DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. 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. The summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

▶ Strategies in primary healthcare to implement early identification of risky alcohol consumption: why do they work or not? A qualitative evaluation of the ODHIN study.

Keurhorst M., Heinen M., Colom J. et al.

BMC Family Practice: 2016, 17(70), p. 1–16.

What do primary care clinicians think would help them bridge the 'implementation gap' in screening for risky drinking and brief advice, and extend the potential benefits to a greater proportion of the population? A European trial found the answer differed depending on distinctive national circumstances.

SUMMARY Simple screening followed by brief counselling has been shown to significantly reduce alcohol consumption in primary healthcare populations (1 2 3 4). However, there is a large gap between population needs and delivery of advice. For example, despite Europe recording the higher levels of alcohol consumption than other continents, in European primary healthcare settings less than 10% of the population at risk are identified, and less than 5% of those who could benefit are offered screening and brief advice.

The EU-funded Optimising Delivery of Healthcare Interventions (ODHIN) trial tested three different strategies (in eight combinations) to promote screening and brief interventions for risky drinking in primary healthcare units in five European countries:

1. **Training and support**: providers were offered two 1–2-hour, face-to-face educational training sessions on screening and brief interventions, and follow-up telephone support.
2. **Financial reimbursement**: providers were offered financial incentives for the delivery of screening and brief interventions.
3. **Referral to an online brief intervention**: providers were able to refer patients identified as risky drinkers to an online brief intervention.

Key points
From summary and commentary

Screening and brief alcohol interventions in primary healthcare may be cost-effective, yet the opportunity is not extended to all eligible patients.

GPs and nurses participating in the European ODHIN trial were asked about factors influencing why, how, for whom, and under what circumstances different strategies could extend the delivery of screening and brief interventions.

While essential ingredients were identified for using training and support and financial reimbursement to boost delivery of screening and brief interventions, features of the social and political culture beyond the direct control of clinicians and providers also have an influence.

While other papers (analysed in the Effectiveness Bank) have covered the effectiveness and cost-effectiveness of these implementation strategies, the aim of the featured study was to explore *why*, *how*, *for whom*, and *under what circumstances* implementation strategies tested in the ODHIN trial worked to extend delivery of screening and brief interventions. The starting point was that it was not only the implementation strategy that changed professional behaviour or processes, but also the participants' reaction to the opportunities provided by the programme that triggered the change, in combination with reinforcing or hindering factors outside the programme.

Of the five trial countries, only England was unable to participate due to lack of funding. Across the Netherlands, Poland, Catalonia (an autonomous community in Spain), and Sweden, 68 of 138 clinicians invited to participate were interviewed between February and July 2014. This included 40 GPs and 28 nurses – just over half (38) from providers with a high rate of screening and the rest (30) from providers with a low rate of screening.

Main findings

Why?

From (in terms of their screening rates) both high- and low-performing providers, many nurses and GPs expressed positive perceptions of their roles in screening and delivering brief interventions. Most had participated in the trial because of their awareness of the prevalence of alcohol-related problems and their willingness to contribute to the prevention of risky drinking.

Two out of three implementation strategies (allocation to training and support, and financial reimbursement) influenced clinicians' views about screening and brief interventions; internet-based delivery did not seem to make any difference.

For most of the clinicians in the trial, the chance of being allocated to training and support was an important motivating factor in their participation in the trial. Polish and Catalan GPs recognised value in financial reimbursement, as well as being

The effectiveness and cost-effectiveness of ODHIN implementation strategies

Summarised below is the reported effectiveness and cost-effectiveness of ODHIN implementation strategies, which the featured paper adds context to.

The combination of implementation strategies that promised to maximally raise what the study found was a very low baseline intervention rate (brief advice reached just 3% of primary care patients whose heavy drinking meant they might have benefited from it) was training and support plus persisting financial incentives in the context of strong government support for brief alcohol interventions and performance management arrangements,

motivated by their willingness to contribute to the prevention of risky drinking. Dutch and Swedish GPs, as well as some Catalan nurses, reported not being motivated to participate for financial reimbursement, whereas Polish and Catalan GPs felt positive about providing good care and getting paid for it as well.

There were no clinicians who mentioned that internet-based delivery was a motivation for participating in the trial. Most were ambivalent towards so-called 'e-health'. Those who were positive primarily thought it useful in providing information to patients [rather than as an intervention in its own right].

guidance, and strategic leadership.

While delivery rates of screening and brief interventions in European primary care are currently low, several possibly cost-effective strategies exist to increase these rates. Training and support combined with financial incentives may offer the most cost-effective strategy for extending delivery, and subsequently reducing alcohol-related harm and associated costs to society.

How and for whom?

Rather than needing to be convinced of the importance of implementing screening and brief interventions, most clinicians in the ODHIN study wanted to know how to implement these and become skilled in doing so. In Catalonia, Sweden, and the Netherlands, training and support increased awareness of national guidelines and prompted many of the clinicians to keep using them. In contrast for Poland, where no official guidelines existed, screening and brief interventions were rarely discussed in the context of guidelines.

For high-performing GPs in particular, training and support provided assistance in integrating screening and brief interventions into daily practice. It was felt that training and support could be made more effective if there was ongoing training, more time to learn intervention techniques, and the strategy was tailored to the barriers clinicians experience, such as a perceived lack of time for conducting screening and brief interventions.

Clinicians from high-performing providers reported that they gave more priority to screening and brief interventions in their daily practice during the ODHIN trial (as opposed to before). After attending training and support sessions, they shifted from feeling that successful delivery was only a matter of having time, to it also being a matter of prioritisation, and felt that it was possible to routinely ask patients about alcohol consumption, even during high workloads. Learning in training and support sessions how to raise the issue of drinking among patients with varying motivations was appreciated, as was the opportunity to discuss their experiences of delivering screening and brief interventions as a team.

Despite positive experiences with training and support, clinicians from both low- and high-performing providers tended to view it as a temporary stimulus, and pointed out that alcohol is just one of many important themes to discuss with their patients. Beyond initial training and support, embedding screening and brief interventions in the long term would require ongoing regular triggers such as booster sessions.

Individual factors, incentives and resources, and social, political, and legal factors were relevant to *how* and *for whom* a financial reimbursement strategy would work. Personnel numbers and salaries made a difference, as did the nature of the financial reimbursement scheme in each country. In Poland and Catalonia, clinicians were reimbursed directly, whereas in Sweden and the Netherlands reimbursement was applied at the level of primary healthcare units.

In Sweden and the Netherlands, clinicians reported that financial resources were of high importance in principle. They went further to say that increased resources from health insurance was required for long-term improvement of the delivery of screening and brief interventions, and as a result showed a preference for being paid at a structural level by health insurance for their preventive services, rather than a temporary project-based payment.

For all four countries, it was primarily the patients' lack of interest that inhibited nurses and GPs from actively referring to internet-based brief interventions. Face-to-face interventions were the preferred method in such cases.

Under what circumstances?

Participating in a trial about preventive services for risky drinking not only raised awareness but the frequency with which clinicians provided these services, suggesting that putting risky drinking on the agenda makes the clinician more active in screening and brief interventions irrespective of their allocation to implementation strategies.

A routine for delivering screening and brief interventions can be supported by including it in protocols and setting reminders. However, even without a routine, clinicians can begin engaging with screening and brief intervention activities, for example through making referrals.

Clinicians frequently reported high workloads, which caused training and support to be insufficient in increasing performance. Another inhibiting factor was the perception that alcohol was competing with other lifestyle prevention themes, among which alcohol received the least media attention.

At the macro level

Driving the success of implementation strategies were individual professional factors, incentives, and resources. However, other domains impacted the extent to which these exerted an influence on daily practice – in particular, the social and political culture.

Despite their intrinsic motivation to shield patients from alcohol-related harm, GPs and nurses felt there was more rationale for selecting patients for screening on the basis of suspected risk, rather than screening whenever there is an opportunity to do so. Furthermore, while nurses and GPs perceived they had a responsibility to deliver screening and brief interventions, this was embedded within a wider societal responsibility, which raised the need for an integrated approach beyond primary healthcare.

The authors' conclusions

The insights gleaned from this part of the ODHIN trial may help to further tailor implementation strategies in order to achieve maximum gains in extending alcohol screening and brief interventions for risky drinking.

Essential ingredients for effective training and support were felt to be gained knowledge and skills, team-based training, and learning to prioritise screening and brief interventions during high workloads. The utility of financial reimbursement, on the other hand, was highly determined by country context and the way reimbursement was provided. Finally, despite internet-based delivery being demonstrably effective, clinicians require clear guidance about how it can improve screening and brief interventions in routine practice. The study confirmed that very few clinicians used e-health in patient care. Clinicians from all countries had mixed levels of trust in the principles of internet-based delivery and felt their patients were not interested in this format.

The influence of factors at the macro level – such as social and political cultures – should also be taken into account. Sustainable funding is an important consideration when implementing (or seeking to improve the implementation of) screening and brief alcohol interventions. In the United Kingdom, the Quality and Outcomes Framework is a reimbursement scheme in which payment is based on a fee-for-service or fee-per-patient system rather than related to quality of care. Though this system can be effective, policymakers should be warned that effects may only be realised in the short term and may not be as large as they would wish. Pay-for-performance has potential, but is not a 'magic bullet'; to achieve sustainable changes, it needs to be combined with other quality improvement initiatives.

FINDINGS **COMMENTARY** The featured study was the strand of the ODHIN trial that asked what primary care clinicians thought would help them bridge the 'implementation gap' in screening for risky drinking and brief advice. The findings reflected the views of volunteers for a study who were keener than average on dealing with risky drinking among their patients, and may not be representative of all primary care clinicians in those countries.

The ODHIN trial tested three strategies (in eight combinations) to promote screening and brief interventions for risky drinking in primary healthcare units. Overall, the findings (see entries on effectiveness and cost-effectiveness in the Effectiveness Bank) supported training and support plus persisting financial incentives in the context of strong government support for brief alcohol interventions, performance management arrangements, guidance, and strategic leadership. This combination promised to maximally raise what the study found was a very low baseline intervention rate; just 3% of primary care patients whose heavy drinking meant they might have benefited from brief advice actually received it. One of the essential ingredients for effective training and support was learning to prioritise screening and brief interventions during high workloads and sharing experiences with other clinicians. The utility of financial reimbursement, on the other hand, was highly dependent on the country of delivery and the way reimbursement was provided.

Proved unfounded were expectations that providing a website to refer patients to would increase the advice rate by relieving clinicians of the need to do the advising themselves. Asking what the clinicians think, the featured paper found that only in respect of website referral as a brief intervention option was opinion negative across the board. In all four countries, "patients' lack of interest inhibited both nurses and GPs from being active in referring patients". This option neither offered clinicians guidance in providing brief interventions nor did it engage the patients, "therefore, face-to-face interventions were the preferred method in such cases". The researchers suggested that clinicians may require clearer guidance about how online access could decrease their workload whilst also being effective and offering them a way to engage with screening and brief intervention activities.

The ODHIN trial adds to a body of literature evaluating screening and brief intervention strategies in primary care whose findings were synthesised in a meta-analysis published in 2015 (free source at time of writing). It found that across all studies, strategies to extend implementation had boosted both screening and the brief intervention rates but not significantly affected drinking. Greatest impacts on screening and brief intervention were seen from multi-strand strategies, and screening benefited from involving staff such as nurses as well as doctors. These findings are consistent with the argument that "To foster development of positive attitudes and effective responses … a focus that extends beyond the individual worker is required. Education and training are a necessary, but not sufficient, condition to ensure health professionals' capacity and willingness to respond to [substance use] issues. Research on organizational culture provides valuable insight into the types of organizational and systems factors likely to influence … attitudes and work practice."

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