

Practices and attitudes of General Practitioners in the delivery of Alcohol Brief Interventions in Scotland

Professor Aisha Holloway
& Dr Edward Donaghy



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ON ALCOHOL PROBLEMS
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Author Details

Professor Aisha Holloway

Professor of Nursing Studies
Nursing Studies
School of Health in Social Science
The University of Edinburgh
Edinburgh

Dr Edward Donaghy

Research Fellow
Medical School
Edinburgh Critical Care Research Group
The University of Edinburgh
Royal Infirmary Hospital
Edinburgh

Corresponding author: aisha.holloway@ed.ac.uk

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Executive Summary

The effects of excessive alcohol consumption across Scottish society have been seen to impact on communities, families, public services, the economy and individual health. In response, the Scottish Government set out a strategic approach to addressing these harms in the Changing Scotland’s Relationship with Alcohol: A Framework for Action (Scottish Government, 2009). A key component of this strategy was to set targets for the delivery of Alcohol Brief Interventions (ABIs), which were subsequently developed into a HEAT H4: Alcohol Brief Intervention (ABI) Standard in 2012/13. ABI delivery was formally linked to the NHS Scotland Local Delivery Plan (LDP) as an LDP Standard for 2015/16.

An Alcohol Brief Intervention (ABI) as defined in national guidance, is a short, evidence-based, structured conversation about alcohol consumption which seeks to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm. Screening to identify those drinking at harmful/hazardous levels and delivering an intervention are based on SIGN 74 Guidelines. In the 2015/16 national guidance, it was reported that at least 80% of the standard ABIs should be delivered in three priority settings: primary care, antenatal and Accident & Emergency (A&E), with the remaining 20% of ABIs delivered in ‘wider’ settings (previous guidance was set at 90% delivery in the priority settings). Within that 80%, the majority of ABIs have been delivered in the primary care setting. Primary care also remains the setting with the strongest evidence base (Kaner et al, 2007). Despite this, there is an acknowledgement that

there remain unanswered questions about ABI delivery in everyday practice (McCambridge & Saitz, 2017).

To inform understanding of GP practices and attitudes towards the delivery of ABIs, an exploratory qualitative research study was undertaken. This involved 13 in-depth one-to-one semi-structured interviews with GPs across different parts of Scotland. The aim of this study was to identify what GPs across diverse areas of Scotland characterised as the facilitators and barriers to delivering an effective ABI based on their everyday general practice work.

Our findings point to the fundamentally central role GPs play in responding to harmful and hazardous drinking through the delivery of ABIs in primary care. The study identified that facilitators for the effective delivery of ABIs fell into two categories, systemic factors and patient-centred factors. The systemic factors mirror those identified in the final MESAS report. However, the patient-centred factors from our data address elements of the gaps identified by the MESAS report (NHS Health Scotland, 2016). Our data provides new evidence and insight to address specific gaps in our understanding of the characteristics of the individuals receiving screening and ABIs, who these individuals are and how that and the context of their lives impacts on the delivery of ABIs. The key facilitators and barriers for ABI delivery by GPs are summarised in Table 1.

These were:

- *Well-organised and appropriately supported ABI training helps facilitate an effective ABI.*
GPs interviewed spoke of significant benefit of having a nationally organised, appropriately funded, structured implementation process in place, providing GPs with time protected quality training around ABI delivery.

TABLE 1
ABI delivery facilitators and barriers

| Facilitators | Barriers |
|---|--|
| <ul style="list-style-type: none"> – 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 | <ul style="list-style-type: none"> – Insufficient time with patient – Poor IT infrastructure – Combining alcohol support services and drug support services under one roof – Drinking at home – Cheaper alcohol in supermarkets – Low awareness amongst patients of what constitutes harmful/hazardous drinking – High levels of alcohol consumption viewed as ‘normal’ across Scotland – Acute changes in patient’s social and personal circumstances |

- *Sufficient time with patients to fully discuss and personalise their ABI in the patient's biographical circumstances helps facilitate an effective ABI.*
GPs spoke of the crucial importance of having enough time to (a) identify and discuss the patient's harmful/hazardous drinking, which can be time-consuming as most patients present with other secondary features of their drinking and (b) locate the delivery of an ABI in the context of that patient's biographical circumstances.
- *Local Enhanced Service (LES) facilitates ABI implementation.*
Having a system of payment for each ABI delivered by a GP helps facilitate their delivery.
- *Fast, easily accessible and user-friendly IT tools with dedicated IT support.*
These factors encouraged both effective delivery and monitoring of ABIs in GP practices, increasing the likelihood of ABIs being mainstreamed into General Practice.
- *Good signposting to community support groups and GP practice links with appropriate community groups.*
To support patients experiencing harmful/hazardous drinking, additional community support services can complement an ABI delivery. Knowledge and signposting of such community services can facilitate an effective ABI delivery.
- *Patient acknowledgement of harmful/hazardous drinking and willingness to change drinking behaviour helps facilitate delivery of an ABI.*
Patients who acknowledge their harmful/hazardous drinking and are willing to act on the advice contained in the ABI are more likely to reduce their drinking.
- *Knowing the patient/having a good GP/patient relationship.*
GPs who knew the patient well and/or had a good GP/patient relationship had a better chance of delivering an effective ABI than a new or locum GP who didn't have this patient knowledge/relationship.
- *Slow, time-consuming IT infrastructures are a barrier to effective ABI delivery and monitoring outcomes.*
To encourage ABI delivery, quick, user-friendly IT infrastructures that also support monitoring of ABIs in practice were advantageous. Not having this was a barrier to ABI delivery.
- *Secondary care alcohol support services being formally organised with drug support services can be off-putting to patients with harmful/hazardous drinking.*
Some patients required further secondary care sector follow-up to address their drinking. Some patients found the stigma of going to these services difficult and this negatively impacted on ability to reduce their drinking.
- *Changing drinking patterns (now more in the home than pubs/clubs), cheaper alcohol in supermarkets and poor knowledge of alcohol units is resulting in people being unaware of their harmful/hazardous drinking levels.*
Some patients are not aware of their harmful/hazardous drinking levels and therefore don't raise the issue or acknowledge the issue with their GP.
- *High alcohol consumption even in excess of safe limits is ingrained in Scottish society and culture and seen as 'normal'.*
Social norms play a part in the barriers to the delivery of an effective ABI, when patients think their drinking levels are the same as their family members and other social networks, and therefore see their drinking as not problematic but 'normal'.
- *Acute/major stressful life events experienced by patients can be a barrier to delivering an effective ABI.*
Delivering an effective ABI can be more difficult in patients experiencing major stressful events such as relationship breakdown, divorce, family tensions, financial worries, benefit changes and/or housing problems. In the experience of many GPs interviewed, a large proportion of patients responded to such events through harmful/hazardous drinking, especially if they had poor social support and weak social networks.

As with the facilitators to effective ABIs, the barriers tended to fall into two categories: systemic factors and patient-centred.

Six key barriers to GPs delivering an effective ABI were identified. These were:

- *Lack of sufficient time with the patient.*
Lack of time was identified as the biggest barrier to delivering an effective ABI, given the complexity of uncovering and then addressing harmful/hazardous drinking in many patients.

Recommendations

This report has been produced with the aim of contributing to the refresh of 'Changing Scotland's Relationship with Alcohol: A Framework for Action', the Scottish Government's strategic approach to tackling alcohol misuse in Scotland. The recommendations presented reflect the key themes that emerged from the data analysis.

- National ABI programme should continue.
- Appropriate funding to support ABI infrastructure, time-appropriate delivery and monitoring outcomes.
- Maintain standardised ABI education programmes that consider intensive motivational behaviour change techniques.
- Implementation of evidence-based 'upstream' population-wide public health policies that address social determinants of alcohol-related harm.
- Legislation to address price, availability and marketing of alcohol are required.
- Support the use of social prescribing to complement ABI delivery.
- Invest in research to formally evaluate the ABI programme and its outcomes: establish a profile of those receiving ABIs, measure the quality & fidelity of interventions delivered and evidence the impact on health and non-health outcomes.

Background: alcohol misuse and policy in Scotland

It is recognised that alcohol is now one of the major risk factors for the burden of disease in established market economies (ISD, 2011). Approximately 3.3 million deaths in 2012 were attributed to alcohol consumption, with 139 million Disability-Adjusted Life Years (DALYS) globally attributable to alcohol consumption (World Health Organisation, 2014). Whilst alcohol misuse is harmful to an individual's health and well-being, it also affects personal relationships and impacts negatively across society in relation to crime and safety, child protection, alcohol-affected pregnancy and impact of Foetal Alcohol Spectrum Disorders (FASD), education, productivity and the economy. In Scotland, alcohol-related harm is estimated to cost £3.6 million each year, the equivalent of £900 for each and every adult in Scotland (British Medical Association, 2016; Scottish Government, 2015).

Despite a trend in recent years, identifying a decline in population consumption in Scotland, the rates of alcohol-related mortality and morbidity continue to be higher than England and Wales and higher than rates in the 1980s. The reason behind this decline and a possible flattening of the reduction is explored further in the final MESAS report, with a number of external factors likely to have contributed to the trends, therefore further reductions in alcohol-related harm in Scotland remain a priority (NHS Health Scotland, 2016). There has also been a decline in alcohol-related hospitalisations in both genders from 2008/9. The final MESAS report identified two factors outwith the strategy that have been thought to contribute to the trends in mortality. These were (i) the ageing and death of what has been identified as a vulnerable cohort associated with a surge of alcohol-related mortality increasing in the 1990s and subsequently decreasing from the mid-2000s due to ageing and death within this group and (ii) reduced disposable income and therefore alcohol affordability amongst those individuals living in the most deprived areas. A stalling in downward trends has also been evidenced in relation to alcohol-related mortality and alcohol consumption (sales), with no decreases in 2013 and 2014. However, whether this is a sustained pattern is subject to longer-term monitoring.

In response to the harm caused by excessive alcohol consumption to the health and well-being of the Scottish population, the Scottish Government has in recent years developed a fresh strategic 'whole population approach' to its alcohol policy. The 2009 Changing Scotland's Relationship with Alcohol: A Framework for Action (Scottish

Government, 2009) built on the existing Licensing (Scotland) Act 2005 and further developed through the Alcohol etc. (Scotland) Act 2010 with the most recent Alcohol (Minimum Pricing) Scotland Act 2012 (yet to be implemented) comprising the four components of the strategy. MESAS (Monitoring and Evaluating Scotland's Alcohol Strategy) has been responsible for the evaluation and monitoring impact of the strategy (Beeston et al, 2013).

Delivering ABIs in healthcare settings is a fundamental component of the Scottish Government Alcohol Strategy and highlights the key role that health services in Scotland have to play in addressing alcohol misuse. The delivery of Alcohol Brief Interventions (ABIs) as a method of addressing alcohol-related harm was set by the Scottish Government in 2008 as a national HEAT (Health Improvement, Efficiency, Access and Treatment) target in three priority settings: antenatal, primary care and A&E. Additional funding and investment in the infrastructure to support delivery by way of provision of training, resources and national co-ordination was provided (NHS Health Scotland, 2016). However, there was variation between each Health Board in relation to their programme of delivery for ABIs i.e. delivery model, payment structures through the Local Enhanced Services Programme and training. The target evolved to become a HEAT standard from 2012/13 with NHS Boards and Alcohol and Drug Partnerships (ADPs) being responsible for the delivery in at least 90% of the priority settings, with the remainder of the ABIs delivered in wider settings e.g. custody suites, prisons, social work, fire & rescue, higher education, in accordance with the national ABI HEAT standard guidance. Since 2008/09 and 2014/15 an estimated 569,792 ABIs have been delivered in Scotland as part of the ABI programme (NHS Health Scotland, 2016).

From 2015/16 ABI delivery has been formally linked to the NHS Scotland Local Delivery Plan (LDP) which has now identified that at least 80% of ABIs (48,865) should be delivered in the priority settings of primary care, antenatal and A&E (this is a reduction from 90% in previous LDP standards) with wider settings delivery increasing to 20%. Each Health Board in Scotland is currently required to identify how they intend to sustain the delivery of ABIs and embed them into routine practice within their Board LDP (Scottish Government, 2015). Within GP practices ABIs are delivered by GPs and practice nurses.

Alcohol Brief Interventions (ABIs)

ABIs are brief time-limited interventions by a non-specialist e.g. GP or practice nurse that centres on changing alcohol drinking behaviours. ABI is

'...a short evidence-based, structured conversation about alcohol consumption with a patient/service-user that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm'

HEAT H4 National Guidance on Data Reporting (NGDR), 2010, p3.

ABIs use detailed techniques for helping people to change their behaviour towards drinking alcohol and are heavily influenced by the philosophy of Motivational Interviewing (MI). MI is a goal-oriented, patient-centered counselling style for eliciting behaviour change by helping patients to explore and resolve uncertainty in a focused and goal-directed way (Tahan et al, 2012). ABIs also incorporate the FRAMES approach, using the principles of Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy (Miller & Sanchez, 1994).

Information Services Division (ISD) Scotland reported in June 2016 that in 2015/16 there were 97,245 ABIs delivered in Scotland, exceeding the LDP standard of 61,081 for 2015/16 by 59%. All but one NHS Board exceeded their target; however at national level, targets for all ABI delivery and 80% target in priority settings were met. ISD reported that in Scotland overall 55% of ABIs were delivered in primary care (ISD, 2016).

There is a large variation between individual NHS Boards in distribution of ABI delivery over settings, but in Scotland overall in 2015/16

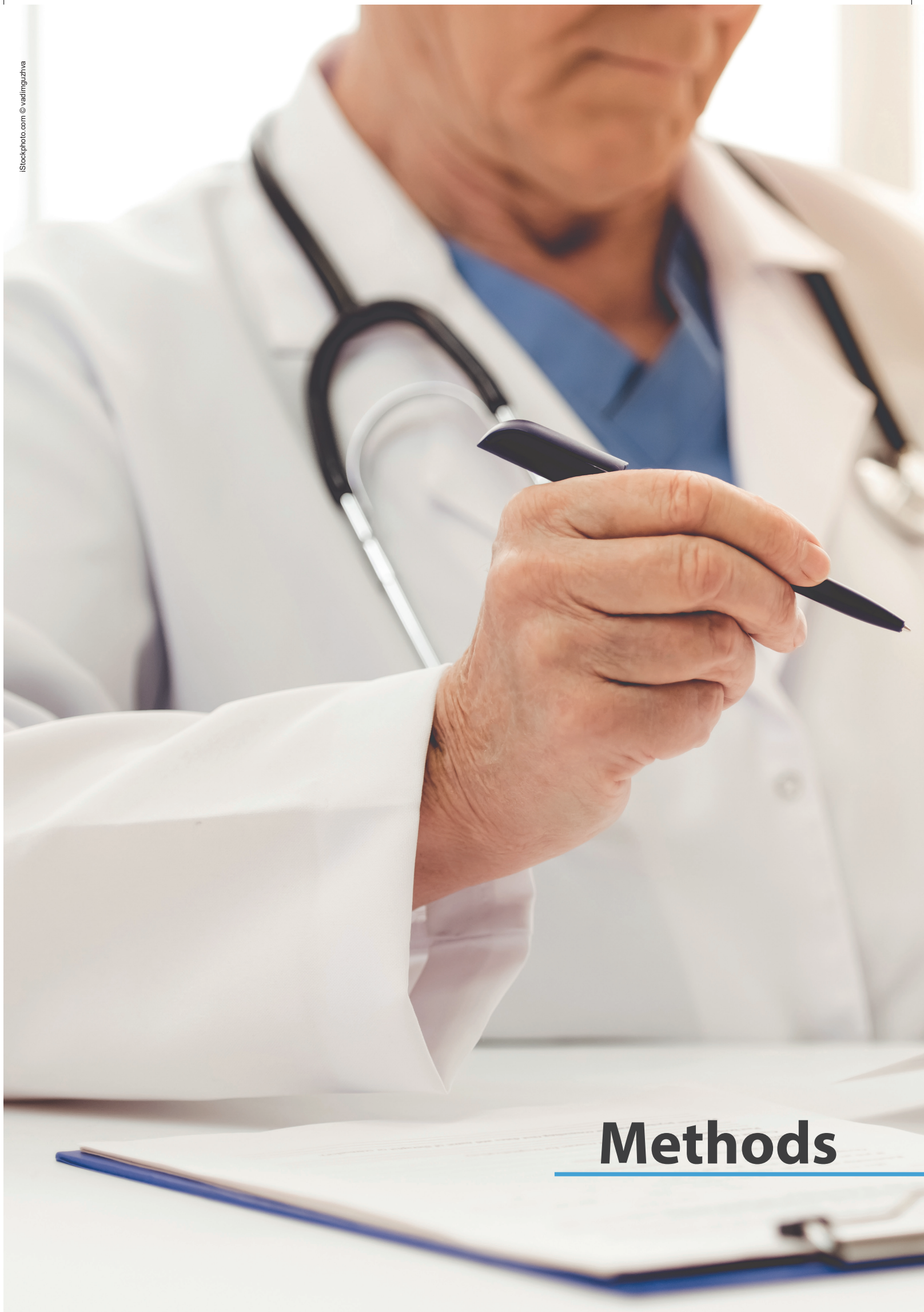
- 55% of ABIs were delivered in primary care;
- 12% in A&E;
- 3% in antenatal; and
- 30% in wider settings.

ISD 2016

There is convincing evidence of the benefits of generic health professionals providing Alcohol Brief Interventions. This comes in the form of simple advice or brief counselling to patients in primary care for those whose levels and patterns of consumption place them at risk of developing alcohol dependency (Kaner et al, 2007; Moyer et al, 2002).

The majority of studies on the delivery and effectiveness of ABIs have occurred in primary care and this is where the strongest evidence for their use lies. Bertholet et al (2005) found that ABIs were effective in reducing hazardous and harmful levels of alcohol consumption in both men and women. Kaner et al (2007) demonstrated that brief interventions led to a reduction in alcohol consumption of 38g per week among people misusing alcohol. A systematic review by Kaner et al (2009) concluded that ABIs can reduce alcohol consumption in men, with benefit at a year after intervention, but noted there is insufficient research data to draw the same conclusion for women. ABIs have also been shown to be cost effective when delivered in primary care (Kaner et al, 2009). Heather (2011) notes that with over 50 randomised controlled trials, ABIs are currently the treatment modality best supported by research evidence in the alcohol field (Heather, 2011).

A major evaluation of NHS-delivered ABIs in Scotland identified a number of challenges in relation to the delivery and implementation in primary care settings (Parkes et al, 2011). The results identified that the majority of primary care patients acknowledged and accepted that discussing alcohol with patients was part of the role of a GP or health care worker. Similarly staff themselves saw the delivery of ABIs as a worthwhile activity and a valid use of NHS resources. A key finding of the evaluation was in relation to the variation in reach, especially in rural and remote areas, and the impact of the ABI delivery programmes across Scotland alongside difficulties in monitoring the impact, due to minimal data being recorded. Differences in the Health Board pay structures for ABI screening and delivery as part of the Local Enhanced Service contracts have resulted in primary care practices focusing on different elements of ABI delivery with different infrastructure and approaches for implementation (Parkes et al, 2011).



Methods

Research design and methods

The study adopted a qualitative approach utilising purposive sampling for the recruitment of GPs from a range of locations across Scotland. Using a number of stakeholders in the alcohol field and GP-related organisations, such as the Scottish Alcohol Research Network (SARN) and the Royal College of General Practitioners (RCGP) Scotland, we contacted GP practices by email and letter. Our goal was to recruit 12-15 GPs. A total of 13 GPs were recruited to the study over seven Scottish Health Boards.

Data analysis

The GP interviews were recorded and transcribed verbatim. Analysis of the data was thematic. Thematic analysis is the most common form of analysis in qualitative research and the most commonly used qualitative method to identify, report, and analyse data for the meanings produced in, and by people, situations, and events (Braun & Clark, 2006; Patton, 2002). Thematic content analysis is a methodological approach for answering questions about the most significant issues that arise from a particular group of respondents and for identifying typical responses (Braun & Clark, 2006; Patton, 2002).

Aim of study

The aim of the study was to explore the barriers and facilitators identified by GPs from different locations in Scotland regarding the delivery of an effective ABI based on their everyday general practice work.

Ethical approval

Ethical approval for this study was sought and granted by the University of Edinburgh, School of Health in Social Science Research Ethics Committee.

Qualitative interviews

Semi-structured interviews were used to obtain data relating to the experiences, meanings and attitudes from people's general social engagements (Pope & Mays, 1994), in this case GPs engaging with patients in the delivery of ABIs. We developed the semi-structured interview questions from a review of relevant literature around ABIs and in line with the study's aims. The majority of the semi-structured qualitative interviews were conducted face-to-face in GP practices (n=10) although, due to budgetary/geographical issues (GPs living in very rural areas) three were conducted over the telephone (n=3). Data was collected between May 2015 and September 2015.

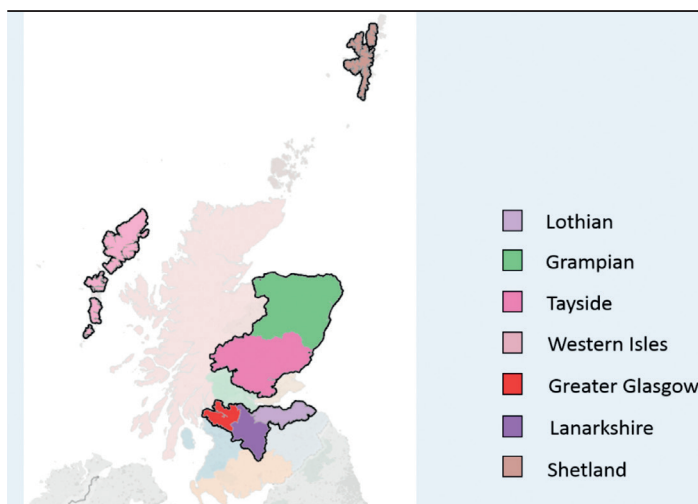


Results

Demographics of participating GP practice areas & GP practices

A total of 13 GPs from seven Scottish Health Boards were involved in the study. These were Greater Glasgow & Clyde, Grampian, Lothian, Tayside, Lanarkshire, Western Isles and Shetland (Figure 1).

FIGURE 1
Map of Scotland with participating Health Board GP Practice Areas



The GP practices of the participating GPs covered areas that included rural, semi-rural, socially deprived, socially affluent, high economic deprivation, and included practices with significant numbers of black and minority ethnic communities.

Themes

GPs provided their experiences and views on ABIs in the context not just of their own experience of delivering ABIs to patients, but related this to wider systemic, patient-centred and societal factors that influence alcohol drinking patterns in Scotland. The principal aim of this study was to identify what GPs across different parts of Scotland saw as barriers and facilitators to delivering effective ABIs and support patients experiencing harmful/hazardous drinking. Following the thematic analysis, we have summarised the key findings into what were identified as the facilitators to effective ABIs and barriers to effective ABIs. The key themes related to facilitators are presented, followed by the key themes related to the barriers.

Facilitators to effective ABIs: systemic and patient-centred factors

GPs identified what, in their experience, were facilitators to conducting a robust, effective or successful ABI. Whilst all GPs stated that more time with the patient was the biggest facilitator, GPs identified a range of factors as key facilitators to delivering an effective ABI.

The identified facilitators for successful delivery of ABIs fell broadly into two categories. Category one was systemic factors (i-v below) and category two was patient-centred factors (vi to vii below).

- (i) Well-organised and appropriately supported ABI training helps facilitate an effective ABI;
- (ii) Sufficient time with patients to fully discuss and personalise their ABI in the patient's biographical circumstances helps facilitate an effective ABI;
- (iii) Local Enhanced Service (LES) facilitates ABI implementation;
- (iv) Fast, easily accessible and user-friendly IT tools with dedicated IT support;
- (v) Good signposting to community support groups and GP practice links with appropriate community groups can help support ABIs;
- (vi) Patient acknowledgement of harmful/hazardous drinking and willingness to change drinking behaviour helps facilitate delivery of an ABI;
- (vii) Having a strong Dr/patient relationship helps an effective ABI.

TABLE 2
Participating GP Practice Demographics

| Health Board | SIMD Quintile* | SIMD Decile* | Practice Size | No. of GPs | Descriptor Practice Area |
|---------------------------------------|----------------|--------------|---------------|------------|---|
| Lothian GP Practice 1 | 1 | 1 | 9,000 | 10 | Outer-city based practice area with high levels of unemployment, social deprivation, a growing BME population, and significant number of patients with harmful/hazardous drinking levels. |
| Lothian GP Practice 2 | 3 | 6 | 7,500 | 8 | Small town practice based on outskirts of large city including ex-industrialised areas, semi-rural areas, affluent areas and pockets of social deprivation. |
| Grampian GP Practice 3 | 1 | 1 | 5,500 | 5 | Inner-city based practice area with high levels of unemployment, social deprivation, and significant number of patients with harmful/hazardous drinking levels. |
| Tayside GP Practice 4 | 4 | 7 | 7,500 | 7 | Inner-city based practice area with areas of affluence and pockets of deprivation. |
| Western Isles GP Practice 5 | 2 | 4 | 8,000 | 6 | Rural area covering mixed areas of affluence and pockets of social deprivation. |
| Western Isles GP Practice 6 | 4 | 7 | 1,100 | 1 | Very rural island area with areas of affluence and small pockets of unemployment, social deprivation and harmful/hazardous drinking. |
| Greater Glasgow & Clyde GP Practice 7 | 1 | 2 | 7,000 | 5 | Inner-city based practice area with high levels of unemployment, social deprivation, and significant number of patients with harmful/hazardous drinking levels. |
| Lanarkshire GP Practice 8 | 1 | 2 | 8,500 | 5 | Inner-city based practice area with high levels of unemployment, social deprivation, and significant number of patients with harmful/hazardous drinking levels. |
| Shetland GP Practice 9 | 3 | 6 | 800 | 1 | Very rural island area with areas of affluence and small pockets of unemployment, social deprivation and harmful/hazardous drinking. |

Participating Health Boards = 7; Participating GP practices = 9; Participating GPs = 13
 Scottish Index of Multiple Deprivation (SIMD, 2012) follows the Scottish Government convention for ordering quintiles and deciles. Quintile 1 is the most deprived (Quintiles go from 1-5) and Decile 10 the least deprived (Deciles go from 1-10).
 *Quintile 1 & 2 = Most deprived; Quintile 4 & 5 = Least deprived
 *Decile 1 & 2 = Most deprived; Decile 9 & 10 = Least deprived.

Well organised, appropriately supported training helps facilitate an effective ABI

Almost all (11 out of 13) General Practitioners stated that they themselves and their practice staff had received up to date (in the last 1-2 years) training around alcohol use/misuse in general and ABIs in particular. Almost all described the training in a positive way and saw it as helpful or very helpful. Most GPs stated that their undergraduate medical training on alcohol use/misuse and alcohol as a public health issue was 'poor', 'not up too

much'. Many GPs stated that the training was too early in the undergraduate curriculum and (especially for GPs) should come later in the curriculum. The importance of alcohol training and education in the medical curricula and the timing of it has been acknowledged over a number of decades (Cape, Hannah & Sellman, 2006; Johnson et al, 2014).

Whilst some GPs cited reservations about targets in delivering health care initiatives, a majority of GPs interviewed spoke of the benefits of having a nationally organised, appropriately funded and structured implementation programme in place, providing GPs with time-protected quality training around ABIs. This was viewed as vital, as such supported training programmes were more likely to result in embedding the implementation of ABIs into everyday practice.

Health Board 3 GP 1

"The initiative of tackling alcohol in Scotland through a national programme to support the delivery of ABIs in primary care and driven through targeted training has made it more likely to facilitate ABIs in general practice. With ABI co-ordinators coming in and providing hands on training to GPs alongside protected and supported time, this has all been really important. It has sent a message on the importance of ABIs in our everyday work. What's really important is that it has been properly resourced in terms of having a structure in place to support its implementation and support training and follow-up. That's not always been the case with other health policy initiatives that have consequences for the workload in primary care".

The majority of GPs interviewed viewed appropriately resourced and supported training positively. The training provided was also viewed in a positive manner by GPs, as outlined below:

Health Board 1 GP Practice 1

"I've been a GP for a long time. Training around how to do an alcohol intervention or alcohol in general certainly wasn't something that was ever given in my initial training. But there's been local training here where I work, particularly to support the alcohol brief intervention contract and that's been very good. There's also an on-line module that everyone can access health-board wide. The trainers when it all first started came out to practices to present locally in-house, which was probably the most effective and that really made a difference. Getting everyone together as a team made it more likely to embed in routine work amongst all the practice staff".

Health Board 4 GP Practice 2

"I'm quite old, so I trained a long time ago and we didn't have these kind of snazzy interventions, we just had to 'welly in', in my young day. The updated training is actually very good I think, and it is very helpful. And I guess after the training I was probably more enthusiastic about alcohol screening and brief interventions than before. The scoring system is actually really helpful. It does surprise people when you present them at the end with the score that says well actually...this is how much you are drinking and this is the damage that could happen if you continue at the same level. That targeted training definitely impacted on my practice skills".

Having a supported infrastructure to deliver ABIs in the GP practice and regularly review their delivery was commented on positively by a number of GPs:

Health Board 1 GP Practice 2

"So here ABIs are looked after by a colleague and every month we get a little graph or table of how many Alcohol Brief Interventions each doctor has done so you can see how you're performing. We also have teaching sessions on ABIs. So when things feel that maybe they're slipping or there's new doctors coming in, we'll have a little teaching session on it where we'll go through the IT side, the booklet side, the 'what you might suggest' side and the 'what you might discuss' side. Reviewing how we are delivering on ABIs helps because in reality after the first training sessions everybody was enthusiastically conducting them where necessary but like everything else there is the danger that it slips off the radar".

A number of GPs stated that the supported training around ABIs recently received was important generally, but particularly in the context of what some regarded as poor training as junior doctors or medical students. The following comment typified this view among these GPs:

Health Board 1 GP Practice 3

"My basic training in addictions in general and alcohol in particular was abysmal, as a medical student and as a junior doctor. There was very little of it and it was poorly coordinated and I don't remember much about it, to be honest. This was, what...early nineties. I was at medical school and then in my GP training –similarly there wasn't an awful lot on the issues then. So, I've done post-secondary qualification training in addictions plus the standard Alcohol Brief Interventions training that was done round all the practices in the board here".

Whilst there was praise for the training provided in delivering ABIs, this was not the view of all GPs interviewed. A number of GPs felt that because all practice staff were involved in the ABI training, it became too generic with one GP stating they found the training 'pretty generic and for many GPs that were getting it, it felt like we were being taught to suck eggs and it felt like a bit of a waste of time'. A small number of GPs interviewed believed the training should have been, and should be, more developed around motivational interviewing:

Health Board 1 GP Practice 3

"I think most GPs would value a bit more in-depth training in motivational interviewing. A lot of us know the basics of assessing people's position on the cycle of change and the like and we develop skills whereby we naturally help people motivate themselves to change. But I think a bit more formal understanding of how to do that is important, from an alcohol perspective. I think that would be useful".

From the perspective of the GPs interviewed for this study, facilitating ABIs into their everyday practice was helped substantially by ABIs having a national directive, with the necessary resources and infrastructure put in place to

support training and implementation. GPs interviewed in this study in general stated that their ABI training was either good or very good. They stated that it improved their awareness of alcohol issues generally and harmful/hazardous drinking in particular. GPs also stated that their training increased their confidence in delivering ABIs that in turn increased the effectiveness of their delivery.

Of equal importance to training from a GP perspective was having adequate time to spend with patients when delivering an ABI.

Sufficient time with patients, to discuss their alcohol consumption and personalise their ABI, helps facilitate a successful ABI

Whilst supporting the delivery of ABIs by GPs in primary care through a national programme, adequately resourced with supported training locally, was seen as a key facilitator to successful ABIs, equally important for GPs was having sufficient time with patients to deliver them. GPs spoke of the importance of delivering an ABI in the context of the patient's biographical and social circumstances and in a way that was meaningful to each individual patient. To do this effectively is time-consuming but with more time GPs believed the intervention had a greater chance of success.

For this GP from Health Board 5, delivering ABIs had to take into account the patient's biographical circumstances and tailor the ABI accordingly. This can, in certain situations, make delivering them more time-consuming:

Health Board 5 GP Practice 9

"I used to work in one of the very affluent practices in the city and we handed out a lot of leaflets when giving out advice. In this practice it's very different. It is inner city, high levels of unemployment, social deprivation and related social problems. I very rarely hand out leaflets and that's because we know that a large proportion of folk up here can't read or write properly or struggle with reading and writing. That's not to say everyone of course, but I very rarely would hand out leaflets. So it's more talking and posing questions and that of course is more time-consuming. But when I have more time with that person I'm more confident about the intervention being successful or partially successful. No question".

One GP believed that their own working circumstances were more favourable than most GPs in that they had more time to spend with patients when delivering an ABI. They suggested more time meant an increased opportunity for a successful ABI:

Health Board 7 GP Practice 9

"I'm working in a privileged position in that I've got really a small list size and when I'm seeing people in my specialist clinic, I've got longer appointment times. I can't even begin to imagine how colleagues in Glasgow or Edinburgh get the time to do this. But I think it's probably when people are trying to conduct an ABI really fast that that's when people end up sounding as though they are, kind of, preaching or being annoying. I've got time with the patient to have a discussion and take into account what's going on in their lives. It definitely makes for an ABI being more likely to be taken on board by the patient in my experience".

Nearly all GPs interviewed noted that sufficient time to deliver an ABI, as effectively as they would have wished, was compromised by a lack of time. GPs spoke of the time needed to discuss in a sensitive way some of the personal issues that might be behind a particular patient's harmful/hazardous drinking. They might be very personal, such as relationship issues, wider family issues, employment issues and financial issues. Getting a patient to open up about these and their harmful/hazardous drinking, GPs noted is a skill and a time-consuming one. Trying to get the patient to locate some of the drivers for their harmful/hazardous drinking was important in delivering an ABI. As one GP said *'It's a sensitive issue, you have to tread carefully and once you've established some of the reasons for their drinking problems, talk about how to address them, motivate them in a way that they can see is doable and reduces their drinking. That takes time'.*

As part of a national programme to address Scotland's alcohol problems, GPs spoke positively about the enhanced service that provided payment for each ABI.

Enhanced service encourages ABI implementation

GPs interviewed believed that enhancing the service through payment for ABIs was a positive move and helped facilitate ABI delivery. One GP who worked in a Health Board region that did not have the payment method for ABI delivery spoke of this:

Health Board 6 GP Practice 8

“Well, I think if my Health Board had the enhanced service that would make it easier to deliver ABIs. That means giving the resources to practices. It means we would get paid for doing it. But we don’t necessarily take that money home remember, it increases the time available to do them. So it’s the resources. It’s a bit like what they do in Lothian, that every time they have an alcohol brief intervention, there’s a payment I think of £20 but was £30. Something like that that grates a bit now because when you come over to this side of the country because it was only a tenner in Glasgow. But Glasgow’s more generous than this Board, which doesn’t pay anything at all. I do think it’s bad that we don’t have it”.

Mindful of different payment structures for ABI delivery operating across Scotland, with contracts negotiated at Health Board level, the issue of funding ABIs to tackle alcohol problems that exist in many of Scotland’s communities was expressed by one GP, in the following terms:

Health Board 1 GP Practice 1

“I suppose it’s a political thing. I think you should call a spade a shovel, think the government should acknowledge that. You want us to address the problems we see routinely with alcohol every day here? You can’t get a cheap service and expect it to be sustainable. So I think they should look at actually how long it actually does take GPs to consult and properly deliver an ABI and actually pay them for the time. I would have thought that given the social and financial cost of alcohol problems in Scotland it would be cost effective”.

Whilst the above three areas were identified by the majority of GPs interviewed as being of central importance in the delivery of effective ABIs, other areas were also identified as important. One key area that GPs mentioned was the need for fast and easily accessible IT support and simple and fast procedures for recording and monitoring outcomes related to the delivery of an ABI.

Fast and user-friendly IT infrastructures facilitate successful ABI delivery and monitoring outcomes

Given previously identified time pressures, GPs wanted rapid access IT support to help facilitate recording and outcome monitoring of ABIs. Many GPs spoke of the importance of simplicity of accessing ABI delivery supports through quick and easy-to-use IT. They also stated that having easy-to-use ABI recording procedures would help with the audit of ABI delivery.

One GP stated:

Health Board 4 GP Practice 5

“A key thing to facilitate ABIs I think, is good IT support, if you’ve got a system that flashes up and pushes forward opportunities and prompts for an ABI intervention then you are going to be a little bit more prone to using it and if you are not then you may well do something else. That’s the way things work”.

Another GP spoke of the benefit of being shown how to access and use quick IT infrastructure to help deliver an ABI:

Health Board 2 GP Practice 1

“Previously, slowness of the IT was a barrier for me. I was put off by the slowness of IT to load the screens and press the buttons. But we got IT people come in and with the teaching session I received I think I’ve got my head around it now and I know that I can do it quickly, and it’s more likely to be used when I know the system is easy to use”.

Having auxiliary support in the form of fast and reliable IT services to support delivery of an ABI was seen by GPs as helpful in facilitating the delivery. In addition, many GPs stated that GPs believed that recording needed to be simplified if ABI activity was to be properly mainstreamed. As other work on ABIs in Scotland has identified, this represents one of the main tensions of delivering ABIs, i.e. low demands on GPs in terms of recording may make it easier to embed ABIs into routine practice but the effectiveness of such practices becomes more difficult to monitor.

Good signposting to relevant community support groups and good GP Practice links with appropriate community groups can help support ABIs

For GPs who were interviewed for this study all felt that GPs in particular and primary care in general was the most appropriate starting point in delivering ABIs. GPs were also of a view that other wider community services should be involved to complement and assist patients experiencing harmful/hazardous drinking. For many GPs interviewed this could make for better outcomes for the patient. A number of GPs stated that in recent years, through other local and national initiatives such as social prescribing projects and link worker projects, they had been made aware of local statutory community groups and third sector community organisations that could be helpful in addressing a patient's harmful/hazardous drinking by providing supplementary support to their ABI. A social prescribing approach is a 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 existing interventions such as ABIs to improve health and wellbeing in general, and in this context, harmful/hazardous drinking in particular.

One GP working in a large city practice with high levels of social deprivation and harmful/hazardous drinking spoke of the importance of GPs knowing about such local community-based statutory and third sector services that could supplement their ABI to a patient:

Health Board 1 GP Practice 1

"I think it's really hard for people who drink to excess here. They really need to go along to other services to address some of the other problems that are often the root cause of or exacerbating their excessive drinking. So I'll refer to the recovery Hub here to get additional support. That's an organisation that has all different organisations under the one umbrella. So the Hub has housing support. They have counselling. They have alcohol workers that can look at detoxing them or encouraging them to cut down. They have lots of other supports under the one umbrella that are relevant for people with alcohol problems. You combine that with a good ABI there's a better chance of a productive outcome in my experience".

This was echoed by another GP when they said:

Health Board 1 GP Practice 3

"I think GPs here have got better access to other supports, whether it be non-statutory and other agencies that can provide support for people with alcohol problems once they get past our level of intervention. That has been a lot better once again with the Gateway Hubs and recovery clinics for people with more severe alcohol problems. They're generally very good, certainly in this locality, there are secondary care nurses, senior nurses, doing the triage, plus there are peer supporters and non-statutory organisations at those clinics as well.

They can direct people either straight into the secondary care service or to one of the non-statutory agencies if need be. That compliments what we are doing with our ABI as GPs and I think it works well. I think the big challenge is going to be making those resources easily accessible to other GPs who are maybe less aware with what's available elsewhere in the community to support people with an alcohol problem".

For many GPs where they were able to tap into additional community resources such as described above, or as other GPs mentioned, resources such as Keep Well and Well North, these positively supported their personal ABI delivery. Most GPs interviewed were of the opinion that such supplementary community supports when aligned with an ABI increased the opportunities for patients to get support in addressing their harmful/hazardous drinking. Many GPs believed this type of supplementary support in the community alongside their ABI delivery made for a more effective outcome to a patient with harmful/hazardous drinking.

Patient acknowledgement of harmful/hazardous drinking facilitates an effective ABI

Most GPs stated that if a patient independently acknowledges their harmful/hazardous drinking, this increases the chances of the ABI having a positive outcome. Patients who did this often came to speak to their GP in response to a family, relationship or work-related crisis caused by their harmful/hazardous drinking. However, some GPs did say that there were patients who would independently raise their harmful/hazardous drinking

and this made for a fuller and more direct discussion around the patient's drinking behaviour, and working out a plan to reduce the harmful/hazardous drinking. GPs stated that this type of patient was easier to raise the intervention with and easier to motivate as they had recognised themselves the need to address their problem.

A typical comment from the GP in this context came from the following GP:

Health Board 4 GP Practice 2

“Obviously if someone has come in and has recognised themselves there's an issue around their drinking and is actively seeking some advice or help, then obviously that makes it much easier to have a discussion around their alcohol consumption and develop a plan. Often it is when a relationship hits a rough patch and, not always, but usually, the man will come in to discuss his problem drinking. Sometimes it can be work related. I've had people in here who are self-employed and their drinking is impacting on their work and earnings. It's often something like that that is the trigger.

I have to say that people like that are a minority. It is usually the case the patient presents with another issue, gastrointestinal or mental health issue and that is the trigger to open up a discussion on their alcohol consumption”.

For most GPs interviewed however, recognition of harmful/hazardous drinking by the patient was usually reached following at least one consultation with their GP to discuss a presenting physical health problem and/or psychological issue. It was after addressing the presenting physical and/or psychological issues that the GP moved on to discussing alcohol intake and a potential ABI being considered. Some GPs commented on the issue of stigma around harmful/hazardous drinking being particularly the case amongst older people that made addressing the issue more time-consuming. Some GPs also noted that the general public health messages around alcohol that have been more prominent in Scotland made it easier to raise the issue of alcohol consumption with patients. In this context, GPs noted that the population-wide approach was a positive and appropriate way of reducing/preventing stigma that could be related to receiving an ABI. It meant that everybody and all groups in society were being targeted, which GPs believed reduced the dangers of stigmatisation.

Having a strong Dr/patient relationship helps an effective ABI

It was stated by many GPs that knowing the patient well and/or having a good professional relationship with them was very conducive to having an effective ABI. Some GPs raised the issue of locums perhaps not being as effective in delivering ABIs due to the transient nature of their relationship with patients:

Health Board 1 GP Practice 1

“And obviously what helps produce a productive ABI it's to do with if you know the person well, or you've seen them quite a few times before, and you've got some likelihood of seeing them in the future. It makes it much easier than to meet someone that's a total stranger. So for example, you know, doctors who are working as locums would find this sort of thing much more difficult to do I think, when they don't have any pre-existing relationship with the patient”.

The issue of good professional relationships between GPs and patients in aiding effective ABIs was amplified to include all relevant health care professionals as this GP stated:

Health Board 2 GP Practice 3

“In terms of being effective, I think sometimes the better a relationship you've had with the patient the more effective (the ABI) it is more likely to be. That was one of the key reasons that we had our health care assistant trained to carry out interventions. She has very good relationships with a lot of the patients, she's been here for a very long time, is local to the area here and it seems like a very natural extension of her role to be able to do that. So I think some of it is around the relationship you have with the patient.

I think maybe that helps the time element as well when you know someone quite well and are seeing them quite regularly you can be that bit more direct and the patient is more likely to open up honestly if there is that relationship there. I can see how it might be a bit more problematic with a new locum who doesn't have that relationship. Same for the patient as well in that situation”.

In the context of having a strong GP/patient relationship a number of GPs did state that the current GP understaffing they are experiencing in Scotland means an increasing reliance on locum GPs. This they believed, could negatively impact on the preparedness of both GP and patient to engage in a free and open discussion around

alcohol misuse. The patient doesn't know the locum GP and is less forthright about their alcohol consumption. And the locum GP, because they don't know the patient, may be less likely to push the issue of the patient's alcohol consumption for fear of upsetting someone they are meeting for the first time.

GP views on barriers to conducting an effective ABI: systemic and patient-centred factors

We asked all 13 GPs to identify, from their overall experience and daily work, what they saw as barriers to conducting an effective ABI. As with the facilitators to effective delivery of ABIs, the barriers tended to fall into two categories; systemic (i–iii) and patient-centred (iv–vi).

- (i) Lack of sufficient time with the patient can be a barrier to effective ABI delivery;
- (ii) Slow, time-consuming IT infrastructures are a barrier to effective ABI delivery and monitoring outcomes;
- (iii) Secondary care alcohol support services being formally organised with drug support services can be off-putting to patients;
- (iv) Changing drinking patterns (now more in the home than pubs/clubs), cheaper alcohol in supermarkets and poor knowledge of alcohol units is resulting in people being unaware of their harmful/hazardous drinking levels;
- (v) High alcohol consumption even in excess of safe limits is ingrained in Scottish society and culture and seen as 'normal';
- (vi) Acute/major stressful life events in patients can be a barrier to delivering an effective ABI.

Lack of time with a patient can be a barrier to effective ABI delivery

All GPs spoke of the biggest and most frequent barrier to an effective ABI from their professional perspective being the lack of time spent with a patient. This GP's comment was typical and representative of why lack of time with the patient can be and is a barrier to conducting an effective ABI:

Health Board 1 GP Practice 1

"The main barrier to an effective ABI? 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 with lots of other issues presented to you (gastro-intestinal for example). It is difficult to tackle something that in fact the patient hasn't raised as an issue (harmful/hazardous drinking) and you're trying to find time within that eight minutes to address the presenting complaint but also to ask about their alcohol consumption, and if the patient acknowledges that they are drinking at harmful levels then work out a plan to address this, you don't have a lot of time. So time is the main barrier".

The same GP also went on to outline how trying to conduct a thorough ABI and encourage a patient with harmful/hazardous drinking can be time-consuming:

"I think a lot of the initial training on alcohol brief intervention was based very strongly on motivational interviewing model which didn't recognise the time constraints of general practice. For a really proper, effective ABI, unpacking what the problem is lying behind the initial presenting problem, getting the patient to be open about their levels of alcohol consumption, then working out with the patient how to reduce their alcohol consumption and change their drinking behaviour, you're talking about a 20-minute conversation. We never, ever, ever have that luxury".

One GP explained the ideal way of addressing harmful/hazardous drinking in patients was to develop a plan around how to address the issue and motivate the patient to change their drinking behaviour but that, in their view, this could be difficult simply due to time constraints, as this GP explained:

Health Board 1 GP Practice 2

“So ideally I think that GPs when they’re turning up people where their alcohol intake is an issue, that GPs should be having the time to arrange to formulate a plan with people and invite them to come back and follow up, and see how that’s gone. But within the current capacity I don’t think that’s realistic. You know, the Scottish Government perhaps should think quite seriously about, planning to grow capacity so that GPs are having more time to do this sort of intervention. I think this might be a really, really important part of our job but GPs are increasingly losing the time to do this type of intervention effectively. I think that actually in the long run that that is less effective and actually more costly all round.”

The issue of lack of time with patients to discuss the patient’s harmful/hazardous drinking and to deliver an ABI in the context of that patient’s own personal circumstances, was cited by all GPs as the biggest barrier to delivering an effective ABI.

For the GPs interviewed, delivering an ABI had to take into account the patient’s social and biographical circumstances and uncover and discuss possible reason/s for their harmful/hazardous drinking. GPs stated that many harmful/hazardous drinkers had to be motivated to address their drinking behaviours. Addressing both these factors, done properly, was time-consuming. This was especially so when the patient was not ‘upfront’ about their harmful/hazardous drinking and found it difficult to openly discuss and not acknowledge they had a problem with their levels of alcohol consumption. Some GPs stated that they did not want to upset their patients by coming across too strong in questioning them about their alcohol consumption. Similarly they didn’t want to come across as ‘preachy’ or ‘evangelical’. This they believed would be counter-productive. GPs believed however that to begin to address the issue of harmful/hazardous drinking, patients had to acknowledge there was an issue with their drinking behaviour or the ABI stood little chance of being effective.

In addressing harmful/hazardous drinking GPs stated that in a consultation they would work towards introducing alcohol as a potential problem, re-introduce the topic in further consultations, and then wait until the patient decided to acknowledge they had an issue with their alcohol consumption. Then they could establish the level of harmful/hazardous drinking and discuss with the patient ways of changing their drinking behaviour. To get to this stage in a discussion with the patient was therefore time-consuming. For the GPs interviewed the more time

with patients to sensitively unpack the patient’s harmful/hazardous drinking and motivate them with a plan to adapt their drinking patterns, the more effective the ABI delivery.

Slow, time-consuming IT infrastructures can be a barrier to effective ABI delivery and monitoring outcomes

A theme associated with the lack of time in barriers to effective ABIs was not having fast, easily accessible and reliable IT infrastructure. As a number of GPs noted, slow or difficult to access IT support for an ABI can be a barrier. Some GPs stated that this could result in a potential ABI not being flagged up and not properly recorded; having quick and accurate recording systems was viewed as important:

Health Board 7 GP Practice 9

“We don’t have recall systems in the same way that we would do for instance with other chronic diseases that we would use for addiction problems. I’m not trying to create extra work but perhaps a way of easier follow up electronically would help”.

Health Board 3 GP Practice 1

“I mean there’s literally no way to record a follow-up of an alcohol brief intervention. So that girl that I mentioned, who I made a point of bringing back because I was concerned about her, I personally know the follow-up was good. But if you came into my practice and said well, can you show me the outcomes of your brief interventions, there wouldn’t be a search you could run, there’s just nothing. So maybe even doing that would be helpful. Even just having a little something, a little Read code. Anyway, some kind of audit trail. But that needs appropriate support and administration and therefore resource”.

Whilst these weren't the only two views on having faster and easily accessible IT to support successful ABI delivery, at the same time some GPs expressed concern about creating extra workload, as one GP noted:

Health Board 2 GP Practice 2

"We haven't actually got around to doing an audit of ABIs, we're three doctors down at the minute. We've got a huge GP recruitment problem in the city, so audits are a bit of a luxury".

Whilst the last GP quoted was addressing a specific local capacity issue, GPs were very clear in their opinion that because of time pressures and wider primary care capacity issues, recording procedures around delivering ABIs had to be as simplified as possible if they were to be mainstreamed into routine practice.

Secondary care alcohol support services being formally organised with drug support services can be off-putting to some patients

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 people might think they had a drug problem that has a bigger stigma associated with it than alcohol. As one GP stated:

Health Board 3 GP Practice 4

"One of the big barriers is actually getting some patients to the out-patient clinics in the first place. One barrier there is that it is a combined drug and alcohol service and I think the drug element keeps away some people with alcohol problems, largely because many people with drug problems are homeless and very socially deprived and drug misuse carries a bigger social stigma.

I think it's a stigma. I suppose it's the same with the chemist. People don't like to go to chemists in certain areas at certain times because that's when the drug addicts are there getting their methadone".

Many GPs interviewed believed that harmful/hazardous drinking was less stigmatised than 15-20 years ago and that public health campaigns around alcohol consumption

and the population-wide approach to addressing harmful/hazardous drinking in Scotland has helped in reducing the stigma of alcohol misuse. Nevertheless, a number of GPs stated that in their experience some patients referred onto secondary services following an ABI found it challenging to attend secondary services due to these services being in the same facility as drug misuse services, as drug misuse still has significant stigma associated with it. In the experience of some GPs some of their patients found attending such secondary care services off-putting because of this. This could have a negative impact on the initial ABI.

Changing patterns of drinking and cheaper alcohol in supermarkets is leading to more drinking at home and patients being unaware of units of alcohol being consumed

GPs were of a view that alcohol was more available, cheaper and more heavily marketed than ever before, especially through supermarket advertising and social media. They spoke of their experiences of changed patient drinking patterns across all social and demographic groups. They noted that people in Scotland are purchasing the vast majority of their alcohol through supermarkets, rather than in pubs and clubs, presenting new challenges in addressing alcohol use/misuse. This manifests itself in people drinking more at home/other people's homes, consequently, not being as conscious of how much alcohol they are consuming. GPs spoke of how in supermarkets and some smaller stores, alcohol can be purchased significantly cheaper than in pubs and clubs. The following two quotes typified the view of GPs on this matter:

Health Board 5 GP Practice 7

"In my experience more people are drinking at home than ever before, they are not going to the pub as much as before. Alcohol is cheaper than ever before, especially when bought in supermarkets. This has a consequence especially around keeping a check on how much people are drinking. This is more difficult to do at home compared to say in the pub. When you are in a pub you order a

round and you order a PINT of beer or lager, a specific measure of gin or vodka I know what it is because I've checked it's either 25ml or a double is 50mls, or 35ml and a double is 70mls, it's the same idea with a MEDIUM or LARGE glass of wine- it's a specific measurement. At home you don't do that. People pour bigger measures, more often, and that's happening more frequently because people are drinking at home more than ever before".

Health Board 3 GP Practice 4

"I don't think people are really aware of unit measures and damaging levels of alcohol until it's pointed out directly. It doesn't look like it from my experience. The gauge people measure themselves against is generally their pal, family member, workmate. That seems to be also what comes out; they say 'yeah, okay, so it sounds like I'm drinking a lot, fair enough', when it's pointed out. But they say 'but I don't drink any more than my pal when I go out in the pub I'm actually not the worst of the lot'. So that's what comes out. They judge their drinking to that of their peers and because their peers are often drinking a lot, that's ok".

The trend towards purchasing cheap alcohol from supermarkets and people drinking more in the home has, in the view of many GPs, increased harmful/hazardous drinking. A number of GPs stated that 20-25 years ago alcohol consumption, broadly speaking, was associated with pubs and clubs, with the exception of special occasions at home, Christmas and New Year. Today, some GPs stated it is normal when people do their weekly/monthly shop to include beer, wine and spirits. As one of the above GPs stated, keeping track of units of alcohol consumed in the home was therefore difficult. This they believed could make it more difficult for some people to realise they were drinking alcohol to harmful/hazardous levels. Consequently, it could make it more difficult for patients to acknowledge their harmful/hazardous drinking.

A number of GPs drew attention to the smoking cessation campaign and the significant increases in the cost of cigarettes, and other initiatives around smoking that they believed were successful in getting smokers to reduce or stop smoking. In the view of many GPs there is a lower price deterrent threshold for addressing harmful/hazardous drinking than there is/was with other key public health initiatives such as smoking cessation. Many GPs believed that if the price of alcohol were increased to a minimum price per unit it would help address harmful/hazardous drinking. All but two of the GPs interviewed stated that they were in favour of Minimum Unit Pricing of alcohol units as one part of public health policy initiatives to address harmful/hazardous drinking in Scotland.

Alcohol, and excess alcohol consumption, being ingrained in Scottish society and culture and seen as 'social norm'

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 twenty or twenty-five years ago people tended to mainly drink at weekends in the pub, in clubs or with a meal in a restaurant. It is much more common and also cheaper to buy and consume alcohol at home and have a drink after a stressful day. As one GP noted:

Health Board 3 GP Practice 1

"There is a group of people I see, very respectable, professional people where their unit consumption is at the level of harmful. When I raise this they'll say 'but I needed to wind down, it's what I need at the end of the day'. Their attitude is 'a couple of glasses, large glasses of red wine, I need that to wind down and recover from the stress of the day and drinking at home is much more common now, so why not. Everybody I know does it'. Because it is seen as normal and what everyone else does it can be more difficult to get the message across".

This point was elucidated on by one GP, who said that because harmful/hazardous drinking was seen by many as 'normal', as most people in their social circle had the same or similar levels of drinking it could make an intervention difficult, as people didn't equate the normal drinking patterns as being problematic or harmful:

Health Board 6 GP Practice 8

"People not acknowledging that the high levels they are drinking is a problem, as high levels of drinking are the sort of social norms here. This can make it difficult to have an effective intervention, if people don't recognise that their drinking is at harmful levels. I mean some of them are clearly sceptical that 6 units is a binge for a woman and 8 is for a man. So I have to tell them, I'm not naïve, I know it's normal round here, that doesn't mean it's healthy. I say to patients, 'do you not notice it's also normal to drop dead quite young round here'? Some of them seem to think I'm some naïve evangelist. You're battling against the whole culture".

A number of GPs interviewed, stated that in spite of labelling units of alcohol on bottles and cans of alcohol having been in existence for some time, many patients they speak to when conducting an ABI still have little or a poor understanding of safe and unsafe drinking levels based on units of alcohol consumed, as exemplified by this GP:

Health Board 4 GP Practice 5

“There’s still a lot of people I see where I will ask how many drinks they have and they have really no idea whatsoever what that comes to in units and what the recommended units are for safe and unsafe drinking. Whether they’re lying to themselves or genuinely ignorant is difficult to be sure. I think probably a bit of both. What I do hear quite a lot is people is patients saying ‘but I drink less or don’t drink any more than my mates’ and seem to think this is ok. They are comparing their drinking with their peers, not comparing it to recommended safe and unsafe unit levels.”

Many GPs stated that it was only when they conducted an ABI with a patient and worked out the number of units they were drinking and related this to guidance on levels of harmful/hazardous drinking and discussed how harmful or potentially harmful this was, that patients actually realised the actual/potential dangers to their own health. GPs argued that this wasn’t about ‘scaring patients’ but rather having an awareness-raising conversation and providing them with support and information to tackle the harmful/hazardous drinking.

Acute/major stressful life events in patients can be a barrier to delivering an effective ABI

Delivering an effective ABI can be more difficult in patients experiencing major stressful events such as relationship breakdown, divorce, family tensions, financial worries, benefit changes, housing problems. In the experience of many GPs interviewed, many patients respond to such events through harmful/hazardous drinking, especially if they had poor social support and weak social networks. Sudden major changes in people’s personal and social circumstances through acute/major stressful life events could cause patients to begin or to revert to excess harmful/hazardous drinking even after a previously successful ABI as one GP related in an example of one of her patients:

Health Board 4 GP Practice 2

“I had a difficult experience recently with one of my patients who is a problem drinker. After an ABI I had referred him to alcohol services locally, he had gone through a very successful detox, had come back and seen me. He was looking great, feeling great, much better. Unfortunately, he got hit by the benefits people, and a few days after he finished his detox, he had to go and have an interview over continuation of benefits. He got really stressed out, went back on alcohol and he’s actually worse than he ever was. And you think, that’s a situation where the benefit changes have actually made his life harder. Now I can deliver another ABI but I can’t address the situation that triggers the return to harmful drinking”.

In the experience of a number of GPs, successful ABIs could be derailed by acute life events such as the above. Other acute life events GPs cited that triggered patients ignoring previous ABI delivery advice or making it more difficult to produce an effective ABI included relationship breakdowns, losing employment, wider family problems and exacerbation of mental health problems. A number of GPs stated that such patients respond to these acute stressful life events through harmful/hazardous drinking, especially if they have poor social support and weak social networks.

Many GPs stated that many patients experiencing stressful life events and undertaking harmful/hazardous drinking required an ABI, but also support to address the actual life events influencing their harmful/hazardous drinking. That was why many GPs stated that knowledge of additional community support services such as local Hubs or Keep Well that provide supports to address social and personal issues are important in complementing their delivery of an ABI in general practice. For many GPs interviewed delivering the ABI was vital, but so too was providing complementary support to address what was influencing the harmful/hazardous drinking to begin with. This was especially the case in male patients who lived alone and who had poor social support.

Results



This exploratory qualitative research study aimed to identify what GPs across diverse areas of Scotland characterised as the facilitators and barriers to delivering an effective ABI based on their everyday general practice work, in order to inform our understanding of GP practices and attitudes towards the delivery of ABIs.

Almost all GPs stated that they themselves and their practice colleagues had received ABI training in the last 1-2 years, describing it as helpful or very helpful. The data would suggest that investment in ABI training has been responsible for building support for ABI delivery in general practice and developed motivation and enthusiasm among GPs. Many GPs stated that their undergraduate medical training on alcohol use/misuse and alcohol as a public health issue was minimal and/or of poor quality. Updated training opportunities for GPs to acquire and refresh knowledge and confidence around ABI delivery should also be maintained.

For GPs interviewed, a crucial factor in making an ABI effective was sufficient time for them to unpack the reasons for, and levels of, the patient's harmful/problem drinking, then deliver the ABI to the patient with harmful/hazardous drinking. From the perspective of interviewed GPs, in addition to developing skills and knowledge, the investment in staff training has also been important in developing support for ABIs at the grassroots level. Those GPs who had taken part in more in-depth training sessions expressed enthusiasm for the initiative and enhanced motivation to become involved in delivering an ABI. The long-term aim of the HEAT H4 target is to embed and sustain ABIs into routine NHS clinical settings including primary care practice. Given that 55% of ABIs are carried out in primary care, the role of GPs and nursing practice staff is crucial. Our research also identified that GPs thought alcohol-related harm training during their undergraduate studies was too little and too early in the undergraduate curriculum, believing it should come later in the curriculum and be continued throughout their professional development.

GPs were of the opinion that recording systems needed to be as administratively simple as possible if ABI activity was to be developed further, mainstreamed and the impact evaluated. This of course gets to the heart of the current debate around pressures facing general practice and GPs in Scotland and represents one of the key tensions around ABI delivery, i.e. reducing administrative demands to make it easier to entrench ABI activities into routine practice. The issue of follow-up and auditing of ABIs was raised by a number of GPs and this was related to resources given to practices and some GPs noted that the system of developing ABIs was not quite universal but arbitrary based on what individual health boards do around ABIs. Overall our data demonstrated that for ABIs to be delivered effectively, appropriate financial, managerial and infrastructure support must be continued.

GPs were of a view that alcohol was more available and more heavily marketed than ever before in Scotland,

especially in supermarkets. They spoke of their experiences of changed patient drinking patterns across all social and demographic patient groups, most notably that people in Scotland are purchasing the vast majority of their alcohol through supermarkets, stores or off-licences, rather than in pubs and clubs, presenting new challenges in addressing harmful/hazardous drinking. GPs identified that this change in drinking patterns manifests itself in people drinking more at home/other people's homes and consequently, not being as conscious of how much alcohol they are consuming. GPs drew attention to the greater availability of cheaper alcohol in supermarkets that they believed was driving the changed drinking patterns referred to earlier in this report. Almost all GPs were in favour of Minimum Unit Pricing.

The GPs interviewed also stated that they saw themselves in the role of 'downstream responders' to Scotland's relationship with alcohol. Consequently, they emphasised the fundamental importance of 'upstream' interventions to address alcohol misuse in Scotland through population-wide health policies that address health inequalities, education, public safety, housing etc. Consequently, ABIs were seen by GPs as only one piece, although a very important piece, of the policy jigsaw to address harmful/hazardous alcohol drinking in Scotland.

GPs noted that when delivering an ABI, because of variations in gender and professional status, educational status, general literacy and numeracy skills (which vary significantly across Scotland) they had to do so in the context of the patient's social and biographical circumstances. To do otherwise would be to over-generalise and reduce the chances of an effective ABI delivery. In addition, a clearly expressed view of GPs was that to effectively deliver an ABI they require sufficient time with patients. This is because of the complexities, subtleties and difficulties in uncovering possible reasons for, and levels of, harmful/hazardous drinking and developing a plan with the patient to address the issue. For GPs, having the time to do this empathetically, in partnership with the patient, and relating the ABI to the person's social and biographical circumstances increases the effectiveness of an ABI. ABIs therefore must be very patient-centred to be effective. This, GPs pointed out, was time-consuming. But time that was a good investment for the patient with harmful/hazardous drinking.

From the perspective of the GPs in this study, GPs as professionals and general practice in general, are the hub of the NHS because of the multiple interfaces they work across, and have a key role in addressing alcohol misuse in Scotland. The interviewed GPs were overwhelmingly of a view that their contribution to responding to alcohol-related harm in Scotland, through ABIs, could be affected by lack of time and capacity. They believed that ABIs in primary care are effective but to continue to do so and to increase the chances of being effective, longer consultation times should be included in future GP work-force projections.

Conclusions

Almost a decade ago, Scotland became the first country in the world to introduce a universal programme of ABI delivery. As part of this, primary care was identified as a key setting for the delivery of this programme. GPs have and continue to play a crucial role in addressing harmful/hazardous drinking in Scotland through the delivery of ABIs in primary care as part of the HEAT Standard. The aim of this study was to identify what GPs across diverse areas of Scotland characterised as the facilitators and barriers to delivering an effective ABI based on their everyday general practice work. The report provides insightful data into the contextual factors and influences that to date has been lacking in the evidence base as identified by McCambridge & Saitz (2017). It is also hoped that these findings will contribute to the refresh of the Scottish Government's national alcohol strategy 'Changing Scotland's Relationship with Alcohol: A Framework for Action' (NHS Health Scotland, 2016).

The study data identified that facilitators for the effective delivery of ABIs fell into two main categories, systemic factors and patient-centred factors (cf. Results, p.11). The systemic factors bear similarities to those identified in the final MESAS report (NHS Health Scotland, 2016) and were largely related to the 'operational' mechanisms of the ABI delivery programme i.e. funding, support mechanisms, training and IT mechanisms for recording. Likewise, these similarities are also found in the results of a systematic review of qualitative evidence of ABI facilitators and barriers, where they were described as 'organisational and provider factors' (Johnson et al, 2011).

However, the patient-centred factors from our data go further and address some of the gaps that the MESAS report identified that exist, with regards to the characteristics of the individuals receiving ABIs, the context of their lives and how this may impact on their engagement with ABIs and their delivery potential. In the opinion of GPs, alcohol misuse (either through binge drinking or daily usage exceeding recommended unit levels) is ingrained in Scottish communities and cultures, regardless of age, social class, gender or cultural background. GPs were also of a view that the changing patterns of drinking and cheaper alcohol in supermarkets is leading to more drinking at home, with patients being unaware of the number of units consumed. Alongside this, patients were often dealing with acute/chronic external social and personal issues that would take priority over concerns related to alcohol, but would then trigger harmful/hazardous consumption. Again, some similarities are seen with the 'service user' factors identified in Johnson et al's (2011) systematic review.

It should be acknowledged that the qualitative findings reported from this study are based on small numbers of interviews that means they are not generalizable or representative of an all-Scottish view of GPs' practices and attitudes towards ABIs. It should also be recognised that there is a possibility of selection bias amongst the GPs participating in this study due to the fact that they may have been more likely to participate due to their particular interest/involvement in alcohol-related harm. The findings reported here are therefore presented to illustrate some of the issues around ABIs from a GP perspective that have emerged in interviews with a number of individual GPs from diverse parts of Scotland.

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Appendix 1: SHAAP Study Information Sheet



SHAAP/University of Edinburgh Study: Exploring the attitudes and practices of General Practitioners (GPs) in the delivery of Alcohol Brief Interventions (ABIs) in Scotland: A qualitative study.

Study Information Sheet

Introduction

You are being invited to take part in a research study looking into the attitudes and practices of General Practitioners (GPs) in the delivery of Alcohol Brief Interventions (ABIs) in Scotland. Before you decide to take part or not, it is important you understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and discuss it with another person if you wish. Don't hesitate to contact us if there is anything that is not clear or if you would like more information about. Please take time to decide whether or not you wish to take part.

What is the purpose of the study?

In 2011 the World Health Organisation noted that the burden of alcohol-related harm is internationally recognised as a global health problem. The associated mortality, morbidity, economic and social problems related to excessive alcohol consumption is estimated to lead to 2.5 million deaths per year.

There is convincing evidence of the benefits of health professionals such as GPs providing alcohol brief intervention (ABI), in the form of simple advice or brief counselling to patients in primary care for those whose levels and patterns of consumption place them at risk of developing alcohol dependency. Such interventions have been shown to be cost effective when delivered in this setting. The delivery of Alcohol Brief Interventions (ABI) as a method of addressing alcohol-related harm was set by the Scottish Government in 2008 as a national H.E.A.T (Health Improvement, Efficiency, Access and Treatment) target in three priority settings. The target evolved to become a HEAT standard for 2011-2013 with NHS Boards and Alcohol and Drug Partnerships (ADPs) being responsible for the delivery in at least 90% of the priority settings: A/E, Primary Care and Antenatal care.

Why have I been invited to take part?

We would like you to take part in our study because you work with patients who have had an alcohol brief intervention (ABI). We want to speak with GPs to gather their attitudes and practices towards the delivery of Alcohol Brief Interventions (ABIs) in Scotland.

Do I have to take part?

Participation is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form which is to demonstrate you understand what the research is about, what it involves, and that you are participating through your own free will. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What will happen if you take part?

You will take part in a confidential one to one semi-structured interview. The interview will last approximately 45-60 minutes. The aim of the interview is to gather GP views on existing service provision around ABIs in Scotland. With your permission the interview will be recorded. We would like to do this because we want to keep an accurate record of everything that is said in the focus group, it also makes for a more effective way of analysing what people said in your and the other interviews. This written record (a transcript) will be securely stored at the university, and only the people involved in organizing the research will have access to the transcript. Your name will not be used in the transcript, you will be identified by a code to ensure that you have complete confidentiality. Should you wish to see a copy of your transcript you can contact us at the address below and we will supply you with a copy. We will keep

a copy of your transcript and the audio recording of your interview securely stored for three years and then it will be destroyed. If you don't wish the interview to be audio recorded we will respect your wishes and will take a written note of the interview instead.

We will write a report based on what people said in the interviews. If you wish, you will receive a copy of this report, or details about where to access the report on-line.

What will happen to the findings of this study?

After the study is completed we will write a report based on the findings. This report will be sent to appropriate local health and social care organisations, Voluntary Sector agencies and the Scottish Government. We will also publish our findings in health care and health service journals. You will not be identified in any report or publication.

Thank you for taking the time to read this leaflet and if you do decide to take part, we very much appreciate your involvement.

Contact Details:

Dr Edward Donaghy
Research Fellow
Medical School
University of Edinburgh
Royal Infirmary Hospital
Room GU: 309
49 Little France Crescent
Edinburgh
EH16 4SB
Tel. 07766 772645
Email: Eddie.doanghy@ed.ac.uk

Appendix 2: Consent Form



SHAAP/University of Edinburgh Study: Exploring the attitudes and practices General Practitioners (GPs) in the delivery of Alcohol Brief Interventions (ABIs) in Scotland: A qualitative study.

GP Consent Form

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that taking part is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical or legal rights being affected.

3. I understand that relevant sections of my interview during the study may be looked at by individuals from the Sponsor(s) (SHAAP and the University of Edinburgh) and I give permission for those individuals to have access to my interview

4. I understand that all information will be treated in the strictest of confidence, will not be traceable to me and will only be used for the purposes of this research

5. I understand the interview will be recorded and that direct quotes may be used in future publications, but that I will not be identified in any way.

6. I agree to take part in the above study.

Name of Interviewee

Date

Signature

Name of Person taking consent

Date

Signature

Original (x1) to be retained in site file. Copy (x1) to be retained by the participant.



SHAAP - Scottish Health Action on Alcohol Problems
12 Queen Street
Edinburgh EH2 1JQ
Tel: +44 (0) 131 247 3667
Email: shaap@rcpe.ac.uk
www.shaap.org.uk



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