

WHO Collaborative Project on Identification and Management
of Alcohol-related Problems in Primary Health Care Phase IV:

Development of a Strategy for Implementing Screening and Brief Intervention
in Primary Health Care in England

Marketing Strategy for Screening and Brief Intervention in Primary Health Care

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Strategy Statement

TARGET ADOPTERS

The main target for the strategy is primary health care professionals who are in an ideal position to carry out screening and brief intervention (SBI) with patients in their day-to-day practice. Hazardous and harmful drinkers are the overall target group for the strategy as these are the potential recipients of SBI.

PRODUCT/SERVICE

Screening (early identification) and brief intervention (5-10 minutes of brief advice and information) for excessive drinkers.

LOCATION

Primary health care settings, including delivery in GP consultations, specified clinics and new patient registrations, where appropriate.

PRICE/COST

The direct cost of delivering one SBI is less than £20.

PROMOTION

A communications strategy to raise awareness of 'risky' drinking, alcohol-related problems, and the effectiveness of SBI in reducing alcohol consumption in excessive drinkers. The strategy is differentiated between the three target audiences of primary health care professionals, stakeholders and the general public.

Introduction

Excessive drinking is a major cause of health and social problems in the UK. It is a risk factor in coronary heart disease, stroke, high blood pressure, oral and upper digestive cancers, pancreatitis and liver cirrhosis. Increases in deaths from liver disease in the last 30 years, particularly amongst 35-44 year old men and women, have been attributed to excessive levels of alcohol consumption and patterns of binge drinking (DoH 2001). Alcohol has also been linked to 65% of suicide attempts, 20-30% of all accidents, 17% of attendances for treatment at A&E departments and 15% of acute hospital admissions. (Alcohol Concern 2000).

It has been estimated that between 60 and 70% of men who assault their partners have done so under the influence of alcohol (Jacobs 1998). Social work teams estimate that at least 50% of parents on their caseloads have either alcohol and/or drug problems (National Institute for Social Work 2000) and 23% of child neglect calls to national helplines involve parental alcohol misuse (NSPCC 1997). Alcohol has also been linked with 40% of contact crime including assaults and muggings (British Crime Survey 1996).

In a recent survey, 60% of employers stated that their organisations had experienced problems such as absenteeism, poor performance and disciplinary action as a result of employees' alcohol misuse (Personnel Today 2001).

Research accumulated over the last 20 years has shown that early identification (screening) and brief intervention (5-10 minutes of brief advice plus a self-help booklet) is effective in reducing levels of hazardous and harmful drinking (Bien et al. 1993; Freemantle et al. 1993; Kahan et al. 1995; Wilk et al. 1997). The widespread and routine implementation of screening and brief intervention (SBI) for excessive drinkers in primary health care (PHC) would therefore help to reduce alcohol-related harm and the costs associated with such harm, and help the NHS meet some of the key national targets for improving the health of the population (Secretary of State for Health 1998, 1999, 2000).

However, despite evidence of its effectiveness and the potential of PHC to reduce the prevalence of alcohol-related problems, general practitioners (GPs) and other health care professionals have generally been reluctant to incorporate alcohol SBI into routine practice (Heather 1996; Heather & Mason 1999). The aim of this marketing strategy is therefore to promote an understanding of the concept of "risky drinking", (i.e., drinking above medically recommended levels), the problems associated with drinking above those levels and the effectiveness of SBI in reducing alcohol consumption among excessive drinkers. Without such an improved understanding of the rationale behind SBI, no attempt at widespread implementation can be expected to succeed in the long term.

Definitions

The medically recommended levels of alcohol consumption have been expressed both in weekly and daily terms. For many years the Department of Health advised that drinking up to 21 units a week for men and 14 units a week for women was unlikely to damage health. In 1995, the "Sensible Drinking" report revised the guidelines in terms of daily benchmarks, stating that regular drinking between 3 and 4 units a day for men and between 2 and 3 a day for women would not accrue significant risk. This has led to considerable confusion in the minds of the public and health care professionals alike, with the daily benchmarks being totted up to give an increased weekly level of 28 units for men and 21 for women.

Regularly drinking above the recommended levels carries a progressive health risk. The Royal Colleges advise that drinking 22-50 units a week for men and 15-35 units a week for women carries increasing risk to health and this has been termed '*hazardous drinking*'.

Drinking more than 50 units a week for men and 35 units a week for women has been termed '*harmful drinking*' because of the imminent risk to health.

The World Health Organisation defines the term '*binge drinker*' as someone who regularly drinks 6 or more units in a single session.

A '*risky drinker*' has been defined as someone having drinking patterns that pose a considerable risk to their own and other people's health.

A '*problem drinker*' has been defined as someone "where there is clear evidence that alcohol use is responsible for (or substantially contributes to) physical or psychological harm, including impaired judgement or dysfunctional behaviour, which may lead to disability or have adverse consequences for interpersonal relationships" (from ICD-10 Mental and Behavioural Disorders Diagnostic Criteria).

Target Adopters

Hazardous and Harmful Drinkers

The overall target group for the strategy is those patients drinking more than the medically recommended levels of alcohol consumption, putting themselves or others at risk of health and social problems as a result of their drinking behaviour. This group is the potential recipient of SBI in primary care. The objective of the strategy is therefore to raise awareness of sensible levels of alcohol consumption and the risks associated with drinking above these levels, and to encourage patients to ask their GP or practice nurse for information and advice on sensible drinking.

Weekly levels of consumption

From 1988 to 1998, the proportion of men in England drinking more than 21 units a week remained largely unchanged at around 27% (see Table 1). Those drinking between 22 and 50 units a week (hazardous drinkers) remained stable at around 20%, as did the proportion drinking over 50 units a week (harmful drinkers) at around 7%. However, the proportion of women drinking more than 14 units a week increased from 11% in 1988 to 14% in 1998. Women drinking between 15 and 35 units a week increased from 9% to 12%, whilst those drinking over 35 units a week remained unchanged at 2%.

For young people between the ages of 16-24, the percentage exceeding the recommended weekly limits of alcohol consumption rose from 31% of men in 1990 to 36% in 1998 and from 16% of women in 1990 to 25% in 1998 (Office for National Statistics 2000a).

The Health in England survey (1998) found that significant factors in predicting the odds of drinking above the weekly-recommended levels included age, income, and household type. For example, the likelihood of drinking above these levels was greater among those with a gross household income of £20,000 or more, for men who lived alone, and for women who lived with other adults but no children. Women in social classes I/II, women who were single and women educated to A-level or above were also more likely to drink above the recommended levels.

Table 1: Weekly levels of alcohol consumption among people aged 16 or over by gender, 1998-99 (1998 GHS survey)

Weekly Alcohol Consumption (units)	England	Population Figures (estimated) ¹	Level of Risk
Men	(%)		
0	8	1,500,000	
1-21	65	12,600,000	Low risk levels
22-50	20	3,900,000	Hazardous levels
>50	7	1,300,000	Harmful levels
Women			
0	14	2,800,000	
1-14	72	14,500,000	Low risk levels
15-35	12	2,400,000	Hazardous levels
>35	2	400,000	Harmful levels

¹ Figures rounded to the nearest 100,000, based on mid-1999 estimates of population by age and sex (ONS 2001)

Daily levels of consumption

In 1998, 17% of men in England reported that they had drunk between 4 and 8 units on at least one day in the previous week (see Table 2). The proportion reporting that they had drunk more than 8 units on at least one day during the previous week was 20% (36% of men aged 16-24). 12% of women reported that they had drunk between 3 and 6 units on at least one day in the previous week; 8% had drunk more than 6 units on at least one day during the previous week (22% of women aged 16-24).

Table 2: Alcohol consumption among people aged 16 or over on the heaviest drinking day last week by gender, 1998-99 (GHS 1998)

Daily Alcohol Consumption (units)	England	Population Figures (estimated) ¹	Level of Risk
Men	(%)		
0	25	4,900,000	
1-4	38	7,400,000	Low risk levels
4-8	17	3,300,000	Hazardous levels
>8	20	3,900,000	Harmful levels
Women			
0	41	8,300,000	
1-3	39	7,900,000	Low risk levels
3-6	12	2,400,000	Hazardous levels
>6	8	1,600,000	Harmful levels

¹ Figures rounded to the nearest 100,000, based on mid-1999 estimates of population by age and sex (ONS 2001)

In the Health in England survey (1995), 12% of respondents who drank at least once a week said they would like to cut down their levels of alcohol consumption (16% of those aged 16-24). Those who reported drinking above the recommended levels were more likely to want to cut down. Two thirds of those who said they would like to cut down had tried to do so in the previous 12 months. Men aged 35-44 (74%) and women aged 45-54 (76%) were most likely to have tried

to cut down. 51% of those who had tried to cut down reported that they were drinking less than they did a year ago.

A recent survey found that 81% of people aged 16 and over said they had heard of the unit system of measuring alcohol consumption (Office for National Statistics 2000a). However, 45% of those respondents who said they had heard of the daily benchmarks did not know what they were, 27% thought that the daily maximum for men was 4 units or more, and 21% thought that it was 3 units or more for women.

With increasing numbers of people drinking above the medically recommended levels, a communications strategy for the general public is necessary to inform people about 'safe' levels of consumption and the risks associated with drinking 'too much', and to encourage them to talk to their GP or nurse for information and advice about alcohol.

Primary Health Care Professionals

The main targets for the communications strategy, however, are PHC professionals. These are the GPs, practice nurses and other health professionals who are based in or attached to primary care groups or trusts. There are over 27,000 GPs and 19,000 practice nurses working in almost 9,000 practices across England and each GP has an average list size of around 1800 patients. 51 million patients in England are registered with a GP (DoH 2000). As 27% of men and 14% of women are drinking above the medically recommended levels of alcohol, PHC professionals are in the ideal position to carry out alcohol SBI with patients in their day-to-day practice.

PHC professionals have contact with the majority of their patients at least once a year, which represents a substantial proportion of the general population. The National Survey of NHS Patients in General Practice (1998) found that 81% of respondents (86% of women and 75% of men) had seen their GP at least once in the last year. 52% of the respondents had consulted a practice nurse and 48% had consulted both a GP and practice nurse at least once in the last 12 months. Women (61%) were more likely to have visited the practice nurse in the last year than men (42%).

80% of patients surveyed thought that the GP and 90% thought that the practice nurse had sufficient knowledge of their condition or treatment. 92% were satisfied with the action taken by the GP and 97% with the action taken by the nurse on their last visit

Heavy drinkers experience more health problems than other patients and consult their GP twice as often as light drinkers (General Household Survey 1984). It has been estimated that a GP with an average list size of 1800 patients will see around 360 excessive drinkers (Kaner et al. 1999). However, in a survey of GPs' attitudes and practices regarding alcohol intervention, 65% of GPs reported that they managed between only 1 and 6 patients for hazardous drinking or alcohol-related problems in the previous year (Kaner et al. 1999). The majority of GPs did not routinely enquire about alcohol, although 88% felt that they should be involved in promoting non-hazardous alcohol consumption. A survey of practice nurses found that 77% of respondents reported seeing at least one patient in the previous month who was drinking above the recommended levels (Deehan et al. 1998). The Health in England survey (1995) found that only 8% of drinkers who had spoken to a GP or other health professional in the previous 12 months had discussed alcohol with them. Men (12%) were more likely to have discussed alcohol with their GP than women (5%). Over half of the respondents who had discussed alcohol with a health professional said that they had found the discussion to be helpful.

PHC professionals are therefore missing the opportunity to intervene with the majority of excessive drinkers in their practice. A communications strategy is necessary to raise awareness of alcohol-related problems in PHC and encourage professionals to implement SBI for alcohol misuse in their practices.

Health Market Environment: PEST Analysis

The implementation of health and social programmes is affected by changes in the wider political, economic, social and technological (PEST) environments (Kotler & Roberto 1989). An effective strategy for implementing screening and brief interventions must therefore attempt to map out the health market environment, assess the impact of external factors upon the strategy and identify relevant opportunities and threats accordingly.

Political Environment

NHS reforms in primary care

'The New NHS' (1997) set out the Labour Government's 10-year programme for the modernisation of the health service. One of the key objectives was the establishment of primary care trusts to commission and provide services for local patients based on their need. 'The NHS Plan' (2000) took this one stage further with the planned future development of 'Care Trusts' to bring primary care and social services together to commission and provide health and social services within a single organisation. This means that GPs will be working more closely in the same organisations as nurses, pharmacists, dentists, therapists, opticians and social care staff. Nurses may take on new responsibilities and some GPs may specialise in treating different conditions. Pharmacists are also searching for ways to expand their professional roles, becoming involved in medication reviews, repeat prescribing and treatment of minor disorders. The plan also aimed to recruit 2,000 more GPs, 20,000 nurses and 6,500 extra therapists.

Since 1998, a number of GPs have been working to a Personal Medical Services (PMS) contract rather than a standard national contract. PMS pays GPs on the basis of meeting set quality standards and the particular needs of their local population. It encourages doctors and nurses to work closer together to provide integrated and innovative services for patients. For example, if an area has a particularly high level of heart disease, the PMS contract sets targets for ensuring that local people at risk are identified and prescribed appropriate treatment. Presently 30% of GP's are working this way and, depending on the result of the new GP contract, the figure could substantially rise.

The new GP contract is a significant plank in the NHS Plan . It aims to reward GPs for the quality and range of their services, rather than the quantity of patients seen. It should allow doctors to work more flexibly and those with specialised interests can opt into *enhanced services*, which have their own payment streams. Alcohol has its own Nationally Enhanced Service, priced at £1000 retainer/practice and £200/annum/patient who misuses alcohol .Practices will have to demonstrate high quality clinical care and suitable accreditation.

Opportunities

- Funding is being moved to primary care to commission and provide services based on local need. Local health needs assessment could be carried out for alcohol misuse.

- New care trusts provide opportunities for a wider range of (integrated) services including those for alcohol.
- There will be opportunities for the development of specialist-generalist GPs and nurses for alcohol misuse.
- PMS contracts could include targets for identifying people at risk from alcohol misuse and providing appropriate interventions.
- If the new GP contract goes ahead, practices will be financially rewarded for treating alcohol misusers as a specific group, and the funding levels appear to be generous

Threats

- There is currently a GP and nurse recruitment and retention crisis, putting pressure on the provision of existing primary care services to the detriment of new service development.
- GPs and nurses are overloaded with the demands of the National Service Frameworks.
- Alcohol misuse is not a high priority compared with smoking cessation and illicit drug use.
- It is unknown whether PCT's will have enough funding in their baseline budgets to fully fund all enhanced services. Some enhanced services may receive more priority than others.
- It is still unclear if the GP contract will go ahead.

Public health policy

'Our Healthier Nation' (1998) set out proposals for a public health strategy which were published in 'Saving Lives' (1999). The strategy aims to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness, to improve the health of the worst-off in society and narrow the health gap. The priority is to concentrate on lifestyle factors such as diet, physical activity, sexual behaviour, drugs, smoking and alcohol consumption as a cause of ill health. The strategy focuses on the four areas of cancer, coronary heart disease and stroke, accidents and mental health, with specified targets to be achieved by 2010.

Proposals for wider action on public health include the development and implementation of a national alcohol strategy by 2004. This will aim to "encourage people who drink to do so sensibly in line with guidance so as to avoid alcohol-related problems, protect individuals and communities from anti-social and criminal behaviour related to alcohol misuse, and provide services of proven effectiveness that enable people to overcome their alcohol misuse problems".
The Strategy

The targets set out in 'Saving Lives' and the National Service Frameworks (together with locally agreed targets) are to be translated into action via Health Improvement Programmes.

Opportunities

- Concentration on lifestyle factors includes alcohol misuse as a major cause of ill health.
- Alcohol misuse is a risk factor in the four national priority areas of cancer, coronary heart disease and stroke, accidents and mental health.
- The Government intends to implement a national alcohol strategy by 2004.
- Alcohol misuse can be identified in Health Improvement Programmes and the links between alcohol misuse and the national priorities explicitly made.

Threats

- Alcohol misuse is a low priority compared with other lifestyle factors such as smoking and illicit drug use.
- There are currently no national targets for alcohol misuse.
- The majority of Health Improvement Programmes include little about alcohol misuse with no local targets set.

Economic Environment

Expenditure on alcohol

The total household expenditure on alcohol in the UK in 2000 was £33 billion (ONS Consumer Trends 2000). The Family Expenditure Survey 1999-2000 (Office for National Statistics 2000b) reported an average weekly expenditure on alcohol of £15.30, representing 4.3% of the total weekly expenditure.

Tax revenue

UK tax revenue from alcoholic drinks was £11 billion in 1999, representing 3.5% of total tax revenue.

Cost of alcohol misuse

The financial cost of alcohol misuse in England has been estimated as at least £10.8 billion a year (Alcohol Concern 1999). Of this, the inpatient costs to the NHS alone have been estimated at £3 billion (Royal College of Physicians 2001). Societal costs, including sickness and absenteeism from work, accidents, premature deaths and alcohol-related crime, have been estimated to be a further £3 billion (Godfrey & Hardman 1994).

Government spending on alcohol prevention and treatment has been estimated at £95 million per annum. This should be compared with £1.5 billion on services for illicit drug abuse. The drinks industry spends £227 million a year on advertisements for its products (Alcohol Concern 2001).

Opportunities

- £15.5 million has been made available in a new joint Drug, Alcohol and Tobacco Prevention Grant (Alcohol Concern 2001). At least a third of these funds could be earmarked specifically for alcohol.
- The implementation of the Government alcohol strategy would raise the profile of alcohol-related problems and set national priorities for alcohol, which would encourage local health and social care commissioners to commit funds to provide alcohol services.

Threats

- There is a dominance of Government spending on illicit drugs to the detriment of investment in alcohol services.
- Health and social care commissioners are reluctant to commit funds to alcohol services in the absence of a national strategy and specific alcohol targets.

Social Trends

Although the proportion of men drinking more than the medically recommended levels has remained fairly stable over the last ten years, the number of women exceeding these levels has increased by almost 50%. This increase has been attributed to a combination of factors, such as increased purchasing power, acceptability of drinking by women and availability of alcohol for home consumption (Alcohol Concern 1999).

The proportion of 16 to 24 year olds who regularly exceed the safe limits has also increased to 36% of men and 25% of women. Young men and women are drinking more heavily than before and, for many, binge drinking (regularly drinking more than 6 units on a single occasion) has become the usual pattern of consumption. This trend has not only been associated with increased purchasing power and access to alcohol but also with the increased advertising and availability of 'new' designer drinks with higher alcohol content and the proliferation of drinks promotions and 'happy hours'.

Teenagers are also consuming larger quantities of alcohol. The European School Survey Project on Alcohol and other Drugs (ESPAD: Hibbel et al. 2000) found that nearly 40% of young people in the UK had been drunk by the time they were 13 years old and almost a third reported binge drinking at least three times in the last 30 days.

Opportunities

- PHC professionals could specifically target young adults for alcohol SBI, with tailored health information and advice on the effects of binge drinking.
- Alcohol SBI could be implemented in other locations accessible to young people, such as young people's services, clinics, youth centres, schools and colleges.

Threats

- PHC professionals have to 'compete' with the power and resources of the drinks industry and the enormous amounts of money spent on alcohol advertising targeted specifically at young people.
- Young people traditionally do not access PHC as often as other age groups.

Technological Trends

Screening Tools

A number of methods can be used to detect hazardous and harmful drinkers, including physical examinations, quantity/frequency questions relating to alcohol consumption, laboratory markers such as GGT tests and the use of drinking diaries. The past ten years, however, has seen an increase in the development and use of screening tools to detect hazardous drinking and/or alcohol dependence. These have been developed for use in a variety of settings, including in-patient, A&E and PHC, and have varying levels of sensitivity and specificity.

- The Alcohol Use Disorders Identification Test (AUDIT: Saunders et al. 1993), AUDIT-C (Bush et al. 1998) and Five-Shot Questionnaire (Seppa, Lepisto & Sillanaukee 1998) have been developed to detect hazardous and harmful drinking in PHC settings

- The brief Michigan Alcoholism Screening Test (MAST: Pokorney, Miller & Kaplan 1972) and CAGE (Mayfield, McLeod & Hall, 1972) can be used to detect more severe alcohol dependence
- The Paddington Alcohol Test (PAT: Smith *et al.* 1996) has been developed to detect hazardous and harmful drinking in A&E departments
- Although originally developed for use in A&E departments, the FAST (Hodgson *et al.*, 2002) is being widely used in primary health care and identifies over 50% of responders with just one question

Information Technology

The NHS Plan (2000) aimed to modernise the use of information technology and electronic patient records in primary care by 2005. All GP practices are now connected to the NHSnet, giving patients improved diagnosis, information and referral. NHS Direct aims to provide a one stop gateway to health care for patients and will be providing health information via digital TV, as well as via telephone and the internet, by 2004. 500 NHS Direct information-points providing touch screen information and advice about health and the health service are also planned for places such as shopping centres and railway stations. In addition, the National Electronic Library for Health (NELH) is intended as a portal of entry for all NHS Direct and Department of Health guidelines and other information for patients and health professionals.

Opportunities

- There are a number of suitable screening tools developed specifically to detect hazardous and harmful drinkers in PHC
- Screening tools with patient specific advice and information could be provided for GP practices with modernised IT systems
- Screening tools with patient specific advice and information could be accessed directly by patients via NHS Direct and internet sites.
- Important information on SBI could be made available on the NELH.

Threats

- Alcohol specific screening tools may be regarded as too focused and threatening for patients.
- Practices differ considerably in their access to, training in and use of IT.

Marketing ‘Mix’

Product / Service Development

The WHO Collaborative Project on Identification and Management of Alcohol-related Problems in Primary Health Care began in 1982. Phase I of the project was the development of a valid and reliable screening tool to detect people at risk from drinking at hazardous and harmful levels. The AUDIT (Alcohol Use Disorders Identification Test) was developed and tested in six centres across the world (Australia, Bulgaria, Kenya, Mexico, Norway and the USA) for use by health workers in both developed and developing countries (Babor *et al.* 1989; Saunders *et al.* 1993).

The AUDIT is a 10-item self-report instrument which includes 3 questions on the amount and frequency of drinking, 3 questions on symptoms of alcohol dependence and 4 questions on personal and social problems associated with alcohol misuse. The questionnaire takes around 2

minutes to complete. A score of 8-12 for men and 7-12 for women indicates a strong likelihood of hazardous and harmful alcohol consumption. A score of 13 or more indicates evidence of significant alcohol dependence and further assessment is advised. The ability of the AUDIT to accurately detect excessive drinkers (i.e. its sensitivity) is 92%, and to exclude false cases (its specificity) is 93%.

Phase II of the project was a cross-national randomised controlled trial to evaluate the effectiveness of brief alcohol interventions in PHC (Babor & Grant 1992; Babor et al. 1994). The SBI package used comprised: a promotional pamphlet; programme guidelines for GPs and also receptionists; the AUDIT questionnaire (to be completed by the patient); a scoring template for GPs to assess patients' scores quickly; an advice handy-card for GPs to use with patients containing information on safe levels of alcohol, the benefits of cutting down and advice on behaviour change and goal setting; and a self-help booklet for patients to take home.

Ten countries (Australia, Bulgaria, Costa Rica, Kenya, Mexico, Norway, the former Soviet Union, UK, USA and Zimbabwe) were involved, recruiting a total of 1655 heavy (but not severely dependent) drinkers to the study. In the core design, participants were randomly allocated to one of three groups: a control group who received a 20 minute assessment but no intervention; a simple advice group who received assessment followed by 5 minutes of advice and a leaflet about sensible drinking; or a brief counselling group who received assessment followed by 20 minutes of counselling and a 30-page problem-solving manual about controlled drinking.

For male participants, the results showed a significant reduction in reported levels of alcohol consumption at follow-up for both the intervention groups, with 5 minutes of simple advice being as effective as 20 minutes of brief counselling. Participants in the intervention groups reduced their alcohol consumption by nearly 25% compared with the control group. For female participants this reduction was around 10% compared with the control group. However, there were significant reductions in both intervention and control groups, suggesting that for women there may be an effect from the assessment itself. Overall, it has been estimated that around 20% of patients identified as hazardous or harmful drinkers who receive a brief intervention will reduce their alcohol consumption.

Price/Cost

The direct cost of delivering one SBI has been estimated as less than £20 (Effective Health Care Bulletin 1993). Direct cost refers to the time of professionals (GP or practice nurse) administering the screening tool and the intervention, and the cost of the materials used in the intervention. Costs will depend upon who delivers the SBI, the method of delivery (e.g. opportunistic or in specified clinics), the screening tool used and the length of the intervention. Associated costs will include the costs of training health professionals, any mechanisms to encourage them to intervene with patients, any support services provided and any increase in referral to the specialist services.

Place/Location

PHC is an ideal location to deliver SBI. Depending on the preferred method of delivery, this could take place within GP consultations, specified clinics or new patient registrations, etc..

Promotion

The aim of the communications strategy is to promote an understanding among the target audiences of the concept of "risky drinking", i.e. drinking above medically recommended levels and the elevated risks of harm associated with drinking at increasing levels. This is primarily a

lifestyle issue and needs to be distanced from concepts of “alcoholism” or severe dependence. Positive messages in relation to moderate drinking and healthy lifestyles need also to be communicated.

The key messages to link all aspects of the communications strategy include:

1. How much is too much? What the recommended sensible /‘healthy’ levels of drinking are.
2. What is ‘risky’ drinking? How drinking too much puts us at risk of a wide range of health and social problems.
3. How many of us drink too much? Why this is an important public health /primary care issue.
4. What can be done to help? How GPs and practice nurses can advise patients on healthy lifestyles and effectively reduce risky levels of drinking.

The objectives of the communications strategy are as follows:

1. Identify and segment the target audiences
2. Identify information to be provided for each target audience and message content
3. Identify the best means of delivering this information, e.g. words, graphics, video, multi-media
4. Identify the most appropriate communication vehicles for each, e.g. mail, telephone, web site, TV, radio, billboards, posters in waiting rooms, workshops, seminars, presentations, conferences, etc.

Communications Strategy

Target Audiences

There are three broad target audiences for the strategy:

1. Primary Health Care Professionals.

In this report, the term PHC professionals refers to those based at or attached to general practice settings, e.g. GPs, practice nurses, health visitors, etc..

2. Stakeholders.

The term stakeholders refers to any individual or organisation that has a vested interest in the implementation of SBI in PHC, the reduction of alcohol-related health and social problems, the improvement of public health and safety and the associated cost savings to the NHS.

3. The General Public.

The wider general public refers to all individuals in England, including targeted sectors such as young people, older adults, parents, professional and non-professional groups, ethnic minorities etc., where appropriate.

Primary Health Care Professionals

The main aims of the strategy for PHC professionals are as follows:

- to raise initial awareness of ‘risky’ or excessive drinking and alcohol-related problems
- to develop widespread interest in SBI for excessive drinkers in PHC
- to encourage the uptake of SBI and related training programmes in PHC
- to promote the implementation of SBI in practice.

Information Needs

Barriers and facilitators to the implementation of screening and brief interventions in PHC have previously been identified (Kaner et al. 1999; Kaner 1999). These have a number of implications for the type of information that needs to be communicated to PHC professionals to encourage and enable them to carry out SBI in practice.

Barriers to alcohol intervention work include:

- health professionals' confusion over the recommended (weekly and daily) levels
- difficulties converting drinks, bottles and cans etc. to units
- the complexity of discussing alcohol with patients (how much alcohol is beneficial and how much is harmful)
- uncertainty as to the differences between excessive drinkers, problem drinkers and 'alcoholics'
- the need for clarification on the size of alcohol-related problems (nationally and locally)

Incentives for brief alcohol intervention work include:

- readily available information on support services to refer patients to
- dissemination of evidence of the effectiveness of SBI
- suitable screening tools and materials relating to alcohol intervention
- clarification of the impact of alcohol on health
- clarification of the official recommendations regarding sensible drinking
- suitable leaflets, posters etc. for patients to read in the waiting room
- identifying related physical and psychological conditions to "trigger" or prompt SBI
- information on the risks to health with facts and figures made available.

A nation-wide Delphi Study to obtain consensus of opinion on how best to implement SBI in PHC asked a selected 'expert' panel how the concept of risky drinking could best be communicated to PHC professionals. Findings show that, in terms of *content*, there was consensus of agreement that 'clear consistent information on the government recommendations' and 'stressing the relevance to their (PHC professionals) work' should be provided.

Recommendations

The findings indicate that clear information is needed for PHC professionals in the following areas:

1. A **consistent** message regarding the medically recommended (daily/weekly) levels and information on units;
2. Up-to-date information on the conversion of drinks (bottles, cans etc.) to units, e.g. using a "ready reckoner" unit calculator;
3. The positive as well as negative effects of alcohol, with definitions of "risky" or hazardous and harmful levels;
4. The links between alcohol and health/social problems, including links to the national priority areas identified by the Government in "Saving Lives: Our Healthier Nation";

5. Statistics on the extent of alcohol-related problems both nationally and locally;
6. Information on common alcohol-related problems/conditions likely to present in PHC;
7. Facts and figures on relative risks;
8. Evidence of the effectiveness of SBI in primary care;
9. The availability of local support services, clear referral procedures and guidelines (developed by the primary care team and local alcohol services);
10. Provision of appropriate leaflets and posters for patients in the waiting room (targeting identified patient groups).

Communication Channels

This information should to be communicated to PHC professionals via appropriate and effective channels. These will differ according to the purpose of that information, i.e., whether it is to raise initial awareness, to disseminate SBI and training packages, or to educate/train professionals in carrying out SBI.

1. Raising awareness of alcohol-related problems and SBI

In focus group discussions, both GPs and practice nurses identified ‘presentations’ or discussions at existing meetings (i.e. by an invited speaker) as being the most effective method of initial awareness-raising. The speaker should be a key identified person (opinion leader) for each particular audience, e.g. an appropriate local consultant or prominent GP for GP meetings. Several dates/times should be offered to access most professionals.

GP postgraduate education meetings (accredited where possible) were identified as a useful channel of communication, particularly as Primary Care Group/Trust (PCG/T) education and training strategies are linked closely to service development. PCG/T training and committee groups for practice nurses were also suggested as being appropriate and effective channels where these exist.

Participants who attended the focus groups, however, were more likely to be representative of those professionals who attend meetings generally. For those professionals who are not able or willing to attend such meetings, practices should be offered the option of having a speaker attend one of their scheduled practice team meetings. These meetings could also be accredited by the PGEA and attendance certified for other members of the team.

The Delphi study expert panel agreed that ‘improved training and education’, ‘utilising PCGs/PCTs’, ‘direct communication between PHC professionals ensuring that alcohol features as an element in all priorities and discussions’, ‘training packages – videos, books CD-ROMs’, ‘articles in health journals’, and ‘a National Alcohol Strategy sending a clear message’ were the most useful ways of communicating to PHC professionals.

2. Dissemination of SBI package and training programme

Phase III (Strand III) of the WHO project was a randomised controlled trial to evaluate the effectiveness and cost-effectiveness of different marketing, training and support strategies in the dissemination of SBI in PHC. 614 GPs were randomly assigned to one of three marketing strategies: postal marketing, telemarketing, and personal marketing. 321 GPs (52%) agreed to

take the programme and 128 of those also agreed to use it for 3 months. The study found personal marketing to be the most effective overall dissemination strategy but telemarketing to be the most cost-effective (Lock et al. 1999).

A review of the Cochrane Effective Practice and Organisation of Care Group (EPOC) literature on what is and what is not effective in changing professional practice and promoting effective innovations found:

- Consistently effective methods include educational outreach visits (academic detailing), reminders or prompts (manual or computerised) at the time of consultation, multifaceted interventions (combination of two or more methods) and interactive educational meetings.
- Sometimes effective methods include audit and feedback, local opinion leaders, and patient mediated interventions (information leaflets or patient held prompts).
- Little or no effect was found of didactic educational meetings or the distribution of printed guidelines.

3. Training primary health care professionals in SBI

In the Phase III study (described above), the 128 GPs who used the SBI programme were randomly allocated to one of three training and support groups: a control group who received the programme with written guidelines only; a training group who received the programme plus practice-based training in the programme's usage, and a training and support group who received the programme, practice-based training and a support telephone call every two weeks. Practice-based training with telephone support was the most effective and cost-effective strategy for encouraging implementation (Kaner et al. 1999).

Similarly, in focus group discussions, most GPs, practice nurses and PHC teams preferred practice team-based rather than individual professional training when considering practical training in SBI.

Recommendations

1. Raising awareness of alcohol-related problems and creating interest in SBI via interactive professional group (education and training) meetings and/or in-house practice team meetings.
2. Dissemination of SBI package and training programme to practices via (follow-up) telemarketing.
3. Provision of interactive practice team-based training with ongoing telephone support.

Summary

Communications Strategy for Primary Health Care Professionals

Objective	Channel	Content	Format
Raising awareness	<ul style="list-style-type: none"> ▪ Professional (GP/Practice Nurse) education/training group meetings ▪ Individual practice team meetings 	<ul style="list-style-type: none"> ▪ Alcohol-related problems (health and social) ▪ Size of problems (nationally and locally) ▪ Public health/primary care issue ▪ Recommended levels ▪ 'Risky' drinking vs alcoholism ▪ What is SBI ▪ Evidence of effectiveness of SBI 	<ul style="list-style-type: none"> ▪ Presentation and discussion ▪ Overhead slides ▪ Handouts ▪ Printed SBI materials for demonstration ▪ Web site
Dissemination	<ul style="list-style-type: none"> ▪ Telemarketing by GP or nurse ▪ Follow-up from awareness-raising meetings 	<ul style="list-style-type: none"> ▪ 'Risky' drinking and primary care ▪ SBI programme details ▪ Training programme details 	<ul style="list-style-type: none"> ▪ Telephone call and 'script'
Provision of SBI tools / materials	<ul style="list-style-type: none"> ▪ Published screening tools ▪ Intervention materials ▪ Clinical guidelines 	<ul style="list-style-type: none"> ▪ Clinical guidelines for SBI and appropriate referrals ▪ Screening questions and scoring ▪ Information on units, sensible, hazardous and harmful levels, benefits of cutting down, strategies for cutting down etc for patients ▪ Available support services 	<ul style="list-style-type: none"> ▪ Written guidelines and decision making diagram/flow chart ▪ Screening tool and scoring template ▪ Unit calculator ▪ BI materials (advice card, handy card, booklet) ▪ CD ROM version ▪ Posters and leaflets for waiting room ▪ Directory of support services ▪ Web site
Training	<ul style="list-style-type: none"> ▪ Practice team based training sessions (accredited) 	<ul style="list-style-type: none"> ▪ Recap of session for raising awareness (see above) ▪ Use of screening tools ▪ Stages of change (Helping people change) ▪ Brief interventions ▪ Motivational interviewing ▪ Diagnosis and treatment of dependence 	<ul style="list-style-type: none"> ▪ Overhead slides ▪ Handouts ▪ SBI Materials ▪ Interactive exercises ▪ Video ▪ Role play

		<ul style="list-style-type: none"> ▪ Available support services and referrals ▪ Audit and feedback mechanisms 	
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Stakeholders

The aims of the strategy for identified stakeholders are:

- to promote ownership of and active involvement in a SBI implementation strategy for PHC.
- to promote ownership of and active involvement in a general public awareness campaign.

Key stakeholders to target for ownership of/involvement in a SBI implementation strategy include:

National	Local
Top Down Approach	Bottom Up Approach
<ul style="list-style-type: none"> ▪ Department of Health ▪ BMA ▪ Royal College of Physicians ▪ Royal College of General Practitioners ▪ Royal College of Psychiatrists ▪ Royal College of Nursing ▪ Medical Council on Alcoholism ▪ Nursing Council on Alcohol ▪ Alcohol Concern ▪ Health Promotion England ▪ Health Development Agency ▪ The Portman Group 	<ul style="list-style-type: none"> ▪ PCT managers/commissioners ▪ NHS trusts ▪ A&E departments ▪ Health improvement groups (linked to HImPs) and HAZ operational groups <ul style="list-style-type: none"> ▪ CHD and stroke ▪ Cancer ▪ Mental health ▪ Older people ▪ Child health ▪ Alcohol and drugs ▪ Accident prevention ▪ Health partnerships (locality based) ▪ Alcohol services (including voluntary agencies) and DATs

Key stakeholders to target for ownership of/involvement in a general public awareness campaign include:

National	Local
<ul style="list-style-type: none"> ▪ Department of Health ▪ Health Promotion England ▪ Home Office ▪ DETR (drink-driving campaigns) ▪ Alcohol Concern ▪ The Portman Group ▪ National media (TV, radio, newspapers etc) 	<ul style="list-style-type: none"> ▪ NHS health promotion departments ▪ Relevant local authority departments (education, leisure, social services, economic development, licensing etc) ▪ Umbrella voluntary organisations ▪ Community organisations ▪ Universities, colleges, schools ▪ Local businesses and employers (Business Links, CBI) ▪ Emergency services (Police, fire and ambulance) ▪ Community safety groups ▪ Domestic violence groups ▪ Pubs, clubs, drinks industry ▪ Sports and leisure organisations (local authority

	and private) <ul style="list-style-type: none"> ▪ Healthy Cities/schools/workplaces schemes ▪ Local media (TV, radio, newspapers etc)
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Links should be made with existing strategies, programmes and campaigns where possible e.g. via HAZ groups, Himps etc.

Information needs

The key messages that need to be communicated include:

- the ‘safe’ and ‘risky’ levels of drinking
- the health and social problems associated with excessive drinking
- the estimated costs of alcohol-related problems to the NHS and industry
- the links to existing health and social policies, priorities and programmes
- evidence of effectiveness/cost-effectiveness of SBI

Communication Channels

Effective communication channels will differ between stakeholders and need to be carefully researched for specific organisations. Options include attending relevant meetings, presentations at local and national conferences, written articles in existing stakeholder publications and providing local seminars and workshops. Utilising an enthusiastic PCG/T, finding a local ‘champion’ to push things forward and setting up an Alcohol Health Improvement Group linked to the health improvement programme would also help to raise the profile of alcohol-related problems.

Recommendations

1. Utilisation of the WHO Phase IV National Strategic Alliance to work together to promote the widespread implementation of SBI
2. Further building of a Local Strategic Alliance to promote the implementation of SBI in the local area and link with existing strategies and campaigns
3. Staging of a national conference to bring together members of the Alliance and key stakeholders, with interactive workshops to further the development of the implementation strategy and encourage ownership
4. Dissemination of SBI research and an implementation programme via stakeholder meetings, conferences, publications and the internet.

The General Public

The aims of the strategy for members of the general public are to:

- Raise awareness of ‘safe’ and ‘risky’ levels of drinking
- Raise awareness of alcohol-related problems (including longer-term health problems)
- Highlight the benefits of drinking sensibly
- Encourage people to ask their GP or practice nurse for alcohol-related information and advice

An effective communications strategy for the general public cannot be ‘one size fits all’. Segmentation into defined target groups, e.g. by age, sex, drinking pattern and associated risk is necessary to tailor message content, format and communication channels. Options for segmentation include:

- Young people (aged 16-24): binge drinkers, concerned with the short-term and physical effects of alcohol misuse, e.g. risky sex, teenage pregnancy and STDs, accidents, mixing alcohol and other drugs etc.
- Parents: their influence on children's awareness of the effects alcohol and drinking behaviour, parental drinking and problems of arguments, violence and abuse
- Professional and non-professional groups: absenteeism and poor performance at work as a result of drinking, driving the morning after a 'heavy' drinking session when still over the limit
- Older adults: drinking with medication, risk of accidents and falls
- Ethnic minority groups: access to culturally appropriate information in different languages

Information

The panel in the Delphi Study were asked how the concept of risky drinking could best be communicated to the general public. There was consensus of agreement that the *content* of such messages should include 'using different information for different groups e.g. young, pregnant', 'a new language away from 'alcoholic'', 'identifying and conveying the risks of drinking at different levels', 'clear consistent information on government recommendations', 'consistent risk messages, not just at Christmas' and 'strong images and information on alcohol-related consequences'.

In focus group discussions, PHC professionals generally thought that patients did not know how much they should or should not be drinking (i.e. the recommended levels), or how many units were in certain drinks (e.g. thinking that a standard pint of beer is one unit rather than two). This was especially felt to be the case in relation to new drinks such as alco-pops and stronger wines and lagers (n.b. many of the professionals in the focus groups were not sure of the number of units in these either). It was also felt that drinking 40 units a week, for example, is considered by many people to be normal and acceptable and is not thought of as excessive. Professionals believed that patients do not generally make the link between excessive drinking and ill health (unlike smoking).

A recent MORI survey of the general public reported that:

- 50% think they are fairly well informed about alcohol associated risks
- 27% would like more information
- 66% had heard of units
- 58% say they had heard of weekly limits and say they know what these mean
- 67% have never heard of daily benchmarks
- 45% agree that they do not take much notice of health promotion campaigns on alcohol
- 44% would like more information on associated risks

In focus groups with patients, many participants had a reasonably accurate idea of the recommended weekly or daily levels of alcohol consumption, and that these levels differed for men and women. The men in the younger age group (aged 18-19), however, were both uncertain and incorrect in their estimates, although they were aware of the unit system and what the equivalent was in terms of different drinks. In general, older men and women were not as sure of how many units a drink contained.

Participants were aware of a number of different problems associated with excessive drinking. Examples given included social, behavioural and health problems, such as crime, aggression, violence, family problems, road accidents, liver damage and stroke. Young male binge drinkers were more inclined to discuss the short-term physical problems of drinking too much, such as feeling sick and dizzy or having accidents, and did not seem aware of the longer-term physical

problems related to excessive drinking. Information about alcohol units and alcohol-related problems had been obtained from various sources, including reading about it in newspapers and magazines, seeing TV coverage, drinking and driving adverts, and seeing a poster in a GP surgery.

All participants agreed that more information about alcohol and alcohol-related problems should be made available to the general public. Suggestions included the provision of information on both the positive as well as negative effects of alcohol to provide a balanced viewpoint, the long-term health effects of excessive drinking, and where to go for information, advice and help. The younger men also suggested that information on the effects of mixing alcohol with illicit drugs would be useful for their age group, and both younger men and women called for greater 'shock' tactics.

A Tyne and Wear Health Action Zone focus group study on binge drinking and young people (aged 16-20) found that participants had a minimal knowledge of units and generally felt that the units system was not relevant to them and that they would not use it (Cooke & Eadie 2001). Most had never made any attempt to monitor their drinking and had no intention of doing so in the future. The majority were unfamiliar with the term 'binge drinking' but defined excessive drinking in physical terms or in relation to the consequences of their behaviour. These were immediate consequences such as hangovers, being sick, losing your friends, having your drink spiked and street violence. Long-term risks were rarely considered and often dismissed as being irrelevant.

In terms of attitudes to health messages, participants claimed that they would not pick up health education leaflets on alcohol in public, despite seeming interested in their contents when shown copies. Many took leaflets away with them following the focus group. However, it is reported that some of the statements in the leaflets were met with "hysteria and ridicule" in the younger unemployed groups, and the authors suggest that "care needs to be taken to pitch information at appropriate levels of maturity and understanding". The report suggests that "a harm minimisation approach has the potential to improve young people's existing personal safety strategies".

Recommendations

1. A consistent message regarding the medically recommended (daily/weekly) levels and up-to-date information on unit content in drinks.
2. The increasing risks of harm associated with drinking at increasing levels including the long-term health effects.
3. Excessive drinking is a lifestyle issue and needs to be distanced from concepts of "alcoholism" or severe dependence.
4. Positive messages in relation to moderate drinking and healthy lifestyles should be communicated, e.g. promoting good health, safety and enjoyment.
5. Information on where to go for information and advice (i.e. local GP or practice nurse) should be provided.
6. Identified messages need to be targeted at the corresponding groups using the right wording, images and formats.

Communication/Dissemination Channels

Appropriate and effective communication channels also need to be tailored to the specific target sub-groups. In focus group discussions, PHC professionals identified having leaflets, posters and displays for patients to read in the waiting room or in community areas such as libraries, sports facilities, shopping centres etc. as a facilitating factor in implementing SBI. It was suggested that these could also include the AUDIT questionnaire with details about contacting the local GP or practice nurse for more information. Health promotion computers for people to access voluntarily were also suggested.

Both GPs and nurses said that they do not tend to see young people, particularly young men, as much as other groups in primary care. Young women tend to be seen mainly in relation to contraception advice. It was felt that this group would be more effectively targeted outside of general practice, e.g. in young people's services, clinics, youth centres, colleges, etc.. Details of appropriate web-sites such as "Wrecked", a web-site about alcohol misuse aimed at young people developed by Health Promotion England, could be included in targeted information.

Media campaigns were considered to be essential to raise the public's awareness of alcohol misuse and related problems and to make it easier to discuss alcohol issues in primary care. The 'flu vaccine campaign was viewed to have been so successful because celebrities (Bobby Robson, Henry Cooper) were used in the adverts. Government health warnings on labels and alcohol advertising (similar to cigarette advertising) were also suggested.

Suggestions from focus groups with patients included increasing the size of labelling of alcohol content and units on cans and bottles to make it more visible, and to have health warnings on labels and also on the shelving in supermarkets or shops where alcohol is sold. Participants agreed that the only way to get messages about drinking across to the public was to use the mass media and either advertise or place articles and stories on TV, in the newspapers and in magazines. It was also suggested that alcohol information should be made specifically available in schools and universities as well as GP surgeries.

In the Delphi study, there was consensus of agreement that the concept of risky drinking could best be communicated to the general public via the following: 'work in schools linked to smoking and sex education', 'media coverage', 'clear factual information (posters, leaflets) in practices', 'free telephone information lines', 'members of PHC teams to take responsibility for dissemination of information', and 'a National Alcohol Strategy sending a clear message'.

Nationally, the NHS Plan (2000) outlined a number of initiatives to provide patients with more information about how they can look after their own health. These include NHS Direct health information via digital TV as well as telephone and internet, and 500 NHS Direct information points providing touch screen information and advice about health in places such as shopping centres and railway stations.

Recommendations

1. Appropriate (and targeted) leaflets, posters, and displays should be made available in general practice waiting rooms and other identified health, community, educational and workplace settings. Health Promotion England provides support and resources to professionals in the field (free to NHS organisations) and run media campaigns. They promote sensible drinking with resources such as Drinkline (a free alcohol helpline), posters and leaflets. Links with

stakeholders would enable leaflets, posters and displays to be made available in the targeted settings.

2. A national media campaign (TV, radio, newspapers etc.) should be launched with the support of the Department of Health and Health Promotion England.
3. Alcohol information should be included in NHS Direct initiatives.
4. Working with initiatives such as “Healthy Cities”, “Healthy Workplaces”, “Healthy Schools”, “Arts in Health” etc. to encourage ownership, active participation and creative work by local communities.

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