

A brief intervention for risky drinking—analysis of videotaped consultations in primary health care

KAIJA SEPPÄ^{1,2}, MAURI AALTO², LIISA RAEVAARA³ & ANSSI PERÄKYLÄ⁴

¹Department of General Practice, University of Tampere, ²Department of Psychiatry, Tampere University Hospital, ³The Research Institute for the Languages of Finland, Helsinki and ⁴Department of Sociology and Social Psychology, University of Tampere, Finland

Abstract

*In order to study activity in conducting brief alcohol intervention, a total of 83 consecutive consultations by eight general practitioners were videotaped. The categorization included the nature of the patient's health problems and whether alcohol consumption was elicited. The discussions were compared to previously given instructions. Alcohol consumption was elicited in 9/34 of the consultations where enquiry was indicated by the instructions, and rarely in any other situations. The activity among the individual physicians varied, but none of them elicited systematically in all situations with indication. No information was given to any of these patients concerning the relation between their symptoms and alcohol consumption. In conclusion, enquiring and advising on alcohol were seldom performed. More training is needed, especially on how to inform individual patients of the health risks of alcohol. [Seppä K, Aalto M, Raevaara L, Perakyla A. A brief intervention for risky drinking—analysis of videotaped consultations in primary health care. *Drug Alcohol Rev* 2004;23:167–170]*

Key words: brief intervention, general practitioner, risky drinking.

Introduction

Much effort is needed to implement brief intervention in risky drinking as part of every-day work in health care. The evidence confirming its efficacy as well as cost-effectiveness is convincing [1–3], but knowledge, skills, self-efficacy and resources to do brief intervention are claimed to be lacking [4–9].

Efforts to implement brief intervention in health care have been undertaken previously in Finland [10]. Starting in 1997 we participated in a WHO Phase IV collaborative study for the widespread implementation of early identification of and brief intervention in risky drinking. Based on this project, and in collaboration with the health care professionals in Tampere City Health Centre, we have produced simple instructions on how to conduct brief intervention [11]. The instructions are based on a postal survey among general practitioners and nurses [8] and on a focus group study among these professionals [12]. In brief, the instructions advise workers to elicit information on alcohol drinking, preferably using an open-ended question, or

to complete the Alcohol Use Disorders Identification Test, AUDIT [13] for patients attending health check-ups or for patients with accident or trauma, high blood pressure, arrhythmia, sleep disorder, depression, anxiety, abdominal complaints, hangover or abnormal blood test value indicative of risky drinking (S-GT, S-CDT, E-MCV). If the patient proves to be a risky drinker, advice on reducing alcohol drinking is given verbally and by a booklet in collaboration with the patient and in relation to his/her complaints. Also, a re-consultation is recommended. The instructions were mailed to all professionals at Tampere Health Centre.

There are several methods to study the activity of health-care professionals undertaking different tasks. The options include interviewing or asking the professionals or the patients, or reviewing patient documents. All these methods include the risk of bias. This is why, to learn about the professionals' activity in conducting brief alcohol intervention, we videotaped consultations in one health centre in the city of Tampere 6 months after the implementation of instructions on conducting brief intervention.

Kaija Seppä, Department of General Practice, University of Tampere and Department of Psychiatry, Tampere University Hospital, Finland; Mauri Aalto, Department of Psychiatry, Tampere University Hospital, Finland; Liisa Raevaara, The Research Institute for the Languages of Finland, Helsinki, Finland; Anssi Peräkylä, Department of Sociology and Social Psychology, University of Tampere, Finland. Correspondence to Kaija Seppä, Medical School, FIN-33014 University of Tampere, Finland. Tel: +358 3 2157101; Fax: +35832156722; E-mail: mekase@uta.fi

Received 24 June 2003; accepted for publication 25 September 2003.

Material and methods

The study was conducted with the permission of the Ethics Committee of the Social and Health Care of the City of Tampere. Before videotaping both physicians and patients gave written consent.

A total of 83 consecutive consultations (one-third of the patients refused) were videotaped at the Health Centre during autumn 1999, 6 months after the implementation of the instructions. Of the 11 general practitioners, eight agreed to participate. Five of them were female and three were male; all were under 55 years of age. Only the first consultation per patient was included. Fifty-five patients were female and 28 were male; the mean ages were 54.7 and 59.7 years, respectively. Five of the consultations were with physicians 4 and 6 (Table 1), nine with P3, 10 with P5, 12 with P7 and P8, 13 with P2 and 17 with P1. For the videotaping the physicians were allowed to choose a suitable day. They were informed that the aim of the study was to examine patient–doctor communication and also how often and how the patients' alcohol consumption is discussed during the consultation. The physicians were also aware of the connection between videotaping and the brief intervention implementation study. The patients were told that the aim of the study was to improve patient-doctor interaction. The camera was left standing in the doctor's surgery without the presence of the researchers.

All videotaped consultations were transcribed. From these we categorized quantitatively all consultations regarding (1) whether the patient's health problem was likely to be alcohol-related (trauma, high blood pressure, arrhythmia, sleep disorders, depression, anxiety, abdominal complaints, hangover, abnormal laboratory results in MCV, GGT or CDT), (2) whether alcohol consumption was elicited, (3) whether the question was open or closed and (4) whether brief intervention was undertaken. The conversation analytical part of the study has been published separately [14].

Results

The physician initiated a discussion about alcohol in 11/83 (13%) of consultations. Additionally, in four consultations the patients took the initiative, stating that

they had succeeded in reducing their alcohol consumption. Thus, in a total of 15/83 (18%) consultations patients' alcohol consumption was discussed. All information about alcohol was based on discussions; the AUDIT questionnaire was not used. Of the questions six (55%) were closed (i.e. eliciting a "yes" or "no" answer) and five (45%) were open (i.e. not strictly specifying the type of appropriate answer).

The indications of the instructions, certain diagnoses or symptoms were fulfilled in 9/11 (82%) of consultations where alcohol was discussed on the doctor's initiative. The two remaining patients were an obese patient (the discussion about diet included alcohol), and one patient having a check-up after a breast cancer operation. There were 25 consultations where the reason for the consultation, according to the instructions, would have required elicitation and brief intervention, but where alcohol was not discussed. In 18 of these 25 the patient had visited the same physician earlier and seven were first-time consultations. Of the latter group, four patients had depression and sleeping disorders, two had high blood pressure and one had arrhythmia. Thus the number of consultations where elicitation would have been indicated by the instructions was 34; of these consultations, questions about alcohol use were actually asked in nine (27%).

Eliciting/not eliciting in relation to the instructions and individual physicians is presented in Table 1; none of the physicians asked every patient indicated by the instructions and only one of them (P1) asked two patients where enquiry was not indicated by the instructions.

Information on alcohol consumption, either verbal or written (the booklet) was given to none of the patients. After enquiring, the physicians did not tell the patient whether or not his/her alcohol consumption was risky. None of the patients was referred to a special clinic because of risky alcohol consumption.

Discussion

The main finding in this study is that even if the consensus on conducting brief intervention in certain situations was agreed and the information to do so was distributed to all general practitioners in the area, the activity of following the instructions was low. In the

Table 1. Physicians' activity in eliciting patients' alcohol consumption in situations where risky drinking is highly probable

	P(physician)1	P2	P3	P4	P5	P6	P7	P8	Total
Elicited	3/6	1/5	1/4	0/2	2/6	0/2	0/5	2/4	9/34
Did not elicit	3/6	4/5	3/4	2/2	4/6	2/2	5/5	2/4	25/34

actual consultations, questions about drinking habits were asked only seldom, and advice and evaluation concerning alcohol were totally absent from our data.

It could be speculated that the process of implementation was not properly carried out. Knowing that it is not effective to implement an innovation using only one single method [15], we used a tailored set of methods of implementation; education, availability of consultants and reminders [11].

In highly probable hazardous drinking situations alcohol consumption was inquired in 27%. This is comparable to the figures found in the study by Arndt *et al.* [16], where the respondent's physician initiated discussions about drinking in 27.8% among hazardous drinkers. However, the figure is clearly higher compared to our recent study among patients, where 11.9% of excessive drinkers were asked about alcohol consumption in the consultation in question [17]. The latter can be explained by the fact that patients, even if asked immediately after the consultation, may forget part of the content of the discussion, but also because it is possible that only the most active general practitioners (GPs) agreed to participate. This may be the more so because enquiry did not include reflection or any advice. Another reason may be that in the present study physicians were more aware of the aim of the study. One way to determine what physicians do could be simply to ask them. However, using this method incorrect information might be obtained and much valuable information would be lost. This is why we chose to videotape and analysed what actually happened.

A special feature of enquiring is that the physicians seem to indicate clearly to the patient their motivation for asking about the patient's drinking habits [14]. A symptom or a disease in which alcohol may be one of the causes is good motivation. In the present study, however, even with patients who had potentially alcohol-related symptoms or diseases, enquiring about alcohol consumption was rare. This may be due to several reasons. First, the situation of the consultation may vary, so that even if the cause for consultation may include the possibility of risky drinking, the physician does not consider the timing appropriate to enquire about it. Secondly, the clinical impression may lead the physician to abandon the possibility of alcohol even if the instructions advise him/her to ask. Thirdly, the physician may consider enquiry useless with regard to those patients with whom (s)he may have earlier been unsuccessful when offering lifestyle advice. This lack of success may, of course, be due to the physician or the patient. Routine means that some tasks are performed without the need to provide reasons. It seems clear that asking about alcohol-related topics is not a routine activity in general practice.

During the past decades much effort has been put into developing questionnaires to detect patients' risky alcohol consumption [13]. However, in this real-life situation the physicians did not seem to be willing to use these structured aids for asking.

Our previous studies have shown that nurses and physicians are willing to ask and advise their patients about alcohol in certain situations [8,12]. The fact that they seldom do so is due probably to the clinical situation, which is much more delicate than routine instructions. The earlier history of the physician-patient relationship and a possible lack of self-efficacy in advising are only two obstacles. It may be that asking alcohol-related questions of 27% of the patients who, according to the instructions, should be asked, is a reasonably good result. With refinement of skills the optimal percentage in real-life situations might be doubled. Special effort should be put into advising patients, which, according to the present study, proved to be totally neglected.

Acknowledgments

The study was funded by the Finnish Foundation for Alcohol Studies and the Ministry of Social Affairs and Health.

References

- [1] Wilk AI, Jensen NM, Havighurst TC. Meta-analysis of randomized control trials addressing brief interventions in heavy alcohol drinkers. *J Gen Intern Med* 1997;112:274-83.
- [2] Berglund M, Andréasson S, Franck *et al.* (eds) *Behandling av alkohol- och narkotikaproblem* [Treatment of alcohol- and drug problems]. Stockholm: The Swedish Council on Technology Assessment in Health Care, 2001.
- [3] Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice with problems drinkers: long-term efficacy and benefit-cost analysis. *Alcohol Clin Exp Res* 2002;26:36-43.
- [4] Weller DP, Litt JCP, Pols RG, Ali RL, Southgate DO, Harris RD. Drug and alcohol related health problems in primary care—what do GPs think? *Med J Aust* 1992;56:43-48.
- [5] Roche AM, Parle MD, Cambell J, Saunders J.B. Substance abuse disorders: psychiatric trainees' knowledge, diagnostic skills and attitudes. *Aust NZ J Psychiatry* 1995;29:645-52.
- [6] Kaner EFS, Heather N, McAvoy BR, Lock CA, Gilvarry E. Intervention for excessive alcohol consumption in primary health care: attitudes and practices of English general practitioners. *Alcohol Alcohol* 1999;34:559-66.
- [7] Kääriäinen J, Sillanaukee P, Poutanen P, Seppä K. Opinions on alcohol-related issues among professionals in primary, occupational, and specialised health care. *Alcohol Alcohol* 2001;36:141-6.
- [8] Aalto M, Pekuri P, Seppä K. Primary health care nurses' and physicians' attitudes, knowledge and beliefs regarding brief intervention for heavy drinkers. *Addiction* 2001;96:305-11.

- [9] Johansson K, Bendtsen P, Åkerlind I. Early intervention for problem drinkers: readiness to participate among general practitioners and nurses in Swedish primary health care. *Alcohol Alcohol* 2001;37:38–42.
- [10] Kääriäinen J, Sillanaukee P, Poutanen P, Seppä K. Brief intervention for heavy drinkers: an action project for health care implementation. *Alcologia* 2001;13:67–73.
- [11] Seppä K, Aalto M. Alkoholisairauksien sekundaaripreventio perusterveydenhuollossa [Secondary prevention of alcohol-related diseases in primary health care]. *Kunnallislääkäri* 2001;16:15–17.
- [12] Aalto M, Pekuri P, Seppä K. Obstacles to carrying out brief intervention for heavy drinkers in primary health care: a focus group study. *Drug Alcohol Rev* 2003;22:169–73
- [13] Saunders JB, Aasland O.G. WHO collaborative project on the identification and treatment of persons with harmful alcohol consumption. Report on Phase I: Development of a screening instrument. Geneva: World Health Organization, 1987.
- [14] Raevaara L. Potilaan alkoholinkäyttö—ongelmallinen puheenaihe terveyskeskuslääkärin vastaanotolla [How the patient uses alcohol—a problematic topic for the general practitioner during office visits]. *Duodecim* 2003;119:313–20.
- [15] Bero LA, Grilli R, Grimshaw JM, Harvey E, Oxman AD, Thomson MA, on behalf of the Cochrane Effective Practice and Organization of Care Review Group. . Closing the gap between research and practice. An overview of systematic reviews of interventions to promote the implementation of research findings. *Br Med J* 1998;317:465–8.
- [16] Arndt S, Schultz SK, Turvey C, Petersen A. Screening for alcoholism in the primary care setting: are we talking to the right people? *J Fam Pract* 2002;51:41–6.
- [17] Aalto M, Pekuri P, Seppä K. Primary health care personnel's activity in intervening in patients' alcohol drinking: a patient perspective. *Drug Alcohol Depend* 2002;66:39–43.