The feasibility and acceptability of introducing brief intervention for alcohol misuse in an urban Aboriginal medical service

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Abstract
We report on the feasibility and perceived acceptability of brief motivational interviewing for hazardous alcohol use in an urban Aboriginal health service. General practitioners (GPs) were trained in brief motivational interviewing, and health workers in other aspects of the intervention. Screening was initially carried out using the AUDIT, but subsequently reduced to two simple questions. Information was obtained through a combination of participant observation by the study team, ongoing ad hoc review and feedback from staff, periodic group meetings, and one-on-one interviews with health workers and GPs. The AUDIT was felt to be intrusive and some questions were poorly understood. Brief intervention seemed to be culturally appropriate, but barriers to wider administration included lack of time and the complexity of patients’ presenting health problems. As a result of the research there was an increase in general awareness and acceptability of addressing alcohol issues at the health service. This study raises a number of issues that both support and threaten the wide implementation of brief intervention in urban Aboriginal primary care settings. [Brady M, Sibthorpe B, Bailie R, Ball S, Sumnerdodd P. The feasibility and acceptability of introducing brief intervention for alcohol misuse in an urban Aboriginal medical service. Drug Alcohol Rev 2002;21:375–380]

Key words: Aboriginal health service, alcohol misuse, brief intervention, indigenous people.

Introduction
Around one in six patients treated in general medical practice report drinking at levels that are potentially harmful to health [1,2] and brief interventions in these settings have consistently been found to help patients reduce that risk. [3–5] Despite these findings, there has been little effort to make these interventions available to Aboriginal or Torres Strait Islander people through their health services.

Brief intervention is a term used to describe a range of strategies including screening, brief advice, referral to specialist support, counselling and brief motivational interviewing. These strategies can be delivered at one or more primary care encounters to individuals who do not present primarily with an alcohol problem [6]. Brief motivational interviewing is designed to avoid the situation in which a health professional provides advice to an unwilling patient who is not ready to change. The idea is to help the patient explore any ambivalence he or she may have towards drinking and provide a ‘motivational nudge’ [7]. In the approach designed by Rollnick and colleagues, raising the issue of ambivalence is couched in terms of discussing the ‘good’ and ‘not so good’ things about drinking, as defined by the patient [8]. This project, undertaken by a research partnership between a community controlled Aboriginal health service and universities, was the first attempt to test the feasibility and acceptability of brief motivational interviewing for hazardous and harmful alcohol use in an urban indigenous primary care setting.

During a 12-month period, two randomized controlled trial (RCT) study protocols were piloted and a revised non-randomized ‘demonstration project’ was...
implemented and ran for 6 months. For reasons reported elsewhere the demonstration project was eventually terminated due to low enrolment. [9] However, over the 12-month period during which we attempted to implement the study, we were able to make some assessment, albeit based on small client numbers, of the acceptability of screening, motivational interviewing and the intervention materials; the impact of the training; the role of general practitioners (GPs) and health workers; and the barriers to incorporation of brief intervention in routine clinical care. We feel it is important to report on this assessment because so little work has been conducted in this area.

Methods

Both the RCT pilots and the demonstration project involved some form of screening to identify people at risk. Health workers were trained to screen patients for eligibility for the intervention using two different tools, the Alcohol Use Disorders Identification Test (AUDIT) (for the RCT) and two questions about alcohol consumption that were already on the clinic’s routine intake assessment form before the trial began (for the demonstration project). Brief interventions were to be delivered by the GP to those identified through screening as drinking at hazardous or harmful levels. The GPs were trained in the technique of brief motivational interviewing and provided with intervention materials including a flip-chart for use in the consultation.

Information on which this paper is based was obtained by a combination of participant observation by members of the study team, ongoing ad-hoc review and requests for feedback from staff, periodic group meetings and one-on-one interviews with health workers and GPs on two occasions. A brief questionnaire was also sent to the GPs 18 months after the termination of the study to see if they were still using brief interventions. We did not conduct any in-depth interviews with participating patients—were planned for the 6 month follow-up visits which never eventuated.

Results

A total of eight health workers and six GPs participated in the project and provided input through the mechanisms described above. Twenty clients received the AUDIT; and 25 received a brief intervention.

The acceptability of screening

There are a number of screening instruments available for assessing levels of alcohol consumption and harm, but reports of their use with indigenous clients are comparatively rare [10–12]. The 10-question AUDIT, which is designed for interview or self-completion, asks about frequency, quantity and the social impacts of drinking. It was selected as the screening instrument for the RCT because it is designed to identify patients with symptoms of alcohol dependence (three items), hazardous and harmful alcohol consumption (seven items), as well as binge drinking. It is suitable for primary health care settings [13] and is also in use with indigenous clients in Australia. During the study there was a mix of interview and self-completion depending on the capacity and inclination of the clients.

The health workers found the AUDIT long and intrusive: the questions were ‘getting too close’, and ‘prying into their private life’. As others have found [14,15], there were also problems with question comprehension. For example, question 8 (‘How often during the last year have you had a feeling of guilt or remorse after drinking’) sometimes needed clarification and had to be reworded along the lines of ‘Do you ever feel “I wish I hadn’t done that?”’. Health workers also observed that clients sometimes ‘fudged’ their responses.

As a result of these problems, when the RCT was abandoned in favour of a demonstration project the AUDIT was replaced by two screening questions on the clinic’s intake assessment form. These questions, which were completed by the health workers and asked average days per week the patient drank, and the amount and type of drinks per day, had not been completed routinely prior to the study. Although health workers were more comfortable with these questions, any alcohol screening presented problems to some workers. One health worker remarked that it was easier to talk about safe sex than about alcohol consumption. Notwithstanding this, there was some evidence from the health workers of increasing comfort with these questions over time.

The acceptability of motivational interviewing

Twenty-five brief interventions were conducted by the GPs before the study was terminated. There was no strict formula but the approach involved a sequence reviewing consumption levels, probable health consequences, the ‘good’ and the ‘not so good’ things about drinking, readiness to change and, if the client showed interest, further advice about ways of cutting down or trying to abstain.

The approach seemed appropriate to the GPs, even though they expressed different views about their level of comfort addressing alcohol misuse with Aboriginal patients. As one doctor observed: ‘Culturally appropriate? I don’t see why not. I think it applies to all people doesn’t it?’. GPs found it to be non-authoritarian and non-judgemental: ‘We are asking the patient what he thinks . . . We’re not imposing ideas on them. They don’t feel threatened. They don’t feel judged.’ At
18-month follow-up five of the six GPs reported that the technique was useful and they were still using it. The reasons why so few interventions were administered during the study, in spite of its perceived appropriateness, are discussed below.

The appropriateness of the intervention materials

Resources were created or compiled for the GPs, health workers and patients. GPs were provided with key articles on brief intervention, a ‘ready reckoner’ to aid calculation of standard drinks and a flip-chart we developed, based on a number of existing resources and formulae, including the ‘Drinking Detective’[16]. The flip-chart, which followed the intervention sequence outlined above, was designed to stand on the doctor’s desk, with coloured illustrations on one side (for the patient) and printed prompts on the reverse (for the doctor). The drawings were designed to be relevant to the largely urban Aboriginal clientele of the service and showed recognizable images of the ‘good’ and ‘not so good’ aspects of drinking. They included a diagram of the human body, illustrated options for cutting down or cutting out alcohol and a diagram of the population-level distribution of ‘safe’, hazardous and harmful consumption, in order to show a patient how his or her consumption compared. Although the flip-chart was well received by doctors (‘It’s a prompt for me . . . it gives me a connection to [the client]’; and ‘It’s good for the client to focus on something’), at 18-month follow-up none of the GPs were still using it, although they did not give reasons why.

The impact of the training

The research literature notes several barriers to intervention by GPs, including the perception that alcohol consumption is a difficult issue to raise, and lack of faith in their ability to influence behaviour [17–19]. Training in the form of continuing education for GPs and other health professionals in the wider community has been found to increase their willingness to offer alcohol screening and to ask patients about alcohol [18,20]. For these reasons, training was a key feature of this project. Because GPs were to deliver the intervention, the training focused on them. The training involved two evening sessions provided by a psychologist experienced in brief motivational interview training. Issues such as motivation, ambivalence and resistance were covered.

Overall the training sessions were more open-ended and orientated to the principles of motivational interviewing than we had anticipated. Because of this, they did not fit well with the more specific guide to an intervention presented in the flip-charts. Views of the value of the training among the GPs varied. Two said that they were already using their own version of such an intervention, and one found the presentation too simplistic. However, two other GPS felt that the training had provided them with confidence. These somewhat ambivalent observations reinforce the importance of tailoring training to GPs pre-existing knowledge and a degree of sensitivity in the management of alcohol interventions.

The role of the doctor

The study focused primarily on the role of GPs because of an increasing emphasis on their role in brief interventions in the wider Australian community, and other work indicating that Aboriginal people respond to advice from doctors [21,22]. Although we did not get any clients’ perspectives on this issue, comments from both the health workers and the GPs themselves supported the view that patients respect doctors and listen to what they say. One health worker observed ‘Aboriginal people have got a thing with doctors. They put them on a pedestal, like a god’.

The role of the Aboriginal health workers and the health service

Although Aboriginal health workers are generally considered to be the cornerstone of interventions to improve Aboriginal health [23], the ambiguities in their social position and professional role sometimes impede this process [24]. From the beginning of the project, health workers expressed concerns about raising alcohol issues with clients: ‘You need someone out of the extended family [to do this], someone out of it all’, said one health worker. They initially showed strong resistance to questioning Aboriginal clients about their consumption, and willingly accepted the proposition that GPs would provide the intervention. Indeed, when the project was suspended so that we could review our slow recruitment, health workers suggested that one solution was for the doctors to take on even greater responsibility for the project processes [9].

Further, there were health workers who, like others in the Aboriginal community, assumed that alcohol problems were the provenance of specialist agencies, the Aboriginal Sobriety Group, pick-up services and those who work with the ‘park people’. Several were puzzled as to why an alcohol intervention should be introduced into a general health service. Intimate knowledge of the community, indeed being part of it, had also produced a degree of despair at the extent of the alcohol problem.

Barriers to the incorporation of brief interventions into clinical care

Although some GPs found the screening useful, as it provided them with a ‘way in’ to discussing alcohol use
with patients, all identified a number of constraints on their ability to deliver the intervention. Some were associated not with the intervention itself, but with the screening process that preceded it. One reason the intervention was not delivered to large numbers of clients was the comparatively low number of patients screened as being eligible to receive it. This was due in part to reluctance on the part of the health workers to undertake the screening, client reluctance to be screened by the health workers, and busy times in the clinic which made screening difficult. Many of those who were screened appeared to be non-drinkers, although this was partially attributable to the age and sex profile of clinic clients—males were particularly under-represented in the 16–25 and 26–44 age groups [25].

GPs identified a number of constraints on their ability to deliver the intervention. Primary among these was lack of time, a barrier also nominated by doctors in general practice elsewhere [26]. The health service operated without appointments and at times the waiting room was very crowded. GPs observed that some of their patients were impatient to have their presenting problems treated, and became annoyed when alcohol was raised as an additional issue. At other times the GPs were so busy they forgot to provide the intervention. Closely associated with lack of time, the other major constraints nominated by GPs were the severity of illness and the complexity of the physical, social and psychological problems with which patients present. Also raised was some client resistance to the intervention. There is nothing to suggest however, that the nature of this resistance was specific to an Aboriginal setting—it is likely that, among any group of patients with alcohol problems, some will object to discussion of the issue.

Discussion

This paper reports an assessment of the perceived appropriateness and acceptability of various aspects of a trial of brief alcohol intervention based on experience with limited client numbers. A second major limitation is that no in-depth interviews were conducted with patients. However, given the paucity of information available on brief intervention as secondary prevention for alcohol misuse in urban Aboriginal populations, it offers some useful insights on a number of issues needing further attention.

For many Aboriginal people alcohol use is considered a private and sensitive matter, particularly in dealings with those considered to be kin, and it can be insulting to ask direct questions about it [27]. It is therefore not surprising that health workers had problems with screening in general and with the AUDIT in particular. Even though it has been found to be unbiased in multi-ethnic groups [28,29], available qualitative evidence from those researchers who have used the AUDIT with Aboriginal people is less than optimistic.

In spite of the sensitivity of the subject of alcohol misuse, the Aboriginal health workers involved in this project became more comfortable with screening over time. In this respect, the clinic supervisor felt that the process had been empowering for health workers. There was a discernible increase in screening in the latter part of the study. One health worker reported ‘It’s a lot easier now, because I’ve been doing it for over 12 months. At first it was very hard. I felt invasive with everybody.’ However, screening using the two questions on the routine intake assessment form was not ideal because they failed to distinguish between occasional binge drinkers and frequent moderate to heavy drinkers. Frequency of drinking in excess of eight standard drinks in a day (or on any drinking occasion) is a much stronger predictor of the adverse consequences of drinking than is a measure of daily consumption [30]. Two carefully worded questions on the frequency of binge drinking, and average daily consumption, would best determine eligibility for an alcohol intervention.

Although relatively few interventions were administered, GPs felt comfortable with the technique. It affords a high degree of autonomy to the patient, is non-judgemental, recognizes that there are good things and less good things about drinking, and is capable of use with people at different stages of readiness to change their behaviour. While it can be administered opportunistically in the context of a usual consultation, the project demonstrated that constraints of time and the severity and complexity of patients’ presenting problems are significant barriers to its routine use.

The study focused primarily on the role of GPs because of an increasing emphasis on their role in brief interventions with the wider Australian community. While health workers may also have benefited from training—to familiarize them with what was being offered to patients and perhaps to administer the intervention—it may be that GPs, as authoritative sources of health advice and respected outsiders, are better able to provide brief alcohol interventions. No matter who provides the intervention, the need for training raises the issue of staff turnover and the challenge of sustainability. The logistics of providing ongoing training need to be considered by any service wishing to incorporate brief interventions into its normal daily practice. In this instance, 2 years after the initial training was provided, four of the original six GPs were still working for the service.

The brief intervention flip-chart was well received, but 18 months after the study finished doctors were no longer using it, even though they were still delivering brief interventions. Because they did not explain why, we are unable to offer any explanation for this. It should be noted, however, that they were not involved in its
development, and this may have reduced its acceptance in the longer term.

There was agreement that participation in the project had helped doctors to give alcohol issues a much more prominent position in their daily work. At the beginning of the project the health workers had conceptualized alcohol problems as being primarily advanced problems and associated them with tertiary services, rather than falling within the embrace of a primary health service. By the end of the study there was increased acceptance that a health service does have a role in earlier intervention; health workers were familiar with standard drinks; and all six GPs felt that a programme such as this should be disseminated to other Aboriginal health services.

Brief interventions can be either a primary prevention activity (advising all patients about safe drinking practices, regardless of their drinking habits), or a secondary prevention activity (preventing a progression to more severe problems) [31]. For Aboriginal people whose drinking is often only given attention at a late stage, it is important that earlier intervention should be part of the armamentarium of approaches to problem drinking. This study raises a number of issues that both support and threaten its wide implementation.

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