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Author(s)	Klimas, Jan; Field, Catherine Anne; Barry, Joe; Bury, Gerard; Keenan, Eamon; Lyons, Suzi; Smyth, Bobby P.; Cullen, Walter
Publication Date	2012
Publication information	drugs: education, prevention, policy, 19 (1): 88-90
Publisher	Informa Healthcare
Link to publisher's version	Unavailable

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Commentary on 'The research translation problem: Alcohol screening and brief intervention in primary care – Real world evidence supports theory'

Jan Klimas^{1,2}, Catherine Anne Field¹, Joe Barry^{3,4}, Gerard Bury¹, Eamon Keenan⁵, Suzi Lyons⁶, Bobby Smyth^{3,5}, & Walter Cullen^{1,2}

¹Coombe Healthcare Centre, School of Medicine and Medical Science, University College Dublin, Dolphins Barn, Dublin 8, Ireland, ²Graduate Entry Medical School, Faculty of Education and Health Sciences, University of Limerick, Limerick, Ireland, ³Department of Public Health and Primary Care, Trinity College Dublin, Dublin, Ireland, ⁴Health Services Executive, Department of Public Health, Dublin, Ireland, ⁵Addiction Services, Health Services Executive, Dublin, Ireland, and ⁶Health Research Board, Alcohol and Drug Research Unit, 3rd Floor, Knockmaun House, 42-47 Lower Mount Street, Dublin 2, Ireland

The paper by McCormick et al. (2010) provides real-world examples of best practice for implementing alcohol screening and brief intervention (SBI) in primary care. We commend the authors for that and also wish to highlight the additional challenges involved in implementing SBI in primary care among vulnerable populations, especially problem drug users.

To explore the scientific evidence on implementing best practice in SBI for problem alcohol use among problem drug users, we conducted a Medline search with the following keywords: setting (primary care), target behaviour (problem alcohol use), population (problem drug users) and implementation strategies (e.g. guidelines, barriers or enablers). The majority of papers we identified concerned the general adult population and we consider this literature in conjunction with that specific to problem drug users, where relevant.

WHAT ARE THE BARRIERS TO SBI FOR PROBLEM ALCOHOL USE IN PRIMARY CARE?

While considerable evidence outlines the benefits of SBI for problem alcohol use in general practice, observed screening and intervention rates are low and barriers to implementing this evidence are likely (Kaner, Heather, McAvoy, Lock, & Gilvarry, 1999; Rumpf, Bohlmann, Hill, Hapke, & John, 2001).

The sensitive nature of alcohol drinking, the reason for consultation, awareness of a patient's alcohol problem, patient characteristics, availability of intervention tools, expectations of effectiveness of interventions, and lack of time are possible factors influencing 'inquiry about patients' alcohol consumption' by general practitioners (Aira Kauhanen, Larivaara, & Rautio, 2003).

These barriers can be further divided into:

- (1) Organizational/educational factors: insufficient training, lack of materials (Koopman, Parry, Myers, & Reagon, 2008), practitioner's workload/lack of time (Ampt et al., 2009; Barry et al., 2004), etc.
- (2) Practitioner factors: GP's knowledge and skills in managing problem alcohol use (Ampt et al., 2009), beliefs about the efficacy of the intervention (Ampt et al., 2009; Koopman et al., 2008) or stigmatizing attitude towards alcohol and/or drug use (Holland, Pringle, & Barbetti, 2009), etc.
- (3) Patient factors: younger age and healthier patients may be overlooked (Berner et al., 2007) and lower socio-economic status (Johansson, Bendtsen, & Akerlind, 2005; Kaner et al., 2001) (although a systematic review has not proved this effect significantly (Littlejohn, 2006)).

Some disagreement between patients and health professionals has been reported regarding the best

person to deliver SBI. Patients report that they would initially raise the issue with their doctor, but professionals have indicated that nurses are best placed to deliver SBI (a better 'people person', less formal than the doctor and more time resources) (Hutchings et al., 2006). In addition to these discrepancies, another study showed that physicians may be more willing to discuss the use of other substances, e.g. tobacco, rather than the use of alcohol (Aira, Kauhanen, Larivaara, & Rautio, 2004).

Although the primary care literature on SBI for problem alcohol use among problem drug users and other vulnerable patient groups is scarce, the implementation of SBIs in such populations may be additionally difficult. For example, problem drug users receiving methadone treatment in an addiction clinic highlighted how attitudes of healthcare providers are critical factors in engaging them with general medical and chronic care treatment and the importance of various forms of support and personal motivation (Nyamathi et al., 2008).

WHAT ARE THE ENABLERS TO SBI FOR PROBLEM ALCOHOL USE IN PRIMARY CARE?

It is nonetheless possible to improve SBI for problem alcohol use by GPs and examples of best practice in this regard have been reported (McCormick et al., 2010). A meta-analysis of strategies designed to increase rates of screening and intervention by GPs has reported that such strategies are associated with an increase in screening and advice-giving by GPs (Anderson, Laurant, Kaner, Wensing, & Grol, 2004a) and a protocol for a Cochrane systematic review on this topic has been published (Anderson, Laurant, Kaner, Wensing, & Grol, 2004b). Various classifications of the strategies which facilitate implementation have been described (Bero et al., 2009; Grimshaw et al., 2001) but generally they comprise two main categories:

- (1) Educational factors: In a multi-centre trial, training and support improved rates of SBI for problem alcohol use (Funk et al., 2005). Similarly, alcohol-related continuing medical education impacts on a GP's diagnostic and management skills (Kaner et al., 2001). Specifically Motivational Enhancement Therapy for postgraduate GP trainees may improve their engagement in substance abuse education (Hettema, Sorensen, Uy, & Jain, 2009).
- (2) Organizational factors: Additional staff can contribute to the increase in screening rates (Mello et al., 2009). Importantly, when combined as a complex intervention, multiple strategies from both categories may have an additive effect on implementation. For example, education/training can be supported by organizational factors and supportive working environment (e.g., job security

and commitment to manage alcohol issues) (Anderson, 2009).

In summary, dissemination research clearly shows that implementation of evidence-based guidelines for clinical practice is more likely to be successful if the implementation strategies target the obstacles and a sound knowledge of the target population/setting is present (Grol, 2001). At the same time, multifaceted strategies should be applied as well, because as Grimshaw et al. (2001, p. II2) comment: 'Most interventions are effective under some circumstances; none are effective under all circumstances'. This approach has been shown to promote the implementation of evidence based care interventions among problem drug users in Ireland (Cullen et al., 2006).

In Ireland, the high prevalence of problem alcohol use has been identified as an important priority in the care of problem drug users. Developing a complex intervention which will promote SBI for problem alcohol use is a priority and this intervention should be informed by evidence-based clinical guidelines for practitioners and by understanding the barriers and enablers to their successful implementation from the perspective of healthcare professionals and patients. Especially where vulnerable populations are concerned, successfully translating research findings in the real-world requires an understanding of what is happening on both sides of the 'waiting room door'.

ACKNOWLEDGEMENT

This review was conducted as part of a Research Project grant funded by the Health Research Board of Ireland.

Declaration of interest: The authors acknowledge that they have no conflict of interests regarding this study.

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