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Health Research*

Implementation of brief interventions in primary care for excessive alcohol consumption: a comparison with smoking

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Conflicts of interest

- I am funded by the NIHR SPHR
 - The views in this presentation are not necessarily those of the NIHR or NHS.
- I have received unrestricted research funding from Pfizer and undertaken consultancy for NICE and charity organisations.

Is brief advice being delivered?

- Analyses of GP recording databases indicate that approx. 50% of all smokers received cessation advice in 2009 (Szatkowski et al, 2009)
- Studies suggest that clinicians rarely undertake screening and brief intervention to reduce excessive drinking
 - GPs only estimated 2% of patients who consumed alcohol excessively in 2003 (Cheeta et al, 2008)
 - Substantial variation in delivery (Khadjesari et al, 2013)

Is brief advice being delivered?

- Advice on drinking typically lasts less than four minutes (Johnson et al, 2011), while brief advice on smoking lasts between 5 and 10 minutes (NICE, 2006)
- Brief advice on drinking is provided less often than patients expect (Johnson et al, 2011).
- Brief advice on alcohol is provided less often than for other lifestyle issues including exercise, diet and smoking (Johnson et al, 2011)



What are the barriers to delivering brief advice?

- Time and service constraints (Rosseel et al, 2011; Ho et al, 2013)
- Not part of their role (Johnson et al, 2011)
- Concern about damaging relationships with patients (Kerr et al, 2007; Aveyard et al, 2012)
 - Provoking aggression in hospitals (Johnson et al, 2011)
- Professionals not believing that brief interventions are effective (Kerr et al, 2007; The Alcohol Academy, 2011)
- Professionals have not had the appropriate training (Kerr et al, 2007; Johnson et al, 2011)
- Professionals lack confidence (Kerr et al, 2007; Johnson et al, 2011)
- *Methodological*
 - *Brief advice may be being delivered but it is not recorded accurately.*

What stimulates the delivery of brief interventions?

- Presence of behaviour-related diseases (Rosseel et al, 2011)
- Education on the association between the behaviour and health (Rosseel et al, 2011)
- Vocational training and structured advice protocols (Rosseel et al, 2011; Johnson et al, 2011)
 - Trainees need to be receptive and committed
- Certain demographic characteristics (Johnson et al, 2011)
 - More willing to intervene with men, the unemployed and some racial groups

What accounts for the difference in the prevalence of brief advice for smoking and alcohol?

- Financial incentives
 - Smoking: Quality and Outcomes Framework (QOF) worth £4,500 for each GP practice per year
 - Alcohol: Small financial incentive (£2.38 per patient in 2013/2014) for using a validated tool to screen newly-registered patients
 - But . . . practices have to elect to offer an alcohol Directed Enhanced Service (DES) to claim the payment
 - DES have had little effect on clinical behaviour
 - Only 9% of newly-registered patients between 2007 and 2009 completed the validated screening tool (Khadjesari et al, 2013)

What accounts for the difference in brief advice for smoking and alcohol?

- Methodological
 - Over-estimation of the delivery of smoking brief interventions
 - **Prior to the introduction of QOF incentives (National Patient Survey)**
 - **Good** correspondence between the rate of recording of GP advice and the proportion of patients recalling advice
 - **Following the introduction of QOF incentives (Szatkowski et al, 2011)**
 - **Poor** correspondence between the rate of recording of GP advice and the proportion of patients recalling advice
 - Excessive alcohol consumption is more difficult to establish than smoking
- Drinking advice is perceived to be less straightforward (reduction is the goal rather than abstinence)

The need for data from the patient perspective

- Figures derived from GP recording may over-estimate the delivery of smoking cessation interventions
- Estimates of delivery for alcohol may be inaccurate as they are based on the rate at which GPs record screening rather than conduct the intervention.
- Up-to-date, reliable and representative data from the perspective of patients are needed
 - How many recall receiving brief advice for smoking and alcohol?
 - What are the characteristics of those who receive brief advice?



Methodology



- We collected data using monthly cross-sectional household surveys of adults in England
- Data were collected between March 2014 and November 2014



Methodology



- Surveys are part of the ongoing Smoking Toolkit Study and Alcohol Toolkit Study
 - Designed to provide tracking information about smoking, alcohol consumption and related behaviours
 - STS started in 2006 and ATS in 2014
 - For further information see:
 - www.smokinginengland.info
 - www.alcoholinengland.info
 - Beard et al (2015). Protocol for a national monthly survey of alcohol use in England with 6-month follow-up: 'The Alcohol Toolkit Study'. *BMC Public Health*, 15:230.



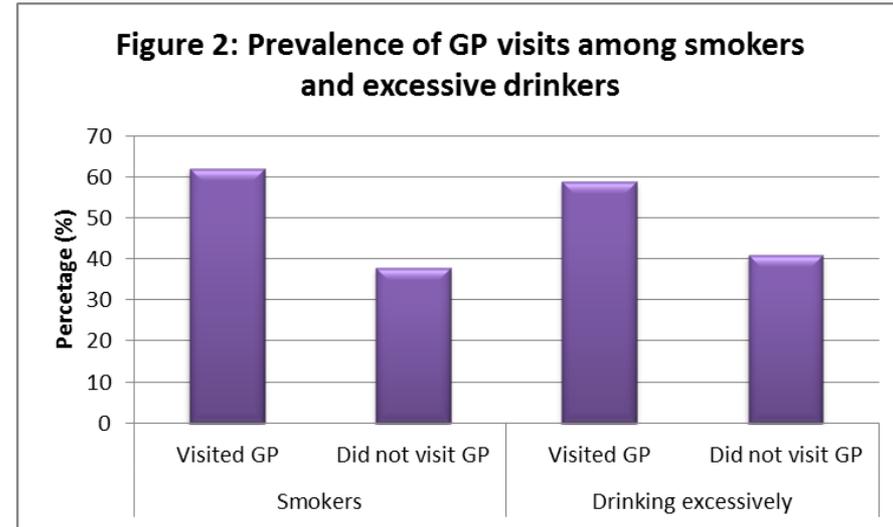
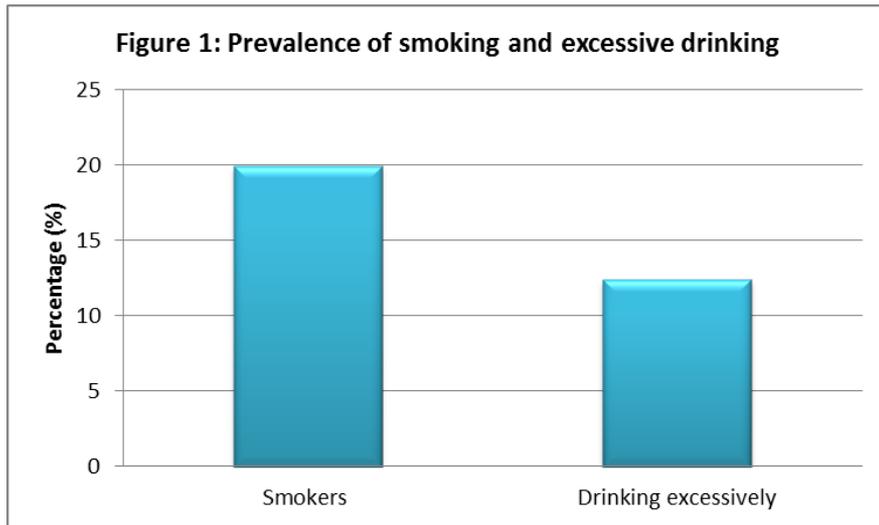
Methodology



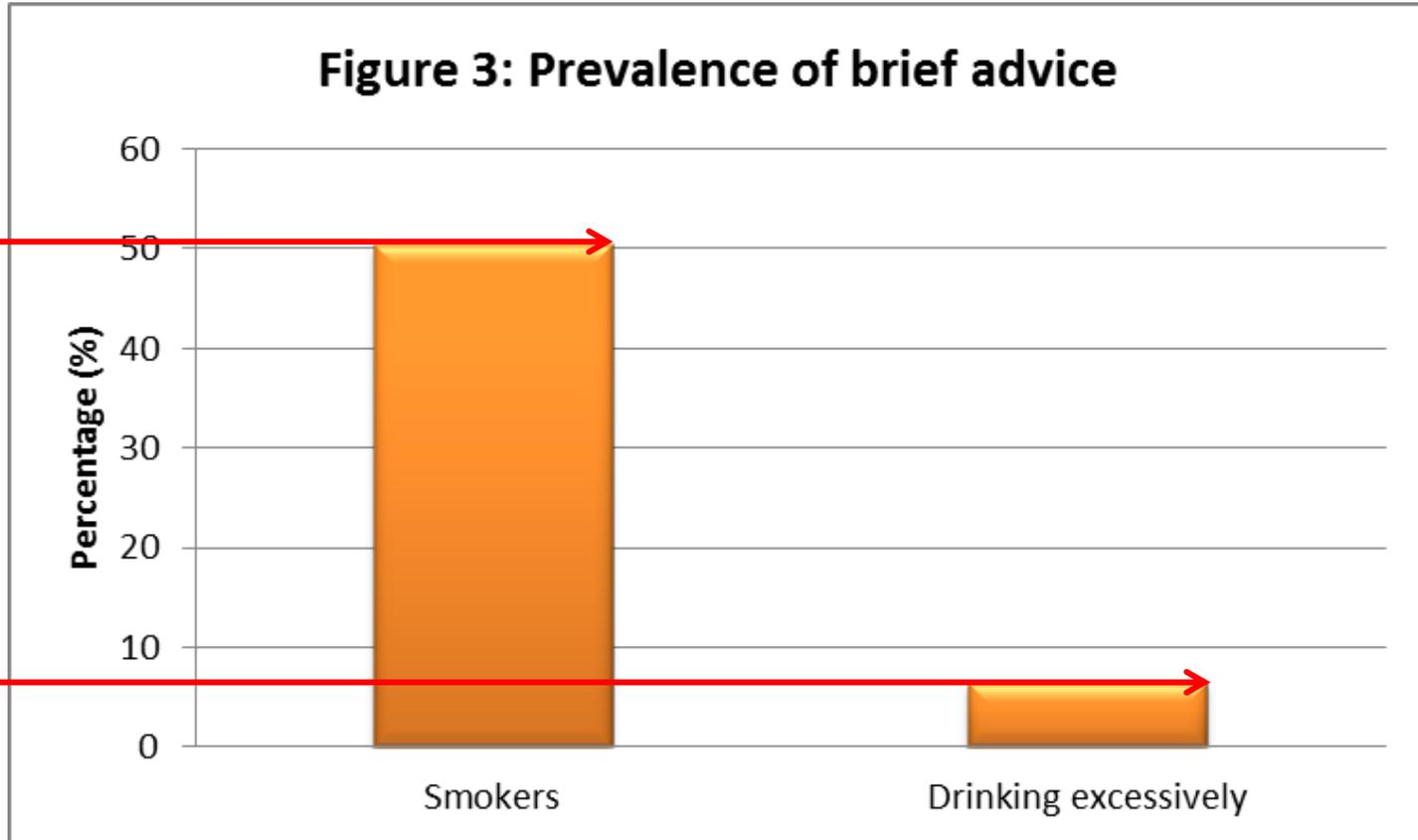
- Participants:
 - Smoked cigarettes or any tobacco product daily or occasionally at the time of the survey or during the preceding 6 months
 - Drank alcohol excessively in the previous 6 months
 - Score of 8 or more on the Alcohol Use Disorders Identification Test (AUDIT)

Findings

- Total of 15,252 adults were surveyed



Findings



Findings



- Smokers receiving an intervention tended to:
 - Be older
 - Be female
 - Have a disability
 - To have made more quit attempts in the past year
 - Have a greater nicotine dependency
 - More likely to have post 16 qualifications

Findings

- Those with excessive alcohol consumption receiving an intervention tended to:
 - Have higher AUDIT scores
 - To be male



Discussion

- Smokers were seven times more likely to receive advice than people drinking excessively
- Similar to estimates of delivery of brief interventions derived from primary care databases (Szatkowski et al, 2011; Taggar et al, 2012)

Discussion

- People with higher AUDIT scores and males were more likely to recall a brief intervention for alcohol
- Previous studies have found:
 - That GPs are better at identifying dependent drinkers compared to those who are hazardous or harmful (Cheeta et al, 2008)
 - That GPs are worse at identifying an alcohol use disorder in women (Cheeta et al, 2008)

Discussion

- Association of smoking brief intervention with age, sex and past quit attempts reflects the profile of treatment-seeking smokers
 - GPs may focus on those who express an interest in quitting (Filder et al, 2009)
 - But guidelines recommend that GPs go straight to the offer of support without assessing interest in quitting (National Centre for smoking cessation and Training)
- Concern for health-inequalities: lower SES less likely to receive an intervention

Implications

- The difference in prevalence of brief advice does not appear to be explained by poorer recording of excessive alcohol consumption relative to smoking.
- This study adds to the evidence that more substantial incentives may be associated with greater delivery of brief intervention for alcohol.



The screenshot shows the website www.parliament.uk. The navigation menu includes: Home, Parliamentary business, MPs, Lords & offices, About Parliament, Get involved, Visiting, Education, House of Commons, House of Lords, What's on, Bills & legislation, Committees, Publications & records, Parliament TV, News, Topics. The breadcrumb trail reads: You are here: Parliament home page > Parliamentary business > Publications and Records > Committee Publications > All Select Committee Publications > Commons Select Committees > Health > Health. The page title is "Health Committee" and the main heading is "Written evidence from Alcohol Health Alliance UK (GAS 27)". Below this is a section titled "ABOUT THE ALCOHOL HEALTH ALLIANCE UK" containing the following text: "6.6 The NICE Guidance on alcohol use disorders states that primary prevention of alcohol-related harm at primary care level is both effective and cost effective.(4) This should be incentivised through including a measure in the Quality and Outcomes Framework for GPs to record the alcohol intake of their patients and to give brief advice where indicated. For patients who do not respond to simple advice there should be a stepped programme of further intervention."

- UK government's alcohol strategy was criticised by the Alcohol Health Alliance
 - Failure to implement a QOF indicator for screening and brief intervention



Where next?



- There is clear guidance on the delivery of brief interventions for smoking
 - National Centre for Smoking Cessation and Training offers an online module
 - Increased the frequency and quality of smoking brief interventions (Hughes et al, 2013)
 - Training to encourage GPs to formulate specific action plans increases the rate GPs ask about smoking (Verbiest et al, 2014).

Where next?

- There is wide debate about what constitutes an effective alcohol brief intervention (Kaner et al, 2013; Kaner et al, 2010; Heather et al, 2014)
 - Any improvement to incentive schemes would likely be enhanced by the simultaneous provision of training on how to deliver brief interventions

Where next?

- Future research should aim to identify the most effective components of brief alcohol interventions (behaviour change techniques) and assess whether training has an effect on the delivery.

How do we identify potentially effective components?

- Professor Susan Michie at UCL has developed a taxonomy of Behaviour Change Techniques (BCTs) (Michie et al, 2013).
- Generic version 1 contains 93 BCTs
- Each BCT has a definition, set of examples and additional notes
 - Example of goal setting (behaviour)
 - Definition: set or agree a goal defined in terms of the behaviour to be achieved
 - Example: agree a daily walking goal with the person and reach agreement about the goal. Set the goal of eating 5 pieces of fruit per day as specified in public health guidelines.
 - Notes: only code goal-setting if there is sufficient evidence that the goal is set as part of the intervention.

Which BCTs are commonly used?

- Michie et al (2012) coded a selection of guidance documents and treatment manuals aimed at reducing excessive alcohol consumption.
 - 42 BCTs were identified
 - 67% used *'provide information on consequences of drinking and drinking cessation'*
 - 50% used *'facilitate action planning/help identify relapse triggers'*
 - Brief interventions that included the BCT *prompt self-recording* were more effective

Where next?

- Are interventions correctly being delivered?
 - ODHIN (Optimizing delivery of health care interventions)
 - Aims to understand how better to translate the results of clinical research into everyday clinical practice.
- What about other settings?
 - Most research has been conducted in primary health care and in high income countries
 - BISTAIRS (Brief interventions in the treatment of alcohol use disorders in relevant settings)
 - Other counties
 - Workplace health services, emergency care and social services.

The end

- Special thanks to all the ATS collaborators:
 - **Jamie Brown**, Robert West, Colin Angus, Alan Brennan, Colin Drummond, Matthew Hickman, John Holmes, Eileen Kaner, Susan Michie