DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study added to the Effectiveness Bank. The original study was not published by Findings; click Title to order a copy. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

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▶ Practices and attitudes of general practitioners in the delivery of alcohol brief interventions in Scotland.

Holloway A., Donaghy E.
Scottish Health Action on Alcohol Problems, 2017

Insight into what helps and hinders the delivery of brief alcohol interventions in general practice, from the perspective of doctors working in Scotland.

SUMMARY In response to the known harms of excessive drinking – to individuals, families, communities, and public services – the Scottish Government developed a "fresh strategic 'whole population approach' to its alcohol policy", summed up in the 2009 publication *Changing Scotland's relationship with alcohol: A framework for action*.

Delivering brief alcohol interventions in healthcare settings is a key part of the strategy. Brief interventions are short, evidence-based, structured conversations, and when applied to hazardous or harmful drinking aim to motivate and support a person to think about or plan a change in their drinking behaviour, even if this was not why they attended the service.

Each health board in Scotland is currently required to identify how they intend to sustain the delivery of brief interventions and embed them into routine practice. Within general practice, brief interventions can be delivered by doctors (in the UK known as GPs or general practitioners) and practice nurses.

The featured study, funded by the Scottish Health Action on Alcohol Problems (SHAAP), was initiated to identify what GPs characterised as the barriers and facilitators to delivering effective brief alcohol interventions based on their everyday work, and involved 13 in-depth, one-to-one semi-structured interviews with GPs across different parts of Scotland.

Key points
From summary and commentary

Interviews with GPs across Scotland reveal what helps and hinders effective delivery of brief alcohol interventions from the perspective of the doctor.

To continue to deliver brief interventions in routine practice (and increase the chances of them being effective) GPs should be supported by longer consultation times, and a simplified administrative system.

Brief interventions are seen as just one piece of the policy jigsaw to address harmful/hazardous drinking in Scotland. GPs see that they have an important role to play, but also stress the need for 'upstream' interventions to address wider social issues and health inequalities.

Main findings

Well-organised and appropriately supported training

Almost all GPs stated that they (and their colleagues) had received training in the last 1–2 years, and described it as helpful or very helpful. Undergraduate medical training, on the other hand, was minimal and/or of poor quality.

In addition to developing skills and knowledge, investment in staff training was perceived to be important in developing support for brief interventions at the grassroots level.

Time to fully discuss and personalise the brief intervention

A crucial factor in delivering an effective brief intervention was sufficient time for GPs to first unpack the reasons for, and levels of, the patient's harmful/problem drinking. This included taking into account the patient's biographical and social circumstances in a way that was meaningful to each individual patient.

All GPs spoke of the biggest and most frequent barrier to an effective brief intervention being the lack of time spent with a patient. One GP's comment was typical and representative of why lack of time with the patient can be and is a barrier:

> *"The main barrier to an effective [brief intervention]? That's easy. Time. Time. Time. Or more specifically a lack of time, which I'm sure you've heard before. Consultations are widely said to be 10–12 minutes but in fact they are not. I think nobody consults in ten minutes. Its eight minutes by the time you've looked at the notes, got somebody in the room and out the room. The consultation can be very busy [… and it is] difficult to tackle something that in fact the patient hasn't raised as an issue."*

Delivering an effective intervention can be more difficult in patients experiencing major stressful events such as relationship breakdown, divorce, family tensions, financial worries, changes to their benefits, and housing problems – especially because many patients respond to these events through harmful/hazardous drinking. GPs said that brief interventions are important, but so is complementary support to address what is influencing the harmful/hazardous drinking to begin with. This is especially the case in male patients who live alone and who have poor social support.

BARRIERS AND FACILITATORS TO GPs DELIVERING BRIEF ALCOHOL INTERVENTIONS

Barriers:
- insufficient time with the patient;
- poor information technology (IT) infrastructure;
- the stigma of alcohol support services combined with drug support services;
- lack of awareness among patients of what constitutes harmful/hazardous drinking;
- high levels of alcohol consumption viewed as 'normal' across Scotland;
- significant changes in a patient's social and personal life.

Facilitators:
- nationally organised and locally facilitated training;
- necessary time to identify harmful/hazardous alcohol consumption in the context of the patient's personal circumstances;
- financial incentive (Local Enhanced Service [LES]);
- strong IT infrastructure;
- good links between GPs and community support services;
- patient acceptance of problem drinking and willingness to change;
- good GP/patient relationship.

Some GPs said there are patients who independently raise their harmful/hazardous drinking, and this makes for a fuller and more direct discussion. This type of patient was perceived to be easier to raise the intervention with, and easier to motivate, as they had themselves recognised the need to address their problem.

Fast, easily accessible and user-friendly tools

GPs want rapid-access computer or information technology (IT) support to help record and monitor the outcomes of brief interventions. They said recording systems need to be as simple as possible if brief intervention activity is to be developed further, mainstreamed, and its impact evaluated.

A number of GPs noted slow or difficult-to-access IT support, which could result in a potential brief intervention not being flagged-up or a brief intervention being improperly recorded.

Signposting and links to community support groups

All GPs felt that primary care in general, and GPs in particular, were the most appropriate starting point in delivering brief interventions, but that local statutory community groups and third sector community organisations could be helpful in addressing a patient's harmful/hazardous drinking by providing supplementary support to the brief intervention.

A 'social prescribing' approach is one way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside interventions to improve health and wellbeing.

A few GPs stated that secondary care alcohol services being formally linked with drug misuse services can make it difficult for some patients with alcohol problems to attend these outpatient services because they fear the association with drug use will (further) stigmatise them.

The doctor–patient relationship

Knowing a patient well and/or having a good professional relationship with them was thought to be conducive to delivering an effective brief intervention. For this reason, locums (who may have a more transient relationship with patients) may not be as well placed to deliver brief interventions.

High levels of consumption, changing drinking patterns

GPs were of a view that alcohol is more readily available and more heavily marketed than ever before in Scotland. They said people in Scotland seem to be purchasing the vast majority of their alcohol through supermarkets, stores, and off-licences, rather than in pubs and clubs. As a result people are drinking more at home/other people's homes and consequently are not as conscious of how much alcohol they are consuming.

Many GPs stated that having a drink of alcohol, either at the end of an evening, with a meal or getting home from work is very common practice now, whereas 20 or 25 years ago people tended mainly to drink at weekends in the pub, in clubs, or with a meal in a restaurant. It is now much more common and also cheaper to buy and consume alcohol at home and have a drink after a stressful day.

Despite units of alcohol having been displayed on bottles and cans for some time, many patients still have little or a poor understanding of safe and unsafe drinking levels based on units of alcohol consumed.

Almost all GPs were in favour of Minimum Unit Pricing [for which see Effectiveness Bank hot topic].

The authors' conclusions

Brief interventions are seen by GPs as just one piece (albeit a very important piece) of the policy jigsaw to address harmful/hazardous drinking in Scotland. GPs perceived themselves to be 'downstream responders' to Scotland's relationship with alcohol. They emphasised the importance of 'upstream' interventions to address the harms of alcohol through population-wide policies, such as tackling inequalities in health, education, public safety, and housing.

GPs said that while they believe brief alcohol interventions in primary care can be effective, longer consultation times should be put in place if they are to continue to deliver them effectively. The administrative demands of brief interventions also need to be reduced to make it easier to entrench brief intervention activities into routine practice.

The report was produced with the aim of contributing to the updated alcohol strategy. The following recommendations were made:

- Continue the national brief alcohol intervention programme.
- Put in place appropriate funding to support brief alcohol intervention infrastructure, delivery and outcome monitoring.
- Maintain standardised brief alcohol intervention education programmes.
- Implement evidence-based 'upstream' population-wide public health policies that address social determinants of alcohol-related harm.
- Enact legislation to address price, availability and marketing of alcohol.
- Support social prescribing to complement brief alcohol intervention delivery.
- Invest in research to formally evaluate the brief alcohol intervention programme and its outcomes: establish a profile of those receiving brief alcohol interventions; and measure the quality and fidelity of interventions delivered and evidence the impact on health and non-health outcomes.

FINDINGS COMMENTARY Brief interventions in healthcare settings were a significant component of the Scottish Government's 2009 alcohol strategy, and the year before were prioritised in the 'HEAT H4' health improvement target. Between April 2008 and March 2011, the Scottish national health service was required to deliver 149,449 brief interventions across three priority settings: primary care, emergency departments, and antenatal care. Later it was extended to the delivery of 61,081 brief alcohol interventions during April 2011 to March 2012, with the aim of embedding these interventions in health service practice.

As documented in the Effectiveness Bank, the Scottish drive to implement brief alcohol interventions seems to have been most successful in GPs' surgeries, where there was perceived to be greater leverage and a

greater acceptance amongst staff. In the three health board areas where these figures were known, 83%, 84% and 92% of brief interventions were recorded as delivered in primary care. In contrast, 17%, 8% and less than 8% of interventions were delivered in emergency departments.

An Effectiveness Bank hot topic considers the potential for brief alcohol interventions to improve health population-wide, including the extent to which benefits generated in research projects can translate into routine practice.

Thanks for their comments on this entry in draft to research author Professor Holloway of the University of Edinburgh. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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