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▶ Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence.

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Johnson M., Jackson R., Guillaume L. et al.
Journal of Public Health: 2011, 33(3), p. 412–421.
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UK-focused review for Britain's National Institute for Health and Clinical Excellence of what impedes or promotes the implementation of brief alcohol interventions at the level of the organisation, the staff doing the work, and the patients targeted by the programme.

Summary As part of their programme to develop public health guidance, this review was funded by Britain's National Institute for Health and Clinical Excellence (NICE) in order to synthesise evidence on barriers and facilitators to the implementation of screening to identify risky drinkers and to offer brief interventions to curtail the risk. Because these have been separately reviewed for NICE, the review excluded educational and school-based interventions. To be considered 'brief' for the purposes of the review the intervention had to last no more than half an hour. It also had be carried out by staff who did not specialise in the treatment of alcohol problems. The review was inclusive in terms of the type of study and the ages of the clients, though in the event no studies were found of children under 15 years of age. However, priority was given to selecting studies which elicited the views of professionals and patients, investigated the process of implementing screening and brief intervention, and were most relevant to current UK practice.

Conducted in 2008, the search identified 47 papers of which 22 documented studies in the UK and 35 evaluated interventions in primary care settings such as GPs' surgeries.

Main findings

Despite evidence of effectiveness, many service providers in primary and emergency care settings do not conduct alcohol screening and brief intervention programmes. Settings

which might also implement such programmes include medical services other than primary care, probation centres, and colleges, but how this might be done is under-researched.

What impedes or promotes the implementation of brief alcohol interventions can be considered at the level of the organisation responsible for the programme, the staff doing the work, and the patients targeted by the programme.

Organisational factors

Acceptability to patients is a major influence on the take-up of screening and brief interventions. Studies found that patients and staff felt these appropriate in contexts such as well-being clinics or registration sessions when lifestyle issues are commonly addressed and nurses involved in patient care. Concerned about 'being seen' to have a drink problem, patients preferred to see a GP or practice nurse rather than an alcohol specialist. They saw practice nurses as having more time to talk, while GPs were seen as more knowledgeable.

Organisational factors were among the most important barriers, including lack of financial incentives or managerial support, and workloads which limited the extent to which practitioners were able or willing to take on extra work. Delegating work to non-clinical staff – such as handing out screening questionnaires – can save time, though (more so than clinicians) receptionists were not keen on changing their roles or taking on this work unless adequately reimbursed. There was consistent evidence that implementation rates were improved by training, especially when this covered skills relevant to detection and management of people at risk of heavy drinking.

Staff factors

Despite organisational barriers, staff generally expressed positive attitudes to health promotion in primary care. Implementation of alcohol screening and brief intervention may be facilitated by involving all relevant staff in discussions from the planning stage onwards. However, a minority of health care professionals did not feel brief interventions were part of their role and some (particularly in emergency departments) referred patients to specialists.

Other barriers were feeling that one lacked the knowledge and confidence to give advice. Practitioners often were unaware of or confused by safe drinking guidelines, and nurses were anxious not to give the wrong advice. Some practitioners were concerned that raising the issue of drinking might upset patients or provoke aggression. In emergency departments, 'clinical inertia' hampered implementation, taking the form of a perceived lack of time or scepticism about formal screening tools as opposed to professional judgement.

In terms of actual delivery, advice on drinking typically lasted less than four minutes and was provided less often than patients expected and less often than advice on other lifestyle issues, such as exercise, diet and smoking. As few as one in three 'at-risk' drinkers were identified, possibly due to a reluctance to raise the issue unless there were clear signs of risky drinking. Detecting 'at-risk' patients requires a specific knowledge base that realistically takes into account levels and patterns of consumption for different sections of society without stereotyping individuals or groups.

Training was found to be more acceptable to nurses when delivered by a nurse, and is more successful when trainees are receptive to its aims and committed to alcohol interventions. But even after training, some professionals do not carry out interventions appropriately and some remain unmotivated, perhaps due partly to organisational barriers.

Patient factors

Staff are more likely to raise drinking with some types of patients than others. Studies have found that men, the unemployed and (depending on the cultural context) some racial groups were more likely to be intervened with, while – feeling they will 'grow out of it' anyhow – GPs may be unwilling to intervene with young risky drinkers.

Once risky drinking is detected, more or less immediate advice is most successful. If further appointments must be made, these should be soon. Studies have found that just 35% of patients attend appointments made in the emergency department, dropping by over half when appointments are two or more days ahead.

Experts have argued that, in order to facilitate implementation, brief interventions should be tailored to the needs of individual patients. Patients and professionals felt that a good rapport between them helped when discussing sensitive topics such as drinking.

Most patients have expressed positive attitudes toward screening and discussing drinking, though some users have felt embarrassed and uneasy, and some have as a result changed their GPs.

The authors' conclusions

This review found that primary care, and especially well-being clinics and new patient registration sessions, provides a potentially acceptable context for patients to discuss drinking. Effective implementation requires adequate financial and managerial support in terms of training opportunities and covering workload. Practitioners require sufficient confidence and knowledge to address drinking appropriately with at-risk individuals, without stereotyping particular groups.

In line with the ethos of brief interventions, patients prefer to discuss drinking with a GP or nurse rather than an alcohol specialist, but the extent to which this can be implemented may be restricted by workload and by limited resources and support. Clinicians are more likely to raise drinking with some types of patients than others. It is important to know which social groups drink most heavily, but there is a related risk of inadvertently creating health inequalities and missing individuals at need. For example, men and women in higher managerial employment have been shown to drink far more frequently than people without a job.

Patients appear to expect more discussion of drinking, yet real or perceived lack of knowledge and fear of upsetting patients prevents staff meeting this expectation. In contrast to GP consultations when the patient presents with a specific, usually non-alcohol related, condition, their emphasis on health promotion make well-being clinics and health check-ups a more acceptable context for alcohol screening and brief intervention.

Most of the reviewed studies were carried out in primary care. The evidence base is less

well developed for emergency care settings, where patients are more likely to have drunk immediately prior to their visit and are also often acutely ill or severely traumatised, complicating decisions about the appropriateness of screening for and discussing drinking problems. Instead of immediate intervention, clinicians may negotiate with patients to refer them for advice, creating a barrier in terms of time lapse. However, where appropriate, for some patients their emergency care visit constitutes a 'teachable moment' in respect of changing their drinking.

FINDINGS The featured review's emphasis on organisational factors such as adequate financial and managerial support, training opportunities, workload management, incentives, and clear direction from the top prioritising this work not just in theory but also in practice via the levers available to management, is in line with another recent review of the implementation of alcohol screening and brief interventions in primary care. Implementation efforts commonly fail most sharply at the first step of screening patients, when few may be asked about their drinking, but the review found that screening rates can be very high when organisations prioritise this enough to ensure staff keep records and hold them accountable for their performance in screening potentially at-risk patients.

The best example was the US health service for former military personnel which at 93% screened the highest proportion of eligible patients. Of those screening positive, 71% were counselled about their drinking. What distinguished this service from others was its extensive and systematic use of the organisational levers at its disposal to monitor, incentivise and support staff engaged in this work. This it was particularly well placed to do due to its hierarchical structure within which clinical staff are employees rather than independent contractors, its central administrative and research resources, and a culture of setting performance goals assessed by measurable efficiency and quality indicators.

On public health grounds, the prioritisation of alcohol screening and brief intervention in the UK has been legitimised by Britain's National Institute for Health and Clinical Excellence (NICE). Its guidance insists that health service commissioners and managers "must" provide the required training, resources and time to implement these programmes, at least in the types of context which the featured review found they were most acceptable.

Though there is a long way to go, Britain does seem to be making progress in implementing alcohol screening and brief intervention as intertwined political, policy and organisational influences create the conditions within which more staff may begin to feel this work is a required and valued part of their 'legitimate' duties. Most systematic has been Scotland. In line with national practice recommendations, national policy 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 years, 174,205 alcohol brief interventions were recorded across the three priority settings – primary care, accident and emergency departments, and antenatal services.

An evaluation of Scotland's national programme found that "healthcare staff see the delivery of [alcohol brief interventions] as a worthwhile activity for NHS staff". Actual implementation was however most successful in GPs' surgeries and other primary care settings. The barriers identified in the featured review remained evident particularly in

emergency care.

Based on the three health board areas where these figures were known, brief alcohol interventions were delivered to just over 6% of the estimated 100,000 alcohol-related attendances per year to Scottish emergency departments. Interviews with emergency department staff revealed that resistance to the programme (feeling that this was not their business and detracted from core activities and objectives) and time pressures sometimes led (contrary to the preferred option) to intervention being by appointment some time after screening rather than immediate, and this in turn reduced attendance rates. Screening rates probably too suffered from inadequate buy-in by staff, but might have suffered more had they had to cater for the possibility that a positive screen would mean they had to spend more precious minutes counselling the patient rather than simply making an appointment for some time in the future.

Primary care is the key setting and there too progress has been made but patchily and with some evidence of the 'tick box' approach identified in the national Scottish evaluation.

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 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.

The requirement to offer screening and intervention contracts to GPs certainly has generated more activity. So far implementation has however been patchy, 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.

For more on the implementation of brief interventions in primary care in Britain see the commentary to this Findings analysis, and for more on emergency department setting see this analysis.

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