which screening and brief intervention become routinely and widely applied, and positive organisational features both in general and in relation to screening and brief intervention. In its favour is that this mechanism 'makes sense' – it would be surprising if the reverse was the case. However, the results could be due to other influences, because none of the studies changed organisational features in randomly selected organisations in order to assess the impact on implementation rates.

Methods mapped by a comprehensive review of how to promote alcohol screening and brief intervention in primary care ranged from designing an effective and suitable intervention, to the influence of economic, political, and social environments. In the middle and seemingly very influential were the 'Inner setting' factors – features of the implementing organisation including the degree to which its structures, communication mechanisms, resources, leadership, and culture facilitate the adoption of innovations, and the degree to which the innovation 'fits' its needs and circumstances.

More than any other national or regional health provider yet documented, the US 'VA' health care system for ex-military personnel has made a determined effort to implement sustained, routine brief alcohol counselling in its primary care clinics. According to the review, the VA system has also been

alcohol counselling in its primary care clinics. According to the review, the VA system has also been uniquely successful, partly because it marshalled the 'Inner setting' organisational influences described above. But the VA's experience also includes a revealing failure which showed that advanced electronic prompts to advise risky drinkers were usually ignored in a clinic where there were no active implementation efforts, little leadership encouragement to use prompts of any kind, and no incentives for their use or for brief alcohol interventions. Instead staff gravitated to advising very heavy drinkers to abstain, not the main role envisaged for brief interventions. At another VA clinic whose culture was that prompts were to be responded to, the picture was very different.

Another US primary care study also found organisational features strongly related to screening and intervention rates, helping at different clinics to generate an intervention rate with positive-screen patients which ranged from 0% to 95%. Associated with more frequent implementation were stable parent organisations supportive of screening and intervention, the presence of an influential on-site coordinator specifically for this work, the clinic's willingness to take advantage of outside technical assistance, and the degree to which clinic staff were able to change relevant operating procedure. Related in the other direction were competing organisational priorities and lack of time.

Organisational commitment can achieve quantity but quality is harder to ensure

Despite the lack of randomised studies, whole organisations have implemented procedures reflecting a high level of commitment to screening and brief intervention and shown that these do make a substantial difference. Prime among these is the VA system mentioned above, where screening was incentivised to near universal levels and (where doctors knew management expected this) electronic prompts led to a recorded 71% of positive-screen patients being advised.

However, quantity was not it seems matched by quality. Screening apparently missed many risky drinkers, and advice had little if any impact on drinking. Most disappointing was a study across an entire VA region conducted soon after the system had implemented a national performance measure incentivising brief intervention, aided by an electronic clinical reminder available to all its facilities. VA records revealed that patients who screened positive for risky drinking and were re-screened around a year later were no more likely to have stopped risky drinking if their records indicated they had participated in a brief intervention than if they had not.

For more on these issues click this link to trigger search in the Effectiveness Bank for studies related to organisational functioning and screening and brief intervention and see this cell of the Alcohol Treatment Matrix.

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STUDY 2014 The effectiveness of alcohol screening and brief intervention in emergency departments: a multicentre pragmatic cluster randomized controlled trial

STUDY 2013 Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial

STUDY 2012 Alcohol screening and brief intervention in primary health care

STUDY 2012 Alcohol screening and brief intervention in emergency departments

STUDY 2009 Does implementation of clinical practice guidelines change nurses' screening for alcohol and other substance use?

STUDY 2011 An evaluation to assess the implementation of NHS delivered alcohol brief interventions: final report

STUDY 2010 Use of an electronic clinical reminder for brief alcohol counseling is associated with resolution of unhealthy alcohol use at follow-up screening

REVIEW 2011 Strategies to implement alcohol screening and brief intervention in primary care settings: a structured literature review

REVIEW 2011 Strategies to implement alcohol screening and brief intervention in primary care settings: a structured literature review

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