

# 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](#). [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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## ▶ [Impact of financial incentives on alcohol consumption recording in primary health care among adults with schizophrenia and other psychoses: a cross-sectional and retrospective cohort study.](#)

**Khadjesari Z., Hardoon S.L., Petersen I. et al.**  
**Alcohol and Alcoholism: 2017, 52(2), p. 197–205.**

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*UK study of how Quality and Outcomes Framework incentives for primary care boosted alcohol screening among patients with severe mental illness shows what could have happened had the incentives been extended across the entire primary care caseload.*

**SUMMARY** Though payment-for-performance schemes are widespread in the UK and USA, there is mixed evidence about their impact on quality of care, and few evaluations considered to be methodologically robust ([1](#) [2](#)).

The [Quality and Outcomes Framework](#) was first introduced in April 2004 to incentivise good practice in primary care – providing financial reward for achieving targets in the monitoring and care of patients for different medical conditions. UK primary care practices have been specifically reimbursed for alcohol screening in people with severe mental illness since April 2011.

The featured study aimed to determine the impact of these financial incentives on alcohol screening in England, Scotland, Wales and Northern Ireland, by comparing rates of screening among people with [schizophrenia](#) and other [psychoses](#) versus those without between 2000 and 2013. A [companion study](#) considered the impact of the Quality and Outcomes Framework among people with [bipolar disorder](#).

### **Describing the recording of alcohol consumption**

A total of 14,860 people with diagnoses of schizophrenia or other psychoses from 409 [general practices](#) were identified between April 2011–March 2013. All were aged 18–99 years old, and just over half were male (54%). The mental health diagnoses were [identified via](#) ‘read codes’ (a standard vocabulary for clinicians to record patient findings and procedures) in patients’ electronic primary care health records.

The researchers calculated the number of patients with a [record of alcohol consumption](#). Rates of recording of alcohol consumption between April 2011 and March 2013 were compared for men versus women, different regions and [socio-demographic groups](#), and for patients registered with the practice within the past year versus those registered for longer.

### **Evaluating the impact of incentives over time**

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#### **Key points**

##### **From summary and commentary**

This study examined the impact of Quality and Outcomes Framework incentives on rates of alcohol screening among people with schizophrenia and other psychoses in UK primary care.

The findings showed that financial rewards corresponded with a substantial boost in screening, particularly after the introduction of the indicator for alcohol consumption recording in 2011.

Almost all the records of alcohol consumption complied with the Quality and Outcomes Framework business rules, ensuring that practices could be financially reimbursed.

To gauge the impact of Quality and Outcomes Framework incentives, the sample was expanded to include people registered with the practices back to the year 2000, including periods when the incentives were and were not in place. A separate cohort of people *without* a severe mental illness was also randomly selected among those of the same sex, practice, and age band (18–29, 30–49, 50–69, and 70–99 years).

The researchers compared the rates of alcohol consumption recording in people with schizophrenia and other psychoses versus without across different time periods:

- April 2000–March 2004 (before the severe mental illness Quality and Outcomes Framework);
- April 2004–March 2006 (severe mental illness Quality and Outcomes Framework introduced);
- April 2006–March 2011 (addition of lifestyle screening to the severe mental illness Quality and Outcomes Framework indicators);
- April 2011–March 2013 (addition of alcohol screening to the severe mental illness Quality and Outcomes Framework indicators).

## Main findings

Rates of alcohol consumption records varied considerably between general practices, ranging from 42% to 100%. Around 21% of men and 10% of women with schizophrenia were recorded as drinking at harmful or higher risk levels. Over three-quarters (78%) of people with schizophrenia and other psychoses had an alcohol consumption record. In virtually all (99%) the cases when drinking was recorded, the recording was eligible for remuneration under the Quality and Outcomes Framework.

In 21% of cases more than one method was used to record alcohol consumption. When only one method was used, it was most often a **read code** for level of alcohol consumed (52%), followed by a record of units of alcohol in a week (27%). A very small number (0.33% or 38 cases) recorded only a **read code** for type of screening test used.

The recording of alcohol consumption increased dramatically following the introduction of the severe mental illness Quality and Outcomes Framework, with an 839% rise (more than eight-fold increase) over the 13-year study period, compared with a 62% increase among people without a severe mental illness. The most substantial rise occurred after the introduction of the indicator for alcohol consumption recording in April 2011.

Alcohol consumption recording varied to a statistically significant degree by age, level of social deprivation, and UK region. The highest levels of recording were observed among those aged 50–79 years old, those living in the most socially deprived areas, and those living in London.

## The authors' conclusions

The findings suggest that financial incentives provided through the severe mental illness Quality and Outcomes Framework have had a substantial impact on alcohol consumption recording among people with schizophrenia and other psychoses in primary care.

Almost all the records of alcohol consumption complied with the Quality and Outcomes Framework **business rules**, ensuring that practices could be financially reimbursed. The same **was not true** in a study of alcohol records among newly registered patients in UK primary care, where the codes necessary for reimbursement under the Directed Enhanced Service were used in only 9% of cases. The most plausible explanation for this finding was that the incentive offered by the Directed Enhanced Service was substantially lower than that offered by the Quality and Outcomes Framework (£2.38 per patient vs. £133.76 per point up to a maximum of four in 2012/2013, respectively), and therefore had less influence on practitioner behaviour.

The Quality and Outcomes Framework has been criticised for incentivising recording practice, rather than quality of care, which includes concerns that focusing on one patient group (such as people with a severe mental illness) will result in detrimental effects on the quality of care for non-targeted patients. This being said, the apparent impact on alcohol consumption screening among patients with schizophrenia is an important finding given the high rates of harmful drinking among these patients **compared with** the general population – 21% men and 10% women with schizophrenia (2011–2013) vs. 1% men and 0.5% women newly registered with a UK general practice (2007–2009). However, it is also important to note that under the Quality and Outcomes Framework, practices could only be financially rewarded for the recording of alcohol consumption among patients with severe mental illness not for any subsequent treatment, which leads to uncertainty over the extent to which the framework supports patients with schizophrenia to actually reduce their drinking.

Guidance from the National Institute for Health and Care Excellence (NICE) on the assessment and management of a coexisting substance use issue and diagnosis of psychosis **advocates** the referral of patients identified in primary care to secondary care mental health services for

assessment and further management. Psychosocial treatment is [recommended](#) for patients drinking at harmful and dependent levels without a severe mental illness, but there is no evidence that it works to reduce alcohol consumption or improve mental health in people with a severe mental illness.

**FINDINGS COMMENTARY** With the Quality and Outcomes Framework being the main way of encouraging wider screening in primary care for priority public health issues, the featured results have a broader significance. [Going back to 2012](#), the UK alcohol strategy said the government was awaiting the results of major English screening and brief intervention trials before deciding whether to incorporate universal screening into the framework. The results subsequently offered no support, and the framework continued to embrace smoking but not drinking. How much of a difference including alcohol might have made can be gauged from the above study on patients with schizophrenia and [companion study](#) on patients with bipolar disorder. The impacts noted suggest that a similar boost to screening rates could have been expected across the entire primary care caseload.

Compared to the year 2000, following introduction of the incentives, alcohol screening among people with schizophrenia and other psychoses increased dramatically in primary health care across the UK – an 839% rise. Among the remainder of the primary care caseload, the increase was just 62%. In the incentives era drinking was recorded for 78% of the patients diagnosed with schizophrenia or other psychosis seen at the general practices in the study, virtually all in such a way that the record qualified the practice for the incentive payment. Per 1000 patients per year, the proportion for whom drinking was recorded had been about the same for patients with the relevant mental health diagnosis and those without, but for the former jumped after 2011 to reach 723 out of 1000 while it lagged at 184 among other patients. However, for just 588 (or 5%) of the 11,585 patients with schizophrenia or other psychosis in the study the practice recorded the use of a screening test, raising concerns over the quality of the identification of hazardous drinking.

The same research team [observed a similar pattern](#) among people with bipolar disorder. Over the same time period, there was a nine-fold increase in recording of alcohol consumption in primary care among people with bipolar disorder, compared with a more modest 57% increase among people without severe mental illness. Between 2011–2013, over 80% of people with bipolar disorder had their current alcohol levels recorded in primary care, with one fifth of general practices attaining 100% recording levels. According to the authors:

*"While the concurrence of this rise in recording with the modification of [the Quality and Outcomes Framework] to include alcohol screening does not prove that the rise is a result of [the Quality and Outcomes Framework], the absence of alternative likely influences, along with the observed relative stability of alcohol recording rates in people without [severe mental illness], supports that the [Quality and Outcomes Framework] for [severe mental illness] has played an important role".*

As previously stated, while payment-for-performance incentive schemes are widely used, there is a lack of evidence about their impact on quality of care. A 2011 Cochrane review [found](#) insufficient evidence to support or not support their use for this purpose. Six of the seven studies identified showed positive but modest effects on a minority of the measures of quality of care. Poor study design led to substantial risk of bias in most studies, and none of the studies addressed issues of 'selection bias' – the ability of primary care doctors to select into or out of the incentive scheme.

Last revised 22 November 2017. First uploaded 27 October 2017

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