

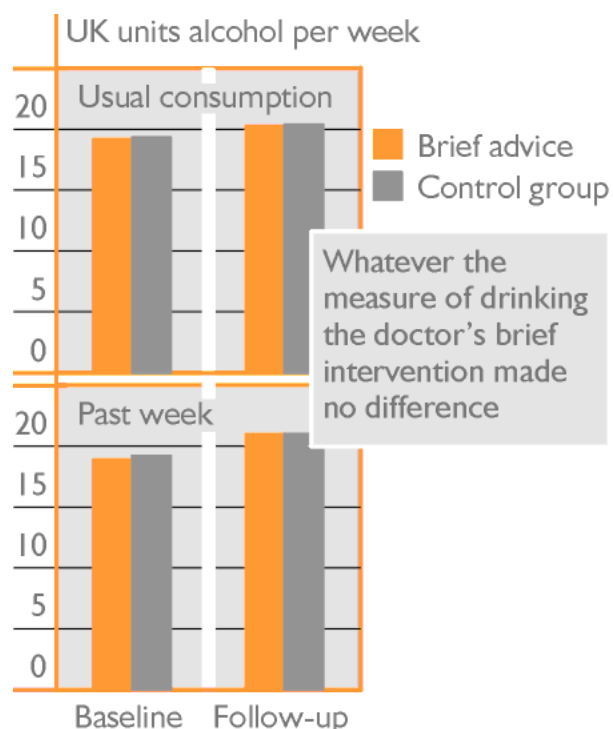
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Universal screening for alcohol problems in primary care fails in Denmark and no longer on UK agenda

No reductions in drinking were found in a Danish attempt to implement in 'real-world' conditions the primary care screening and brief intervention protocol for heavy drinkers which emerged from World Health Organization (WHO) trials, also the origin of a model officially recommended for England. Findings suggest it was right for UK policy to turn away from universal screening but whether the favoured alternative – targeted screening – will prove effective and cost-effective or deliver public health benefits remains unclear.

FINDINGS Of the 426 GPs invited to join the [featured study](#),¹ 39 did so. Each was required to have practice staff to recruit patients for the study and hand them a screening questionnaire for completion in private in the waiting room. This consisted of the 10-item AUDIT screening test plus questions about how much the patient usually drank. Patients were also given a survey to be completed at home assessing how much they had drunk in the past week.



Of the nearly 7000 patients who agreed to join the study, a randomly selected half (the control group) simply dropped their sealed

screens in to a ballot-style box and saw the doctor in the normal way, who was unaware of their scores. The other half handed their questionnaires to the doctor who scored the AUDIT tests. About 1 in 6 scored high enough to be considered hazardous or harmful alcohol drinkers. Of these, about 13% were eliminated from the study because they might actually be dependent on alcohol.

The remaining risky but presumed non-dependent drinkers – about 1 in 8 of all the screened patients – were to be given the 10-minute intervention consisting of feedback on their scores, advice on cutting back, a self-help booklet, and a suggested further consultation (which fewer than a fifth returned for). Follow-up data sought a year later from these 442 patients was compared with that from their 464 counterparts in the control group to assess whether the doctor's advice had curbed their drinking. Data was collected by means of a further AUDIT test and alcohol consumption survey mailed to patients, to which about 60% responded.

On none of the [several measures](#) of alcohol consumption or problems² had intervention patients improved to a statistically significant degree relative to control patients. The pattern of the results makes it unlikely that findings from a larger sample would have been more decisive.

IN CONTEXT The featured study 'seamlessly' combined AUDIT-based screening with brief intervention during the same visit and was exclusively conducted in GP practices, making it a close test of the recommendations which emerged from the [WHO study](#).³

One concern is that heavier drinkers were excluded or disproportionately lost to the study. Nearly 8 in 10 patients who did participate denied usually drinking amounts in excess of Danish guidelines. Comparison against these guidelines risked validating their drinking. Heavier drinkers might have seemed a more legitimate target and (as one [review](#) found) might also have responded better.⁴ On the other hand, initial drinking averaged about 26 UK units a week and patients with higher AUDIT scores did not respond better to the intervention.

The large loss to follow up (especially among intervention patients) is a significant weakness but one likely if anything to have tipped the balance in favour of the intervention.

Defensive reactions to the intervention might account for this extra loss and for the rejection of further counselling. Such reactions were noted by the doctors during '[debriefing](#)' sessions.⁵ The doctors themselves seemed deeply uncomfortable with the intervention, fearing that doctor-patient rapport would be damaged by introducing drinking 'artificially' when the patient was attending for some other reason and without a naturally emerging clinical prompt. Despite the likelihood that the GPs who volunteered for the study were highly motivated, almost universally they said they would not carry on screening.

Recent [meta-analyses](#) combining the results of similar studies have concluded that once patients reach the point of being randomised to receive a brief intervention, compared to screening alone or screening plus usual care, this leads to a reduction of about 5 UK units a week in their drinking, noticeable at least a year after the intervention.^{4 6}

However, the great majority of screened patients never reach this point because they do not score as risky drinkers, are unavailable, excluded by research criteria, or fail to participate, leading to [an estimate](#) that on average 1000 patients have to be screened to gain 12 months later just two or three who have stopped drinking excessively.⁷ Outside a research context when (as in the featured study) intervention can seamlessly follow a positive screen, attrition might be less.

Screening too is rarely applied to more than a small minority of patients. Initiatives like practice visits and training, especially when combined with ongoing support, do [modestly improve](#) screening rate and intervention rates,⁸ but these remain low.

In Britain at least [two studies](#) have found that primary care brief intervention did reduce drinking.^{9 10} They demonstrated the approach's potential, but not necessarily that it *would* work in typical practices which themselves identified patients for intervention, and with patients not subject to the multiple selection gateways applied by the studies.

Perhaps importantly, in both patients were selected explicitly on the basis of excessive consumption and either no ceiling or a very high one was set before they were excluded. The result was a sample of on average clearly excessive drinkers (the men averaged over 60 UK units or 480g of alcohol a week). Most would have been towards the far end of the national distribution against which their drinking was compared during the intervention.

Other British effectiveness studies (see [background notes](#) for citations) were either not reflective of primary care or inconclusive about the benefits of intervention. Feedback from staff and the sometimes very low rates of screening and intervention suggested lack of enthusiasm and/or of resources (such as skills, time and organisational support) for screening and intervention, but this may have been partly due to the burden of the associated research.

Further UK studies have minimised this burden, but even in willing practices offered training and ongoing support, the results confirm that attempts at universal screening (and in respect of nurses, opportunistic screening too) result in only a small fraction of risky drinkers being advised about their drinking.

Most practices never reach this point because they refuse screening or fail to implement it. As in Denmark, generally nurses and doctors are prepared to screen (if at all) only when this emerges naturally in the course of addressing the patient's complaint or because it is a logical component of a procedure applied to all patients in certain categories, such as those undergoing general health checks, new patients, and patients being monitored for chronic conditions which might be related to or aggravated by drinking.

PRACTICE IMPLICATIONS The featured study and related British studies suggest that universal screening for risky drinking is not feasible in normal primary care practice. An alternative model emerging from the research as possibly feasible and effective involves targeted/selective screening using AUDIT or shorter screens as part of overall health checks, or when the patient's complaint might be related to or aggravated by heavy drinking (either individually or routinely at clinics dealing with such complaints), and then offering brief advice to risky drinkers. What that advice best consists of is unclear.

Selective screening and typical and promising intervention approaches have been codified

in a protocol called [How much is too much?](#),¹¹ recommended in [English guidelines](#) for commissioning such work from GPs as an enhanced service.¹² 'Enhanced' status means GPs are not required to undertake this work unless they have agreed to do so under contract to their local health authority, and authorities are not required to ensure its provision in their areas.

England's national alcohol charity believes this option [will be taken up by only a small proportion](#) of GPs.¹³ Selective screening may also mean few patients are screened. The combination seems likely to undermine the hoped-for public health benefits of a mass programme identifying 'hidden' risky drinking before it becomes noticeable in drink-related complaints, though individual patients who *are* screened and advised may benefit.

The enhanced service guidelines follow the commitment to selective screening and brief intervention in the 2004 [English national alcohol strategy](#) and [resultant guidelines](#).^{14 15}

Scotland has similar [practice recommendations](#) and [policy proposals](#).^{16 17}

Thanks for their comments on this entry in draft to Anders Beich of the University of Copenhagen. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

1 **FEATURED STUDY** Beich A. et al. [Screening and brief intervention targeting risky drinkers in Danish general practice – a pragmatic controlled trial](#). *Alcohol and Alcoholism*: 2007, 42(6), p. 593–603.

2 Usual amount, amount in previous week, reduction below excess drinking levels, ceased binge drinking, reversion to below AUDIT risky drinking score, or at least one of the last three without deterioration on the other two.

3 Babor T.F. et al. [Brief intervention for hazardous and harmful drinking: a manual for use in primary care](#). World Health Organization, 2001.

4 Bertholet N. et al. [Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis](#). *Archives of Internal Medicine*: 2005, 165, p. 986–995.

5 Beich A. et al. [Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners](#). *British Medical Journal*: 2002, 325(870).

6 Kaner E.F.S. et al. [Effectiveness of brief alcohol interventions in primary care populations](#). *Cochrane Database of Systematic Reviews*: 2007, 2.

7 Beich A. et al. [Screening in brief intervention trials targeting excessive drinkers in general practice: systematic review and meta-analysis](#). *British Medical Journal*: 2003, 327, p. 536–542. The estimates were [hotly contested](#).

8 Anderson P. et al. [Engaging general practitioners in the management of hazardous and harmful alcohol consumption: results of a meta-analysis](#). *Journal of Studies on Alcohol*: 2004, 65(2), p. 191–199.

9 Wallace P. et al. [Randomised controlled trial of general practitioner intervention in patients with excessive alcohol consumption](#). *British Medical Journal*: 1988, 297, p. 663–668.

10 Anderson P. et al. [The effect of general practitioners' advice to heavy drinking men](#). *British Journal of Addiction*: 1992, 87(6), p. 891–900.

11 Newcastle University Institute of Health and Society. [Brief interventions - alcohol and health improvement](#), accessed 5 July 2008.

12 [Primary care service framework: alcohol services in primary care](#). NHS England, 2008.

13 Alcohol Concern. [Addressing alcohol through the new GP contract. A briefing for primary care organisations](#).

2004.

14 Prime Minister's Strategy Unit. [Alcohol harm reduction strategy for England](#). 2004.

15 Department of Health and National Treatment Agency for Substance Misuse. [Alcohol misuse interventions: guidance on developing a local programme of improvement](#). Department of Health, 2005.

16 Scottish Intercollegiate Guidelines Network (SIGN). [The management of harmful drinking and alcohol dependence in primary care](#). September 2003.

17 Scottish Government. [Changing Scotland's relationship with alcohol: a discussion paper on our strategic approach](#). 2008.

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