Symposium 3 – 2018 Nordic Implementation Conference

Scaling the translational divide for brief alcohol interventions

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Introduction

Despite the considerable health, social and economic benefits that could be achieved through more effective implementation of preventive interventions aimed at reducing the non-communicable disease burden, only a small fraction of these innovations are delivered in routine practice, often many years after they were first developed. Brief behavioural interventions for heavy drinking represent a prime example of the persistence of this translation gap.

There have been over three decades of high quality research demonstrating the effectiveness of questionnaire-based alcohol screening and brief intervention (ASBI) programmes in reducing heavy drinking when delivered in primary care settings, including multi-centre WHO-sponsored studies and dozens of randomised controlled trials. Yet application of ASBI remains inconsistent, with an estimated four out of five heavy drinking individuals failing to receive appropriate advice or treatment worldwide.

Recent research suggests that training, support and financial incentives have the potential to increase delivery rates, but improvements to date have been relatively modest and short-lived. Moreover, whilst the majority of activity thus far has taken place in Western, developed countries, there is growing demand for ASBI to be rolled out in low and middle income countries, intensifying the need for more successful models of implementation.

Aim and learning objectives

This workshop aims to present worked examples of how theories, tools and techniques from implementation and scale-up science can be used to encourage and evaluate improved adoption of ASBI in health care. The team bring over 40+ years' experience of implementation-focussed ASBI research in several European countries including the European BISTAIRS project, an evaluation of the Swedish Risk Drinking Project, and NIHR School for Primary Care Research examining the delivery of ASBI in English primary care. The objectives of the workshop are threefold:

1. To consider the challenges involved in translating evidence-based interventions to real-world practice;
2. To discuss the potential for using implementation theory to encourage and evaluate intervention delivery in complex health systems;
3. To reflect on implications for future implementation research, policy and practice in the alcohol prevention field and beyond.

Workshop content

- **Nadine Karlsson & Janna Skagerström** will present initial results from three population surveys of ASBI implementation in routine healthcare settings carried out in England, Sweden and the Netherlands to illustrate current rates of delivery in Northern Europe.
- **Amy O'Donnell** will outline findings from Normalisation Process Theory-informed interviews to understand the barriers and facilitators experienced by English GPs as they implement ASBI in primary health care.
- **Latifa Abidi** will describe the development and evaluation of an ASBI implementation program based on the Behaviour Change Wheel and the Theoretical Domains Framework for GPs in the Netherlands.
- **Bernd Schulte** will outline the protocol for the forthcoming multi-centre SCALA project (Scaling-up primary health care-based prevention and management of alcohol use disorder at the municipal level in middle-income countries in Latin America), which seeks to test the extent to which embedding primary healthcare-based prevention and management of alcohol use disorder with supportive municipal action leads to more patients with heavy drinking receiving appropriate advice and treatment.

Throughout the workshop, participants will be encouraged to share their own experiences, and to consider future opportunities for implementation research and evaluation, including new studies or collaborations. Professor **Per Nilsen** will act as discussant, drawing on his extensive knowledge of implementation models, theories and frameworks.

Details are provided below.

Presentation 1: Implementation of alcohol prevention in healthcare in Sweden, England and the Netherlands (Nadine Karlsson)

Background

Closing the evidence to practice gap for alcohol screening and brief interventions (ASBI) requires a robust understanding of the multiple and interrelated factors that shape their effective implementation. Yet we have little knowledge of the motivations or beliefs of patients, or of the duration, content and effects of alcohol prevention delivered in routine healthcare.

Project aim

To address key knowledge gaps on the implementation of ASBI in routine health care by means of a RE-AIM informed population survey. Specific research questions are: (1) How extensively are alcohol interventions currently implemented in healthcare?; (2) Are alcohol interventions being delivered as intended in healthcare with regard to duration and contents?; (3) Are alcohol interventions delivered in routine healthcare settings effective?; (4) What are the attitudes of patients towards alcohol prevention in healthcare consultations?

Project methods

The study consists of three cross-sectional population surveys of adults in Sweden (n=3000), England (n=3400) and the Netherlands (n=2000) collected in 2017. We have the following data for each country: sociodemographic data, data on alcohol consumption and data on the beliefs and attitudes on alcohol prevention in healthcare.

Project results

This research is ongoing. We will present emerging results from each national survey, including descriptive summary statistics, alongside general comparisons between countries.

Preliminary or final conclusion / discussion

The findings will inform our understanding of the societal conditions that underpin a succesful strategy for the delivery of ASBI in routine healthcare at population level.

Presentation 2: Normalising alcohol intervention delivery in primary health care: a qualitative study of English GPs (Amy O'Donnell)

Background

Various measures have been introduced to encourage alcohol screening and brief intervention (ASBI) implementation in English primary health care, including the publication of clinical guidelines, the incorporation of consumption questions in annual health checks, and the introduction of financial incentives between 2008-2015. However, there has been limited evaluation of their impact.

Project aim

To use Normalisation Process Theory-informed interviews to understand the barriers and facilitators experienced by English GPs as they implement ASBI in routine clinical practice.

Project methods

In-depth semi-structured interviews with 14 GPs based in North East England were audio-recorded and transcribed verbatim. Data was analysed in two-phases: (1) framework analysis to identify emergent themes; (2) thematic mapping against core NPT constructs (coherence, cognitive participation, collective action, reflexive monitoring).

Project results

We found multiple factors shaped provision. GPs were broadly cognisant and supportive of preventative alcohol interventions (coherence) but this did not necessarily translate into personal investment in their delivery (cognitive participation). This lack of investment shaped how GPs operationalised such "work" in day-to-day practice (collective action), with ASBI mostly delegated to nurses, and GPs reverting to "business as usual" in their management and treatment of problem drinking (reflexive monitoring).

Preliminary or final conclusion / discussion

There has been limited progress towards the goal of an effectively embedded preventative alcohol care pathway in English primary care. Future policy should consider screening strategies that prioritise patients with conditions with a recognised link with excessive alcohol consumption, and which promote more efficient identification of the most problematic drinkers. Improved GP training to build skills and awareness of evidence-based ASBI tools could also help embed best practice over time.

Presentation 3:A theory-based program for alcohol screening & brief interventions in general practices (Latifa Abidi)

Background

Previous studies have shown that alcohol screening and brief intervention (ASBI) in general practices can lead to significant reductions in alcohol consumption among patients, yet ASBI is rarely implemented into routine clinical practice.

Project aim

The aim of this project is to describe the development and evaluation of an ASBI implementation program aimed at increasing ASBI delivery rates. More specifically, the following two goals were formulated: 1) To investigate which patients GPs screen for alcohol use (i.e. which physical, social and psychological signs these patients have); 2) To investigate whether GPs who receive the implementation program increase either overall or targeted screening compared to GPs in a control group.

Project methods

A four-step method was used to identify relevant determinants of change and intervention components based on the Behaviour Change Wheel and the Theoretical Domains Framework. We developed a program consisting of an e-learning module, a tailored feedback module and environmental support and materials for GPs. The program was evaluated in general practices in The Netherlands in a two-arm cluster randomized controlled trial which investigated the effect of the program on GPs' ASBI delivery behaviour by measuring ASBI delivery behaviour on baseline and post-intervention.

Project results

Preliminary findings show that the overall screening rate significantly decreased over time ($F=8.9$ (1), $P < .05$) and that there was a significant difference in change over time between the groups ($F=5.1$ (1), $P < .05$). Specifically, the intervention group had a significantly smaller decrease over time in overall screening than the control group. Regarding targeted screening of patients with "frequent visits and an unclear/unexplained pattern of symptoms" a marginally significant group x time interaction was found indicating higher screening rates in the intervention group at post-measurement.

Preliminary or final conclusion / discussion

The larger decrease in overall screening in the control group might indicate that GPs in both conditions started out motivated (i.e. high screening), but decreased to normal levels in the control group, while decreased less in the intervention group (possibly due to the limited effect). It's difficult to assess whether these results are due to difficulty of implementation the intervention, or difficulty in implementing the research study (as seen by a high drop-out in this and other studies).

Presentation 4: Scaling-up the prevention and management of alcohol use disorder in Latin American primary care (Bernd Schulte)

Background

Primary health care (PHC) based prevention and management of alcohol use disorder (AUD) is clinically- and cost-effective but remains poorly implemented. Practice level training and support programmes to increase activity rates have had only modest and short term impacts. More effective uptake could be achieved by embedding activity within broader community and municipal support systems.

Project aim

To test the extent to which embedding PHC-based prevention and management of alcohol use disorder with supportive municipal action in three cities in Latin America (Peru, Columbia and Mexico) leads to higher rates of patients with heavy drinking receiving appropriate advice and treatment.

Project methods

Quasi-experimental study. In the implementation cities, PHCUs will receive training embedded within ongoing supportive municipal action over an 18-month implementation period. In the comparator cities, practice as usual will continue at both municipal and PHCU levels. The primary outcome will be the proportion of consulting adult patients intervened with (screened and advice given to screen positives), assessed at baseline, mid-point and end-point. Full process evaluation will be undertaken, coupled with an analysis of potential contextual, financial and political-economy influencing factors.

Project results

This presentation will provide an overview of the SCALA approach, based on the Institute for Healthcare Improvement's Framework for 'Going to Scale': (1) Set-up (preparing ground for introduction/testing of the scale-up package); (2) Develop the Scalable Unit (early testing phase); 3) Test of Scale-up (in a variety of potential contexts); and (4) Go to Full Scale (enabling adoption in additional sites). In doing so, we will consider the value of moving beyond individual/organisation implementation strategies to those which address the wider social, political and economic context.

Preliminary or final conclusion / discussion

he study is ongoing. We hope that the findings from SCALA will provide a validated framework and strategy that has the potential to support evidence-based health system interventions to go to full-scale in the future.