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

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Applying a systematic and comprehensive framework to map the strategies trialled in attempts to implement screening and counselling for risky drinking primary care patients gives some clues to what it has taken to achieve a high screening rate, the essential first step in the process.

Summary This review's starting points were the observations that screening for risky drinking in primary care patients followed by brief counselling as needed has been shown to reduce drinking, and is in some countries considered a public health priority, yet sustained implementation in to routine clinical practice has not occurred, and what might facilitate implementation remains unclear. To inform implementation efforts, the review drew on the international literature to map evaluated efforts to implement screening and brief counselling, and attempted to relate the degree of success of these implementations to the strategies used to encourage implementation.

To map implementation strategies, the reviewers used the Consolidated Framework for Implementation Research. In respect of health care innovations in general, this model identifies five implementation domains, each divided in to several sub-domains. The five main domains with relevant examples are:

- *Characteristics of the intervention* (in this case, alcohol screening and brief intervention in primary care) such as the strength of the evidence for its effectiveness and how far it was adapted to fit the particular circumstances in which it was being implemented.
- *Outer setting*, which refers to the economic, political, and social environment surrounding and influencing the organisation undertaking the implementation – in this case, typically primary practices and organisations offering primary care services; included here might be national political drivers, the demand from patients and their

identified need for the intervention, and the degree to which the implementing organisation is networked with others (such as accreditation bodies) in ways which might promote or hinder implementation of the intervention.
• *Inner setting* is pertinent features of the implementing organisation including the degree to which its structures, internal communication mechanisms, resources, leadership, and culture facilitate the adoption of innovations, and the degree to which the particular innovation 'fits' the organisation's needs and circumstances.
• *Characteristics of the individuals conducting the intervention* − in this case, doctors and other primary care staff − such as what they believe about the intervention and how enthusiastic and ready they are to implement it.
• *Process of implementation* − the extent and quality of the implementation effort, including the degree to which relevant staff are actively engaged, the efficiency with which the implementation is carried out, the extent to which progress is appropriately monitored against specific goals and progress news fed back to the participants, and the extent to which this feedback is used to adapt and promote implementation.

Methodology

English language studies available up to March 2010 were included in the review if they evaluated the implementation of alcohol screening and brief intervention into routine primary care practice when screening and intervention were primarily conducted by usual primary care staff rather than research staff. For each implementation the analysts calculated the screening rate (the proportion of patients who should have been screened actually were) and the brief intervention rate (the proportion of patients who screened positive for risky drinking were actually counselled). These outcomes were related to the extent to which each implementation adopted the implementation strategies mapped in the Consolidated Framework for Implementation Research.

Main findings

Although the analysts found 17 relevant reports, these derived from just eight implementation programmes. These efforts spanned nine countries and involved 533,903 patients (127,304 of whom were screened), 2001 providers, and 1805 medical clinics. Across the programmes the screening rate varied hugely from 2% to 93% and so did the brief intervention rate, from 1% to 73%. The programmes adopted between 7 and 25 of the 38 detailed strategies identified in the Consolidated Framework, generally adopting at least one from each of the five major domains.

At 93%, the US health service for former military personnel screened the highest proportion of the patients intended to be screened. In this study the implementation effort was distinguished by extensive use (12 of 14 sub-domains) of Inner Setting domain strategies, of Process of Implementation strategies (7 of 8 sub-domains), and of Outer Setting strategies (3 of 4 sub-domains). Two other US programmes achieved the next highest screening rates of 65% and 60%. They too used several Inner Setting (5 of 14) and Process of Implementation (4 of 8) strategies, but not to an obviously greater degree than the remaining programmes with much lower screening rates ranging from 2% to 26%.

Of patients who screened positive for risky drinking, again it was the programme mounted by the US health service for ex-military which (at one of the implementation sites) achieved one of the highest proportions counselled. At 71%, their record was

exceeded only by the 73% recorded in another US study. As noted above, the programme for former military personnel was implemented using a uniquely broad range of strategies but the same could not be said of the top-ranking programme, and no clearly successful configuration of strategies emerged from the remaining studies, whose rates ranged widely from 1% to 66%.

The authors' conclusions

The programme mounted by the US health service for ex-military personnel reported a substantially higher rate of alcohol screening than others and could be distinguished from other programmes by its focus on multiple elements of the Inner Setting, Outer Setting, and Process of Implementation domains of the framework. Strategies focused on the Inner Setting and Process of Implementation domains also characterised the two programmes next in the screening rate ranking. This suggests that focusing implementation strategies on Inner Setting, Outer Setting, and Process of Implementation domains is associated with high rates of screening. However, the picture was nether detailed nor entirely consistent: implementation programmes with the highest rates of screening did not consistently share a focus on the same sub-domains within these broad categories and, when they did, were not easily discernable from programmes which did not report high rates of screening.

It may be relevant that each of these three very successful screening implementation efforts deployed electronic medical records and some form of performance accountability via measurement and feedback. They also all took place in large, geographically diverse networks of clinical practices with centralised administrations that included a research infrastructure. Possibly their screening successes were partly due to being conducted within infrastructures aligned to the implementation and evaluation of programmes. This is, however, not to say that smaller networks or single practices cannot (perhaps with different methods) achieve good results.

Though for screening rates there was some indication of what distinguishes a successful implementation, this was not the case for the next phase of the procedure, engaging positive screen patients in counselling about their drinking. It seems likely that the strategies necessary to implement screening differ from those necessary for brief intervention. Screening involves the application of a validated screening survey or other method, which can be done either by the patient or by clinical staff at all levels. In contrast, counselling risky drinkers is more complex, typically requiring individualised assessment and judgement regarding the specific feedback and advice to be offered.

Though this review was able to offer limited guidance on what makes for a successful implementation, the framework on which it was based (or other similar frameworks) can be useful in other ways. Firstly, as a roadmap for planning an implementation programme, and secondly, as a structure for documenting the strategies tested in an implementation effort.

However, this particular framework and others too perhaps have their limitations. The framework assumes that a single intervention is being implemented, when, in fact, implementing screening and brief intervention involves multiple steps, each of which may be responsive to different implementation strategies. Also it is often unclear whether a strategy belongs in the Inner or Outer Setting domain. For example, when the clinic where the work is taking place is part of a larger organisation, is that organisation an Outer or Inner domain influence? It also seems likely that there is no single answer to what is needed to successfully implement alcohol screening

and brief intervention in primary care practices. In different circumstances, different strategies will be needed and be effective. When for example the existing environment, organisation and staff are already highly conducive to implementation, domains identified by the framework may be less closely related to success than in less conducive circumstances.

FINDINGS In recent years Britain has certainly made progress in extending alcohol screening and brief intervention to more primary care patients, but it is unclear whether this has been to the degree needed to make noticeable public health gains, and provision remains patchy. The framework adopted by the featured study offers one way to audit which implementation levers have been activated and which have yet to be adequately activated, revealing the gaps in implementation efforts.

In both England and Scotland, the prime objective for primary care is to screen new patients and/or those thought in advance to possibly be at risk from their drinking. Screening newly registered patients was the reimbursement indicator for the enhanced alcohol service. Initially for two years from 2008 but then extended to March 2013, this requires all primary care trusts in England to offer GP practices in their areas the chance to contract to provide alcohol screening and brief intervention to their new patients. If they wish, local commissioners can go further to contract for more extended services. Also in England, directors of public health are expected to include such activity among attempts to address the population-wide determinants of ill health.

In line with Scotland's own practice recommendations, national policy in Scotland prioritises screening and brief intervention, backed by a health service target for 2008/09–2010/11 to deliver 149,449 brief interventions supported by dedicated funding. The target was exceeded; over the three-year period 174,205 alcohol brief interventions were recorded across the three priority settings – primary care, accident and emergency departments, and antenatal services. In 2008, the Welsh Assembly Government announced its intention to instigate a programme to promote alcohol brief interventions in both primary and secondary health care settings.

These policy initiatives implement guidelines from Britain's National Institute for Health and Clinical Excellence (NICE), which encourage screening for new patients and in circumstances where both patient and doctor might feel it was 'natural' and justified to ask about a patient's drinking. Touching on a key barrier to widespread implementation beyond these circumstances, the guidelines cautioned that, "Clinical consultations for non-alcohol-related medical problems can be an inappropriate time to discuss alcohol use, given that users are focused on the condition for which they are seeking advice", and recognised the greater acceptability of discussing drinking "in a context that is related to the purpose of the visit (such as lifestyle assessment or chronic condition monitoring)".

It is unclear how far things have moved on since 2008 when an national audit found that systematic screening by GPs in England was the exception and few patients were screened or offered brief advice. The requirement to offer screening and intervention contracts to GPs has generated more activity, but far from consistently, and the quality and even the reality of the services supposed to have been provided has been questioned. In London in 2010 a survey of staff responsible for local alcohol policy indicated low levels of investment in developing the role of GPs in screening and treating alcohol use disorders. Nearly two thirds of areas had yet to invest in or develop screening

systems beyond those nationally required. In one large London borough not known for the rarity of its drinking problems, over half the practices which had contracted to provide screening failed to identify any risky drinkers using the stipulated screening survey, and in a year screening resulted in just ten people being referred for treatment. Whilst reluctance to address drinking 'out of the blue' is understandable, there is even reluctance to raise the topic in general health and well-being assessments.

As expressed in the featured report, brief interventions have tremendous public health potential. A remaining major challenge is how to consistently realise that potential. This hot topic search retrieves relevant documents on the Findings site, but as yet these do not include the unpublished results from a government-funded national implementation trial in England, whose findings are expected to be highly influential.

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