ALCOHOL RESEARCH UK
Reducing alcohol-related harm

A randomised controlled trial of training and support strategies to encourage screening and brief alcohol intervention

Introduction

Excessive drinking is a major source of health and social problems in the UK each year. Alcohol-related problems are experienced by a high proportion of the population and are by no means confined to alcohol dependent drinkers. Thus tackling excessive drinking in the broader population has a greater impact on reducing alcohol-related problems in society than a focus on the smaller number of extreme cases. There is good evidence to show that excessive drinking is responsive to brief alcohol intervention in primary health care. However, most of the research to date has focused on general practitioners (GPs). Nurse involvement in brief alcohol intervention is low, despite the fact that they may be more cost-effective at delivering brief intervention in primary care.

This study, carried out by Dr Eileen Kaner, Ms Catherine Lock, Professor Senga Bond and Professor Brian McAvoy from the University of Newcastle upon Tyne in collaboration with Professor Nick Heather and Dr Eilish Gilvarry from the Centre for Alcohol and Drug Studies, aimed to identify the most effective and cost-effective strategy to encourage nurses to implement a screening and brief alcohol intervention programme in primary health care. A randomised controlled trial evaluated the impact on implementation of providing nurses with written guidelines related to programme use (controls), guidelines plus practice-based training related to programme use (trained nurses), and guidelines plus training and ongoing telephone support related to programme usage (trained and supported nurses). The research hypothesis was that there would be a positive relationship between intensity of the training and support strategy and subsequent implementation of the brief alcohol intervention programme.

Of 312 nurses who were randomly sampled into the study, 270 (87%) were eligible for recruitment and 212 (79%) nurses agreed to use the programme for three months in their practices (76 controls, 68 trained nurses and 68 trained and supported nurses).

Findings

After 3 months 128 (60%) nurses had implemented the programme. In total these nurses screened 5,541 patients (range 0-332), identified 1499 (27%) patients as 'risk' drinkers and provided a brief intervention to 1333 (89%) patients.

There was a significant difference in implementation rate between the intervention conditions. Fewer controls (39%) implemented the programme than trained (74%) or trained and supported nurses (71%).

When the costs of training and support were set against implementation rates, it was found that training nurses was the most cost-effective implementation strategy. The costs per nurse implementing the programme were £155 for controls, £119 for trained nurses and £122 for trained and supported nurses.

Nurses' feedback concerning the brief intervention approach was positive. In addition, direct experience with the brief alcohol intervention programme generated positive attitude changes towards alcohol-related issues, which were sustained beyond the immediate study period.

Implications

This study showed that primary care nurses are interested in screening and brief alcohol intervention and many of them are willing to incorporate this approach into practice.

Giving nurses intervention materials plus written guidelines alone was not sufficient to change practice behaviour. Skill-based training in practices was the most effective and cost-effective implementation strategy in this study.

The results of this study should provide direction for future planning of health promotion programmes and policies in primary health care, which could contribute to decreasing the health and social costs of excessive alcohol consumption in the population.

Further Information

Most of the nurses who implemented the brief alcohol intervention programme in this study did so opportunistically, that is when they had enough time to undertake the extra screening and intervention activity, Programme implementation also tended to occur in specific contexts such as new patient registrations, well person checks or in chronic disease monitoring clinics. Restriction of screening and brief alcohol intervention to specific contexts was due to the part-time working status of many nurses and a tendency of nurses to specialise on particular health issues. Future implementation research may need to take account of the working context of primary health care nurses and adopt a flexible approach to use of interventions in practice.

Most nurses in this study did not have receptionist help in giving out screening questionnaires. However, when such help was available, nurses implemented the programme more extensively. Nurses reported that they could not ask receptionists to help them with extra work in practices without seeking permission from GPs or practice managers. It is possible that securing assent for involvement in brief alcohol intervention from the whole of the primary health care team, and in particular from GPs, might enable more efficient delivery of screening and brief alcohol intervention in routine practice.

Overall screening and brief intervention rates in the study were low. These low rates were partly due to the fact that analysis included all nurses, including those who dropped out of the study. However, they were also due to the fact that at least some nurses used the programme inaccurately, either by not intervening with all risk drinkers identified or by inappropriately intervening with non-risk drinkers. Thus at least some nurses used criteria other than (or in addition to) patients' risk drinking status to determine who should receive brief alcohol intervention and future analysis may need to investigate this issue further.

Research Team

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