

Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners

Anders Beich, Dorte Gannik, Kirsti Malterud

Abstract

Objective To explore the suitability of a screening based intervention for excessive alcohol use by describing the experiences of general practitioners who tried such an intervention in their everyday practice.

Design Qualitative interviews with general practitioners who had participated in a pragmatic study of a combined programme of screening and a brief intervention for excessive alcohol use. Doctors were interviewed either individually or in focus groups. A computer based, descriptive, phenomenological method was used to directly analyse the digitally recorded interviews.

Setting and participants 24 of 39 general practitioners in four Danish counties who volunteered to take part in the pragmatic study were interviewed.

Results The doctors were surprised at how difficult it was to establish rapport with the patients who had a positive result on the screening and to ensure compliance with the intervention. Although the doctors considered the doctor-patient relationship robust enough to sustain targeting of alcohol use, they often failed to follow up on initial interventions, and some expressed a lack of confidence in their ability to counsel patients effectively on lifestyle issues. The doctors questioned the rationale of screening in young drinkers who may grow out of excessive drinking behaviour. The programme needed considerable resources, and it interrupted the natural course of consultations and was inflexible. The doctors could not recommend the screening and brief intervention programme, although they thought it important to counsel their patients on drinking.

Conclusions Screening for excessive alcohol use created more problems than it solved for the participating doctors. The results underline the value of carrying out pragmatic studies on the suitability of seemingly efficacious healthcare programmes.

Introduction

General practice is emphasised as a suitable place for screening programmes because of the frequency of encounters between doctor and patient. A consensus is emerging that screening for excessive alcohol use

followed by a brief intervention to modify drinking behaviour (box 1) should be implemented in general practice and that research should focus on the implementation of such programmes.¹ Studies have shown that the implementation of these programmes is far from straightforward.^{2,3} The bulk of evidence consists of efficacy studies rather than pragmatic studies. We interviewed general practitioners who took part in a pragmatic study of the effectiveness of a combined screening and brief intervention programme to ascertain their experiences of and opinions on the programme.

Participants and methods

The initial pragmatic study

A World Health Organization project aims to develop strategies for implementing screening and a brief intervention in primary care for excessive alcohol use.⁴ In 1997 in Denmark a research project (with AB as project leader) undertook to investigate the suitability, validity, and effectiveness of such a programme. In this project 39 general practitioners from four Danish counties volunteered to fully implement a screening and brief intervention programme for eight weeks in

Central Research Unit and Department of General Practice, University of Copenhagen, Panum Institute, DK-2200 Copenhagen, Denmark

Anders Beich
research fellow
Dorte Gannik
associate professor

Section for General Practice, Department of Public Health and Primary Health Care, University of Bergen, Ulriksdal 8c, N-5009 Bergen, Norway
Kirsti Malterud
professor

Correspondence to: Anders Beich
a.beich@pract.ku.dk

bmj.com 2002;325:870

Box 1: Screening and brief intervention for excessive alcohol use

The combined screening and brief intervention programme attempts to systematically identify hazardous and harmful non-addictive drinking by screening, typically using a questionnaire on drinking or on health in general

In the case of a positive screening result the doctor makes a more detailed assessment of the patient's drinking

If the assessment confirms the screening result the patient receives a brief intervention, typically comprising:

- Feedback on present drinking habits
- Information on the risks to health of hazardous drinking and on the benefits of sensible drinking, and
- Advice to cut down or avoid binge drinking

Self help materials are often supplied and follow up consultations offered

Box 2: Summary of a pragmatic study of a screening and brief intervention programme in general practice for excessive alcohol use

Overall objective

To establish the basis for deciding when to use a screening and brief intervention programme by studying:

- Aspects of excessive alcohol use among patients
- The validity of the AUDIT questionnaire in the intended context
- The real life effectiveness of a brief intervention among patients identified by screening
- The experiences of general practitioners who implemented the programme in their practice
- The literature on screening based interventions for use in general practice.

Methods and results

- Thirty nine general practitioners in four counties in Denmark volunteered to fully implement the WHO's screening and brief intervention programme for a study period of eight weeks in 1997-8. They all received one to three days of training. They offered screening to all eligible patients during the study period
- Of 7691 eligible patients 6897 (aged 18-64 years) were screened by completing the AUDIT questionnaire (the other 794 patients refused to participate)
- Screening showed that 1087 patients (15.8%) drank excessively
- Alcohol dependency was suspected in 181 patients (2.6%)
- Of the patients shown by screening to drink excessively (mean consumption 13 units a week), 906 (607 men) were randomised to a brief intervention group or to a control group
- 554 patients (61%) responded to follow up 12 months later
- Other results of the study are in preparation

1997-8 (box 2). The screening tool used in the programme was the alcohol use disorders identification test (AUDIT).⁵

Interviews with the general practitioners

We chose focus groups as a method for exploring the general practitioners' experiences.⁶ To validate the results of the focus group interviews (and because some views might not emerge in a group discussion) we also performed individual interviews with five additional doctors chosen from each end of a spectrum of views on the programme: three were enthusiastic interventionists while two had carried out the programme but were more sceptical about its effectiveness. The structure of the individual interviews followed that of the focus group discussions. All of the two hour group interviews and the one hour individual interviews took place 3-12 weeks after the period of the pragmatic study, before anybody knew the overall effectiveness of the programme, and all were audiotaped.

The focus group discussions were semistructured around specific questions (box 3) and took place in course facilities in two of the counties. Individual interviews took place in the doctors' surgeries. The doctors

were reimbursed for lost working time. All interviews took place in a reflective, relaxed atmosphere and also served a debriefing function.

Analysis of data

To minimise loss of shades of meaning and keep as close as possible to the original data we analysed the audio data directly rather than use transcriptions.⁷ We used the Qualitative Media Analyzer software (CVS Information System, Aarhus, Denmark) to analyse digital versions of the recordings. Group and individual interviews were analysed in parallel and the results presented together, as all interviews followed the same structure. The analysis used a modified phenomenological approach that aims to derive knowledge from everyday experience and to be descriptive rather than explanatory.^{8,9} The analysis comprised four steps: establishing themes for coding; classification of the units of meaning; abstraction and condensation; and synthesis into consistent statements.

Results

For practical reasons six of the 39 general practitioners in the original pragmatic study were not invited to a focus group or an individual interview. Of the other 33 doctors, 24 were interviewed—19 in the two focus groups (four in one group and 15 in the other) and five individually. These 24 doctors were representative of the whole sample in terms of age (mean 48 (SD 5) years), sex (28% women), number of years in practice (mean 13 (SD 7)), proportion in rural practice (25% in rural practices), and number of patients screened during the study period (mean 177). The background variables of the sample did not differ significantly from the average Danish general practitioner.

The analysis identified doctors' experiences relating to the relevance of drinking problems identified by screening, the programme's acceptability to the patient and doctor, and the doctors' sense of the programme's

Box 3: Interviews with general practitioners on their experiences with the screening and brief intervention programme

- The main question was "What are your experiences with screening and brief intervention?" The general practitioners were asked to:
 - Comment on which patients were located by the screening
 - Describe how patients reacted to the screening and intervention
 - Describe how they followed up the interventions
 - Reflect on the influences of screening and intervention on the doctor-patient relationship
 - Recall how they felt about their role in putting the programme into practice
 - Describe personal and other factors (such as self confidence) that might affect their ability to carry out the brief intervention (to establish rapport, ensure compliance with advice, and initiate a process of change)
 - Explain, having tried the programme, their opinions on screening for harmful or hazardous drinking
 - Say whether they would recommend the programme or parts of it to their colleagues

effectiveness. The analysis also identified some conclusions on whether the screening and brief intervention could be recommended.

Should screening target young binge drinkers?

The identification by the screening of a large group of young hazardous drinkers surprised most of the doctors. Many doctors felt that the prevention of alcohol problems in young people should chiefly take place earlier and elsewhere in the community and in their families. The doctors felt that systematic interventions for young drinkers were not a natural part of their job, and they questioned the rationale of screening in young drinkers, because they often grow out of hazardous drinking: "Most of them [young patients]—it's something they get over and get through after all. They quit and come to heel, don't they?" (group 2). Some doctors did think it was important to deal with drinking among young people, but they found it difficult to do so.

Truthfulness of the patients' responses

Most doctors were convinced that some patients did not respond honestly to the AUDIT questionnaire. Many heavy drinkers declined screening or gave poor excuses for not being able to participate, or they gave obviously false answers to the screening questions. Several doctors from smaller communities conveyed descriptions from patients or staff of how word of the screening got around and how some patients avoided visiting the centre during that period: "Some patients give false answers. They get a low score and are not in for counselling, so we don't waste our energy on them. That's a good thing about the questionnaire" (group 1).

Effects on the doctor-patient relationship

Almost all the doctors experienced negative reactions from some patients, ranging from uneasiness or embarrassment and lying about their drinking behaviour to finding another doctor. However, most doctors considered their relationships with their patients robust enough for them to give systematic advice on sensible drinking. The doctors said that the few negative reactions were counterbalanced by a positive reaction in most patients, who felt that the screening was implemented out of concern for their health and wellbeing: "Most of them react positively to having a doctor who cares to deal with more than just the usual humdrum" (group 2).

However, most patients in the intervention group who revisited their general practitioner had not been followed up on their drinking. Some doctors felt that they had been intruding into the private life of their patient and needed to leave the subject for a while. Others could not give reasons for their not following up on excessive drinking among their patients.

Difficulties of counselling patients on drinking

All doctors agreed that counselling on health is an important part of their work and that it should continue to be so. They saw advice on alcohol as an important part of such counselling, despite the fact that counselling is not easy and that counselling on alcohol easily implies an unwanted moral dimension: "There is nothing new in it, is there? We are health counsellors, it's the main part of our everyday work, this is what we spend most of our time doing" (doctor 5).

Most doctors found that the screening conflicted with establishing rapport (especially among middle aged and elderly patients), because it set an agenda in advance. They were generally surprised at how difficult it was to generate rapport and to ensure compliance with interventions to address risky drinking behaviour or to reduce harm and to arrange follow up consultations. Explanations given by the doctors included that screening was a clinically insensitive way of finding alcohol problems, that they lacked the right communication skills for the task, and, in some cases, that their own attitudes were inappropriate.

Some doctors said that they felt they had been just part of a campaign and did not always feel comfortable with their role in it, which was almost that of a judge or examiner: "It's the view of the patient you need to tackle, and their motivation and thoughts, and I had some difficulties sitting there with a questionnaire that supplies you with a score. It's like taking an examination, you go to the teacher and you're supposed to be judged" (group 1).

Some doctors said that a few patients may have been encouraged to take steps to modify their drinking behaviour, but in general the doctors were deeply sceptical about the effect of the intervention on patients' drinking behaviour. The patients' lack of interest in the follow up consultations seemed to confirm this scepticism. The doctors said that if any response was evoked it was among a few middle aged and elderly patients who were already highly motivated to modify their drinking behaviour.

Practical and skills constraints

Two important barriers to the effectiveness of the programme seemed to be lack of time and lack of training. Screening and assessment became a major addition to the workload in many practices. Ten minutes of intervention several times a day was experienced as stressful by the doctors, and the stress influenced the quality of the intervention. Several doctors believed that 10 to 15 minutes was too little time anyway, as alcohol problems were often part of much more complex problems.

Many doctors questioned their own attitudes and skills. They felt that were they to improve their counselling skills they might become more effective as health counsellors, although this would take time and training: "Maybe this just tells us that we need to spend more time training in communication and things like that when we're having such a hard time talking to patients about such things" (doctor 4).

Doctors' conclusions

Both focus groups and four of the five doctors who were interviewed individually concluded that they could not recommend screening for excessive alcohol use, nor would they screen their patients in the future. One doctor said he would think about ways of using the screening questionnaire in his practice.

Three arguments prevailed. Firstly, the screening and brief intervention programme was seen as awkward to implement in the normal flow of a consultation. It disturbed the agenda, and patients seemed to be distracted from the subject that made them seek health care in the first place. Secondly, doctors could not work in their usual patient centred way because of the agenda setting imposed by the screening. Thirdly,

the extra workload was too high, taking resources from other functions of general practice and in general disrupting the pattern of working together in the practice: "To me, just asking everybody about their drinking habits is in part comparable to if I had to do a rectal examination on all patients that came to see me" (group 2).

Discussion

Brief interventions on lifestyle matters are efficacious: they can work in ideal conditions and for selected patients.^{10–13} However, how general practitioners actually feel, think, and perform with respect to such programmes may diverge from the official rhetoric on health promotion programmes in general practice.^{14–16} Studies have shown that the implementation of screening and brief intervention programmes in general practice has not been successful, indicating that the promotion of screening packages has not resolved doctors' ambivalence.^{2–3}

The general practitioners who volunteered in our study to implement a screening and brief intervention programme in their own practice could not subsequently recommend it. They found it surprisingly hard to establish rapport and compliance with advice on drinking. They also questioned the rationale of screening in a population with a large proportion of young hazardous drinkers—a point that has some support in the findings of research into young people's drinking and remission of drinking problems.^{17–19} The doctors found that many heavy drinkers avoid screening or, when identified by screening, resist advice on modifying their drinking. Our findings support concerns that clinical health promotion programmes should take account of the professional, practical, technical, and ethical factors of a given context.²⁰

Consistency, range, and generalisability of the findings

To ensure a basic degree of reliability the first author (AB) consulted one of the coauthors for clarification of any question of interpretation in the analysis (especially during the abstraction and condensation step). Although the two focus groups differed in size they gave similar results, which were also similar to the results of the individual interviews, indicating the reliability of the findings.⁶

The participating doctors were probably more committed to lifestyle interventions than the average general practitioner. The generalisability of the results could therefore be questioned, but it is unlikely that general practitioners in general would have a more favourable attitude than our doctors to screening and brief intervention.

Conclusions

Our results underline the value of pragmatic studies of the suitability of apparently efficacious programmes before they are implemented on a wider scale. Screening based brief interventions might create more problems than they solve. Doctors would like the means to deal with a range of alcohol related problems, but the screening and brief intervention programme may fail to detect harmful drinkers, while requiring considerable resources for primary prevention in groups of hazardous drinkers with no current problems. The

What is already known on this topic

Efficacy studies have shown that in ideal conditions a brief intervention in primary care can lower alcohol consumption

Health authorities recommend the implementation of screening for excessive alcohol use and a brief intervention to modify drinking behaviour, but such screening and brief intervention programmes have not yet proved to be successful

What this study adds

General practitioners who have tried a screening and brief intervention programme in their practice find the extra workload onerous and have problems in establishing rapport with excessive drinkers located by screening

The programme disrupts normal patterns of work and cooperation in the general practice setting while failing to detect and deal with some problem drinkers

screening based brief intervention leaves the general practitioner with a sense of failure in achieving rapport and compliance and is thus not congruent with contemporary approaches to dealing with lifestyle issues in general practice.^{21–22}

We thank all 39 GPs for participating. We also thank the AlcoholGroup members (Sverre Barfod, Lene Carlsen, Lars Hansen, Arvid Jørgensen, Eli Sørensen, Thorkil Thorsen, Per Vendsborg, and Annelise Zachariassen) for ideas, support, and encouragement. Finally we thank Stephen Rollnick and Claire Lane of the Department of General Practice, University of Wales College of Medicine, for comments and advice.

Contributors: AB and DG planned and designed the study. AB carried out the interviews and performed the data collection and the first three steps of the data analysis, under the supervision of DG and KM. All authors were involved in the final step of the analysis. AB drafted the manuscript, while AB, DG, and KM jointly prepared the final manuscript. AB is guarantor for the study.

Funding: This study was supported by the Danish Ministry and Board of Health, the Association of County Councils in Denmark (the Forskningsfonden), and quality development committees in the counties of Vestsjællands Amt, Storstrøms Amt, and Bornholms Amt.

- 1 Babor TF, Higgins-Biddle JC. Alcohol screening and brief intervention: dissemination strategies for medical practice and public health. *Addiction* 2000;95:677–86.
- 2 Kaner EF, Lock CA, McAvoy BR, Heather N, Gilvarry E. A RCT of three training and support strategies to encourage implementation of screening and brief alcohol intervention by general practitioners. *Br J Gen Pract* 1999;49:699–703.
- 3 Hansen LJ, Olivarius N, Beich A, Barfod S. Encouraging GPs to undertake screening and a brief intervention in order to reduce problem drinking: a randomized controlled trial. *Fam Pract* 1999;16:551–7.
- 4 World Health Organization Collaborative Project on Identification and Management of Alcohol-Related Problems in Primary Health Care. Development of country-wide strategies for implementing early identification and brief alcohol intervention in primary health care. www.who.alcohol-phaseiv.com/index.htm (accessed 26 May 2002).
- 5 Saunders JB, Aasland OG. WHO collaborative study on identification and treatment of persons with harmful alcohol consumption. Report on phase I: development of a screening instrument. Geneva: World Health Organization, 1987.
- 6 Powell RA, Single HM. Focus groups. *Int J Qual Health Care* 1996;8:499–504.
- 7 Tesch R. Software for qualitative researchers: analysis needs and program capabilities. In: Fielding NG, Lee RM, eds. *Using computers in qualitative research*. Thousand Oaks, CA: Sage, 1991.

- 8 Giorgi A. Sketch of a psychological phenomenological method. In: Giorgi A, ed. *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press, 1985
- 9 Malterud K. Shared understanding of the qualitative research process: guidelines for the medical researcher. *Fam Pract* 1993;10:201-6.
- 10 Bien TH, Miller WR, Tonigan JS. Brief interventions for alcohol problems: a review. *Addiction* 1993;88:315-35.
- 11 Wilk AI, Jensen NM, Havighurst TC. Meta-analysis of randomized control trials addressing brief interventions in heavy alcohol drinkers. *J Gen Intern Med* 1997;12:274-83.
- 12 Edwards AG, Rollnick S. Outcome studies of brief alcohol intervention in general practice: the problem of lost subjects. *Addiction* 1997;92:1699-704.
- 13 Heather N. Interpreting the evidence on brief interventions for excessive drinkers: the need for caution. *Alcohol Alcohol* 1995;30:287-96.
- 14 Lawlor DA, Keen S, Neal RD. Can general practitioners influence the nation's health through a population approach to provision of lifestyle advice? *Br J Gen Pract* 2000;50:455-9.
- 15 Williams SJ, Calnan M. Perspectives on prevention: the views of general practitioners. *Sociol Health Illness* 1994;16:372-93.
- 16 Thom B, Tellez C. A difficult business: detecting and managing alcohol problems in general practice. *Br J Addict* 1986;81:405-18.
- 17 Fillmore KM. Prevalence, incidence and chronicity of drinking patterns and problems among men as a function of age: a longitudinal and cohort analysis. *Br J Addict* 1987;82:77-83.
- 18 Fillmore KM, Hartka E, Johnstone BM, Leino EV, Motoyoshi M, Temple MT. A meta-analysis of life course variation in drinking. *Br J Addict* 1991;86:1221-67.
- 19 Harnett R, Herring R, Thom B, Kelly M. Exploring young men's drinking using the AUDIT questionnaire. *Alcohol Alcohol* 1999;34:672-7.
- 20 Rollnick S, Butler C, Hodgson R. Brief alcohol intervention in medical settings: concerns from the consulting room. *Addict Res* 1997;5:331-41.
- 21 Rollnick S, Mason P, Butler C. *Health behaviour change: a guide for practitioners*. Edinburgh: Churchill Livingstone, 1999.
- 22 Hollnagel H, Malterud K. From risk factors to health resources in medical practice. *Med Health Care Philos* 2000;3:257-64.

(Accepted 15 August 2002)