ALCOHOL AND OTHER DRUG BRIEF INTERVENTIONS IN PRIMARY CARE

Final Report

Turning Point

Alcohol & Drug Centre

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FINAL REPORT

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CONTENTS

LIST OF TABLES

ACRONYMS

A&E	Accident and Emergency
ABI	Acquired Brain Injury
AOD	Alcohol and other drug
BI	Brief Intervention
CBT	Cognitive Behavioural Therapy
CHS	Community Health Service
CNC	Clinical Nurse Consultant
DHS	Department of Human Services
DPSB	Drugs, Policy and Services Branch of the DHS
ED	Emergency Department
PC	Primary Care

1 EXECUTIVE SUMMARY

In 2007/08, Turning Point Alcohol and Drug Centre was commissioned by the Victorian Department of Human Services' Drugs, Policy and Services Branch to review the delivery of alcohol and other drug brief interventions (AOD BIs) across Victorian primary care settings. The review focussed on defining documented models of AOD BIs and their effectiveness, describing AOD BI good practice in Victorian primary care settings, and identifying enablers and barriers to delivery. The project methodology incorporated a literature review, semi-structured interviews with key informants (N=17) and the development of case examples.

Primary care settings are well suited to the delivery of AOD BIs by virtue of their contact with large numbers of the population. Despite this, the uptake of AOD BIs in primary care settings has been poor. This has been attributed to under-utilisation of practice nurses, competing health priorities, lack of BI awareness, poor AOD knowledge and skills, negative practitioner attitudes, and insufficient training and support. The literature identifies a number of enablers to AOD BI uptake, including direct dissemination strategies, workforce development and multi-faceted training techniques. In addition, supportive, stable and resourceful organisational environments, innovative models and positive client attitudes to BIs facilitate AOD BI uptake. Key themes from the literature include improved dissemination of AOD BI guidelines, increased and enhanced primary care training, promotion of BI effectiveness and further research.

This project found that AOD BI delivery among Victorian primary care providers is limited. As noted in the literature, few Victorian providers reported proactive AOD BI delivery. Some providers were delivering all the elements of BI but did not identify them as such. System-level barriers included limited workforce knowledge of BIs and a lack of incentives. At the program level, negative staff attitudes, time constraints and lack of management support limited BI uptake by staff. Client readiness to change, attitude towards treatment, level of intoxication, physical and emotional state, cultural background and literacy skills presented barriers at the client level.

A number of models of very brief interventions and extended AOD BIs were documented in Victorian primary care settings. Their considerable diversity is reflected in the 15 models presented. The three-phase BI was a feature common to all models, incorporating assessment, intervention and referral. Intervention phases ranged from a single 2-30 minute session for a very brief interventions to 20-30 minutes over 3-5 sessions for extended BIs. The provision of information and advice was central to both very brief interventions and extended BIs, although the latter had a greater focus on therapeutic engagement with clients. The innovative work at one setting provided an outstanding example of good AOD BI practice in the field.

Features of good practice in AOD BIs entailed client assessment, engagement, timely and goal-oriented intervention. The provision of written information, consideration for the stages of change and the development of linkages were also noted. Enablers of good practice included workforce training, identification of champions to promote BI delivery, organisational support, and the linking of BIs to assessment processes.

This project found that significant attention to increasing the uptake of AOD BI across the primary care sector is essential. This should occur through workforce development, awareness raising activities, and system- and organisation-level support for AOD BI delivery. In order to produce the required cultural and attitudinal shift across the workforce, networks of BI champions should be established with a focus on knowledge-sharing and integrating these activities into mainstream treatment, education and training. Leadership should be fostered and innovation acknowledged.

Primary care settings offer early intervention opportunities to a significant population of clients. The capacity to intervene before AOD use becomes significant, entrenched and dependent is unique to this sector and can produce a marked positive impact on clients. As such, work towards enhancing the uptake of AOD BI across the primary care sector warrants immediate and ongoing attention.

2 BACKGROUND

In July 2007, Turning Point Alcohol and Drug Centre's Health Services Research and Evaluation Team was commissioned by the Drugs Policy and Services Branch (DPSB) of the Department of Human Services (DHS) to undertake a review of alcohol and other drug (AOD) brief interventions (BIs) across primary care settings in Victoria. The project aimed to:

1. Define models of alcohol and other drug brief intervention (AOD BI)
2. Document the effectiveness of these models, with particular attention to the health care settings involved
3. Describe examples of good AOD BI practice in Victoria
4. Identify enablers and barriers to the implementation of AOD BI
5. Provide direction regarding models of implementation for AOD BI

3 METHOD

The evaluation methodology included several components:

- Literature Review
- Semi-structured interviews with key informants
- Case examples of models of AOD BIs
- Project Steering Committee

3.1 LITERATURE REVIEW

A comprehensive literature review was conducted as part of this project. The review identifies models of AOD BI, examines their effectiveness, and summarises the enablers and barriers to AOD BI implementation in primary care settings. Predominantly, the AOD literature focuses on alcohol-specific BIs, as opposed to BIs that are targeted towards the use of other drugs (e.g., amphetamines).

Literature searches were conducted on MedLine, PsychInfo, PubMed, and Cochrane Library databases using the following terms or relevant combinations: "brief intervention", "screening", "primary care", "community health", "hospital", "implementation", "effectiveness", "alcohol", "drug", "amphetamine", "substance abuse", "practitioner", "nurse". Searches were refined by excluding studies published prior to January 1997 and those in languages other than English.

The relevant abstracts were retrieved and reviewed, and a refined list of articles was generated. The reference lists of all relevant articles were inspected for additional literature, not previously identified in the literature search.

A number of key documents were identified by the literature review. These included:

Babor, T. F., & Grant, M. (1992). Programme on Substance Abuse. Project on identification and management of alcohol-related problems. Report on Phase II: A randomized clinical trial of brief interventions in primary health care. Geneva: World Health Organisation.

Babor, T. F., Higgins-Biddle, J., Dauser, D., Higgins, P., & Burleson, J. A. (2005). Alcohol Screening and Brief Intervention in Primary Care Settings: Implementation Models and Predictors. *Journal of Studies on Alcohol, 66*(3), 361-368.

Kaner, E. F., Beyer, F., Dickinson, H. O., Pienaar, E., Campbell, F., Schlesinger, C., et al. (2007). Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database Syst Rev*(2), CD004148.

Nilsen, P., Aalto, M., Bendtsen, P., & Seppa, K. (2006). Effectiveness of strategies to implement brief alcohol intervention in primary healthcare. A systematic review. Scand J Prim Health Care, 24(1).

3.2 KEY INFORMANT INTERVIEWS

Key informants, who had experience with AOD BIs in primary care settings, were invited to participate in this study. Key informants primarily included clinicians (GPs, nurses, nurse practitioners, pharmacists, specialist AOD, mental health and dual diagnosis workers). One key informant was a researcher who had explored BI implementation in a primary care setting. Key informants were drawn from the following settings:

- General Practice
- Community Health Centres
- Pharmacies
- Emergency Departments (EDs) within public hospitals
- Specialist AOD services
- Mental health services

Potential key informants for this project were identified via internal identification and snowball sampling. Based on an original list compiled in consultation with the Health Services

Research and Evaluation team, all potential key informants were asked to identify individuals working within the primary care sector who could potentially contribute to the project, based on their knowledge or use of AOD BIs. An assertive follow-up process was undertaken in order to maximise opportunities to access the knowledge base.

Potential key informants were screened to assess suitability for interview. Those deemed suitable had knowledge of or experience in delivering AOD BIs within the primary care sector, within the literature's definitions of very brief interventions and extended BIs. Over the three month recruitment period it became increasingly obvious that the potential sample of practitioners with the necessary experience and expertise regarding AOD BIs was limited. Of the 67 potential key informants identified from internal mechanisms and snowballing sampling, only 17 satisfied the screening process and were identified as suitable for interview (see Appendix 1 for participating key informants). These participants were invited to participate in a semi-structured interview of approximately 45 minutes duration.

The interview schedule (see Appendix 2) was based on key evaluation questions. It sought to identify models of AOD BI delivery, as well as the features, enablers and barriers to good AOD BI uptake and delivery.

Key informant semi-structured interview data were thematically analysed using the qualitative software package NVIVO 8. This allowed key themes to be drawn from the qualitative interviews that addressed the evaluation's key questions. Key informant interview data are represented in text as (n=#) to represent the number of key informants.

3.3 CASE EXAMPLES

In order to illustrate the various models of BI delivery across primary care settings, case examples have been developed from 15 key informant interviews. Case examples were validated through consultation with key informants in 13 of 15 cases. The case examples illustrate the diversity of BI practice occurring in the Victorian primary care sector across different settings and client groups. They also identify type of BI, client pathway to the BI, who provides the BI and what the BI entails. An overview of the key features of the 15 case examples is provided in section 5.3. The 15 individual case examples are presented in Appendix 3.

3.4 PROJECT STEERING COMMITTEE

The final aspect of the project involves the presentation of draft findings to the Steering Committee.

4 LITERATURE REVIEW: AOD BRIEF INTERVENTIONS

High levels of alcohol and other drug (AOD) use have been associated with a broad spectrum of medical, social and psychological problems. There is growing evidence that treatment for AOD problems is effective for many individuals. One particular treatment strategy that has attracted a great deal of attention in recent years is that of brief intervention (BI). This treatment model aims to facilitate behaviour change, motivating individuals who use substances at harmful levels to reduce their use (Aalto, Pekuri, & Seppa, 2001).

This literature review focuses on BIs in relation to AOD problems, particularly those related to alcohol and amphetamine use. However, it should be noted that BIs are not a treatment strategy unique to the AOD area. In fact, they are often employed by health care professionals to address a diverse range of health behaviours, for example, to stop smoking, alter dietary habits, and moderate cholesterol levels (Fleming & Manwell, 1999).

As evidence mounts regarding the effectiveness of BIs in the alcohol and drug field, attention has turned to implementation, especially in primary care settings. The current review identifies models of AOD BI, reviews their effectiveness, and identifies the enablers and barriers to their implementation.

4.1 MODELS OF AOD BI

The definition of a BI varies considerably throughout the literature and it should not be regarded as a homogeneous entity. This is largely because BI is a treatment strategy that varies in length, has the flexibility to operate from a variety of frameworks and can utilise numerous techniques (Heather, Raistrick, & Godfrey, 2006)

AOD BIs are designed to reduce substance use by facilitating health behaviour change, particularly in individuals who engage in high-risk levels of consumption (Roche & Freeman, 2004). They also aim to increase an individual's understanding around the risks associated with substance use, highlight the importance of reducing consumption levels, and recommend strategies that assist in changing the hazardous behaviour/s. It is important to acknowledge that the objective of a BI is to motivate individuals to achieve moderate, non-hazardous levels of substance use rather than complete abstinence (Moyer & Finney, 2004).

Poikolainen (1999) made the distinction between two models of BIs: very brief interventions and extended brief interventions.

4.1.1 VERY BRIEF INTERVENTIONS

Very brief interventions are time-limited, patient-centred consultations that aim to motivate patients to change their drinking and drug use behaviour. They typically consist of a single session of information and advice, ranging anywhere between 5-20 minutes, and are often

supported by self-guided patient booklets and details of local services (Babor, 1994; Poikolainen, 1999).

Given their short duration and low intensity, interventions of this type are often conducted in non-specialist, primary care settings such as community health centres and accident and emergency (A&E) departments. In these contexts, health professionals have the ability to intervene and offer brief advice if AOD issues are identified during the assessment or treatment of a non-drug problem (e.g., diabetes) (Lee, Caporilli, Connolly, & Barratt, 2004). As such, very brief interventions are also referred to as 'opportunistic' interventions.

Very brief interventions frequently target individuals who do not experience substance dependence, but consume substances at hazardous or risky levels[1]. Thus, very brief interventions provide generalist workers, such as general practitioners, hospital practitioners, and nurses, with a means of intervening at an early stage, in the onset of substance-misuse (Babor & Higgins-Biddle, 2000).

Depending on the health professional that delivers the BI and the health setting in which it is conducted, the content and structure of a very brief intervention can vary somewhat. Bien, Miller, and Tonigan (1993) identified six common elements of very brief interventions delivered in primary care settings. These have been synthesised into the acronym, FRAMES:

- ***Feedback:*** providing relevant feedback to the client regarding the personal risks associated with his/her AOD consumption;
- ***Responsibility*****:** an emphasis on the client's personal responsibility and choice to reduce his/her AOD use;
- ***Advice:*** the provision of explicit advice to the client about changing his/her hazardous AOD behaviour;
- ***Menu of change strategies:*** providing the client with a range of alternative treatment strategies and self-help options so that they are able to find an approach that is appropriate to their own situation.
- ***Empathy:*** an empathic, warm and reflective approach adopted by the health professional; and
- ***Self-efficacy:*** reinforcement and enhancement of the client's self-efficacy.

[1] The National Health and Medical Research Council (2001) defines 'risky' drinking as "a level of drinking at which risk of harm is significantly increased beyond any possible benefits" (p. 128). For males, risky drinking has been quantified as 7 to 10 standard drinks (per day) in the short-term and 5 to 6 in the long-term and for females it is 5 to 6 standard drinks in the short-term and 3 to 4 in the long-term.

Nationally, the FRAMES approach has been recommended as the framework through which a BI should be delivered (Shand, Gates, Fawcett, & Mattick, 2003).

4.1.2 EXTENDED BRIEF INTERVENTIONS

In some cases, a BI can extend beyond a single session of information and advice to a 20-30 minute structured therapeutic intervention that extends over multiple (usually no more than three to five) sessions (Babor & Higgins-Biddle, 2000; Heather et al., 2006; Poikolainen, 1999). Generalist workers in primary care settings can deliver extended BIs as part of their normal follow-up process (often described as "booster" sessions). Alternatively, they can be delivered in more specialised settings, such as AOD agencies, as an alternative to longer treatment regimes (Nilsen, Aalto, Bendtsen, & Seppa, 2006; Shand et al., 2003).

In order to determine whether a client qualifies for a single session or extended BI, healthcare professionals may conduct an assessment to identify client need (Beich, Gannik, & Malterud, 2002; Shand et al., 2003). Screening can be conducted systematically using various standardised and validated questionnaires, which have mainly been developed in relation to alcohol. BI packages utilised in Australia (e.g., the 'Drink-Less Program' and 'AlcoholScreen') have employed popular screening instruments such as the Alcohol Use Disorders Identification Test (AUDIT; Babor & Grant, 1992). In terms of illicit drug use, screening tools such as the Drug Abuse Screening Test (DAST) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) can be implemented (Roche & Freeman, 2004).

Extended BIs are normally directed towards individuals who are willing to accept help for their hazardous AOD use. Treatment-seeking individuals who do not respond to simple advice (such as that delivered in a very brief intervention) and who require more extensive assistance in reducing their AOD use to safer levels may also be targeted (Heather et al., 2006).

Extended BIs may also incorporate condensed forms of cognitive behavioural therapy (CBT) and motivational interviewing. As such, Fleming (2003, as cited in Lee et al., 2004) identified several important elements of these more specialised BIs, these included:

- Assessment
- Direct feedback about health and other issues associated with use
- Contracting, negotiating and goal setting
- Behaviour modification techniques
- Self help, written information
- Follow-up and reinforcement

The level of training required to effectively conduct this style of intervention is considerably greater than that required for the provision of general advice and information. Therefore, more specialised health professionals, such as psychologists and alcohol and drug workers, often carry out this form of BI, although generalist workers can also implement them with appropriate training (Lee et al., 2004).

KEY POINTS

- A BI is a treatment strategy of short duration that is designed to facilitate health behaviour change and motivate an individual to reduce their AOD use to safe levels.
- BIs can be divided into two categories: very brief interventions and extended BIs.
- Very brief interventions involve a single session of information and/or advice and can be delivered by generalist workers in primary care settings. They are often opportunistic in nature.
- Extended BIs extend over multiple sessions, can incorporate therapeutic principles (such as CBT), and they are commonly delivered by appropriately trained personnel.

4.2 EFFECTIVENESS OF AOD BIS

While BIs may be used to target many health behaviours, much empirical research has investigated their effectiveness in relation to alcohol consumption. In a recent meta-analysis of 21 randomised controlled trials, Kaner et al. (2007) concluded that BIs, when conducted in primary care settings, were effective in reducing alcohol consumption by an average of four standard drinks per week. Furthermore, the results of a systematic review conducted by Bertholet and colleagues (2005) demonstrated that the positive effects of a BI (including reduced alcohol consumption) persisted at 6 and 12 months follow-up, for both males and females.

BIs have also been found to result in benefits that extend well beyond a reduction in alcohol consumption. These include: a reduction in alcohol-related problems and the associated morbidity (Israel et al., 1996; Richmond, Heather, Wodak, Kehoe, & Webster, 1995); a decrease in health-care utilisation and emergency department visits (Fleming et al., 2002); and fewer motor vehicle violations and accidents (Mundt, 2006). Given their potential to prevent serious and costly problems, on both individual and societal levels, it has been argued that BIs are a highly cost-efficient treatment option (Wutzke, Shiell, Gomel, & Conigrave, 2001).

Both very brief interventions and extended BIs have proven to be effective in reducing AOD use, which has prompted some studies to investigate whether differences exist between the effectiveness of these models. One such study was conducted by the World Health Organisation (WHO; Babor & Grant, 1992). This was a collaborative, multi-country,

randomised controlled trial that compared the effects of a five minute session of brief advice about hazardous drinking versus a brief 20 minute counselling session that included as many as two follow-up consultations. The interventions were delivered by trained primary health care professionals (usually a nurse). Both forms of BI produced a significant reduction in alcohol consumption, compared to the control condition; however, no differences between the two intervention models were observed. Thus, it was concluded that, in a population of hazardous drinkers, behaviour change is more a function of individual factors (e.g., motivation to change) and social influences, rather than the length of the BI. However, it should be noted that the extended BI in this study was deliberately designed to be brief, non-invasive and suitable to be delivered by a generalist primary care professional. Therefore, an extended BI that included more specialised therapeutic techniques, such as brief CBT, may have resulted in a greater effect.

A meta-analysis conducted by Poikolainen (1999) also investigated the differences between very brief and extended brief interventions. They concluded that extended BIs were superior to very brief interventions in reducing alcohol consumption; however, this effect was only significant for women. The study found that although there was a decrease of a similar magnitude for males there was a significant lack of statistical homogeneity between studies and, as a result, robust conclusions could not be drawn for this group.

Wutzke, Conigrave, Saunders, and Hall (2002) went on to investigate the long-term impact of very brief and extended BIs for the Australian arm of the aforementioned WHO study. A significant reduction in alcohol consumption was reported at the nine-month follow-up interval for both intervention groups when compared to controls, but again no differences between very brief and extended interventions were observed. The study also failed to find evidence that either of the intervention models had an impact at 10-year follow-up, with no significant differences in alcohol consumption or alcohol-related problems (psychological, social or legal) evident between intervention and control subjects. Thus, this research provided evidence for the short-term effectiveness of alcohol-related BIs, with the researchers concluding that without regular follow-up and reinforcement, the long-term efficacy of these interventions is limited.

This suggestion that follow-up and continued reinforcement is necessary to sustain the long-term impact of BIs concurs with the results of a study conducted by Fleming and colleagues (2002). This study was a randomised control trial of Project TrEAT (Trial for Early Alcohol Treatment), which involved the delivery of an extended BI. The intervention comprised a structured 15-minute consultation with a physician and a booster session one month later. Participants in the intervention group were also followed-up via telephone by the office nurse, two weeks after each physician intervention session. Compared to the control group, the intervention group experienced significantly better outcomes, including reduced alcohol consumption at six months post-intervention. Furthermore, this reduction was sustained for

up to four years following the trial. The authors concluded that BIs, along with booster sessions and follow-up contact, result in enduring improvements for clients who engage in hazardous alcohol use.

As mentioned previously, considerably less research has focused on the efficacy of BIs for illicit drug use, in comparison to alcohol use. There is, however, some evidence to support the effectiveness of extended BIs among regular users of amphetamines (Baker, Boggs, & Lewin, 2001). The results of a randomised controlled trial conducted in Australia, indicated that amphetamine users who received an extended BI experienced greater rates of abstinence over a six month period, when compared to controls (Baker et al., 2001; Baker et al., 2005). The extended BI in this study utilised a cognitive behavioural therapy approach and was delivered by trained therapists (in an unidentified setting), over a period of three-four sessions (30-60 minutes each). Each session focused on the acquisition of skills which would assist participants to reduce their amphetamine use. However, whether these results would translate into primary care settings, where non-specialised practitioners would deliver the amphetamine-focused intervention, needs to be investigated further.

KEY POINTS

- People with hazardous AOD use and associated problems, particularly those related to alcohol consumption, are responsive to BIs delivered in primary care settings.
- BIs involving five minutes of simple advice have been shown to be as effective as brief counselling interventions that extended over multiple sessions. These BIs were delivered by generalist health professionals.
- Regular follow-up and reinforcement increases the long-term efficacy of BIs.
- Extended BIs, involving a brief form of CBT, are effective in reducing amphetamine use among regular amphetamine users.

4.3 AOD BIS IN PRIMARY CARE

In Victoria, the majority of primary care is provided by community health services; though other providers include divisions of general practice, acute health services, district nursing, and aged care assessment services (Department of Human Services, 2006). Given that health promotion and prevention are important facets of such services, primary care is considered to be a particularly valuable point of contact for the provision of BIs. Indeed, primary care has long been identified as an appropriate setting in which to deliver BIs.

Primary care settings are accessed by approximately 85% of the Australian population each year and do not carry the stigma that may be attached to AOD treatment services (Britt et al., 2007). Therefore, primary care workers, particularly general practitioners, have been described as being in the unique position to identify and intervene with clients who

experience substance use problems. Often, practitioners develop an ongoing relationship and rapport with their clients, which can lead to an increased sense of respect and trust. While some literature has reported that clients consider their practitioners to be a credible source of advice for a range of health issues, including alcohol use (Lock, 2004a), recent Victorian research suggests that a lack of confidence in treatment providers' knowledge of drugs is a major barrier to service access by AOD clients, particularly in relation to general practitioners (Mugavin, Swan, & Pennay, 2007).

As outlined previously, the effectiveness of BIs in primary care (especially in relation to alcohol) has been well demonstrated. Despite this existing evidence, BIs are yet to be adequately integrated into primary care settings (Lock, 2004b). It is important, therefore, to determine whether it is possible to increase the engagement of primary care professionals in screening and BI activity. In order to achieve this, however, it is important to first identify the enablers and barriers associated with BI implementation in primary care.

4.4 ENABLERS AND BARRIERS TO AOD BI IMPLEMENTATION

The enablers and barriers that impact BI implementation may be conceptualised as falling into three main areas: system design (i.e., promotion of BI effectiveness; workforce development; organisational support; practice nurses), program delivery design (i.e., competing health priorities; practitioner skill and awareness; practitioner attitudes; innovative models), and client factors (i.e., client attitudes; client demographic characteristics)[2]. Table 1 (see below) provides a summary of the enablers and barriers specific to AOD BI implementation in primary care settings, as identified in the literature. These are described in detail throughout the following sections of the review.

[2] The conceptual framework is based on the Improving 'Chronic Illness Care' Model put forward by Wagner (cf. http://www.improvingchroniccare.org/).

Table 1: Enablers and barriers to the implementation of BI in primary care settings

	Enabler	Barrier
System design	Direct dissemination strategies (e.g., telemarketing and academic detailing) - promote awareness of BIs and their effectiveness.	Dissemination of research findings alone is not sufficient to initiate change in clinical practice and increase BI activity.
	Developed, stable, resourceful organisations - provide a strong base for BI.	Low baseline role security, so staff are less inclined to change their practice.
	Multi-component training strategies, involving outreach training and ongoing support; incorporation of BI training at the undergraduate level; continuing medical education.	
	Organisational support - internal negotiation to support uptake; onsite support agents/facilitators; promotion of a shared care model; integration with existing programs/services.	
	Practice nurses are in a good position to deliver BIs, they feel it is a legitimate part of their role, and have been shown to do so effectively.	Nurses an under-utilized in primary care settings, even though they are a cost-effective resource.
Program delivery design		Competing health priorities - GPs note the need to attend to issues such as high blood pressure and chronic disease.
		Practitioner awareness - less than half of self-reported problem drinkers are asked about their alcohol consumption.
		Negative practitioner attitudes and lack of motivation - GPs feel they may jeopardise their relationship with their clients by discussing sensitive issues, such as AOD use.
		Practitioner skill – lack of knowledge and skills, and insufficient training and support regarding BI.
	Innovative models, for example, on-line screening and BI services	
Client	Attitudes - practitioners are regarded as trustworthy and approachable, a reliable source of information.	
	Characteristics – those more likely to receive a BI are male, unemployed, and technically trained	Characteristics – those least likely to receive a BI are female, students, and university-educated.

4.4.1 SYSTEM DESIGN FACTORS

System design factors comprise: the promotion of BI effectiveness; workforce development; the need for organisational support; and the utilisation of practice nurses in primary care settings.

4.4.1.1 PROMOTION OF BI EFFECTIVENESS

The effectiveness of alcohol BIs in primary care has been well documented in the research literature. However, healthcare professionals are unlikely to incorporate research findings into their everyday clinical practice without the appropriate dissemination of new information and knowledge. As a result, dissemination has been identified as a crucial first step for implementing BIs into primary care settings (Kaner, Lock, McAvoy, Heather, & Gilvarry, 1999).

A collaborative study conducted by the WHO examined various dissemination strategies and compared their effectiveness in promoting an evidence-based BI program among general practitioners in primary care (Funk et al., 2005). Direct approaches for dissemination, such as telemarketing and academic detailing (i.e., personal visits) resulted in significantly higher BI acceptance rates (i.e., requests for the BI program), when compared to an indirect, mail-based dissemination approach. It was also found, however, that an acceptance of the BI program by general practitioners did not necessarily translate into a change of practice behaviour; subsequent training and support was required to increase BI activity.

Therefore, although the passive dissemination of information is a necessary first step for implementing a BI program, a specific implementation strategy, which takes into account a range of factors (e.g., training and support), is also required. In this way, healthcare professionals are provided not only with an awareness of BIs, but an opportunity to develop the skills and motivation needed to effectively implement BIs into their daily practice (Bero et al., 1998; Roche, Hotham, & Richmond, 2002).

4.4.1.2 WORKFORCE DEVELOPMENT

Workforce development provides one avenue for addressing the barriers to BI implementation in primary care, particularly those associated with insufficient knowledge and awareness of BI. Many studies have investigated BI training and support methods, and their impact on the successful implementation of BIs (as measured by material utilisation, screening and the level of BI activity; Nilsen, 2006). Active training strategies (e.g., outreach training and ongoing support) result in more clients being screened and advised about their hazardous drinking, when compared to less intensive strategies (e.g., written guidelines or a single training session). These findings have been seen to apply for both physicians and nurses (Funk et al., 2005; Kaner, Lock, Heather, McNamee, & Bond, 2003; Kaner, Lock et

al., 1999; Nilsen et al., 2006). Therefore, it has been concluded that effective training strategies appear to be those that are multifaceted and combine both educational components and continuing office-based support (Anderson, Laurant, Kaner, Wensing, & Grol, 2004).

Furthermore, Fleming (2004) indicated that effective BI training programs should incorporate a number of strategies, including: skills-based role-playing, performance feedback, and clinic-based education. Fleming (2004) also noted that credible experts in the area should conduct such training. In order to encourage participation in BI training events, initiatives such as offering Continuing Professional Development (CPD) points (from the Royal Australian College of General Practitioners) could be applied.

It has also been argued that addressing BI issues in the basic education of healthcare professionals (starting at the undergraduate level with reinforcement throughout their professional career) would support the enhancement of knowledge and skills and could be beneficial for their later motivation to deliver these interventions (Babor & Higgins-Biddle, 2000; Nilsen et al., 2006; Roche et al., 2002).

4.4.1.3 ORGANISATIONAL SUPPORT

Factors such as organisational support, stability, and leadership have been identified as enabling factors that are associated with the successful implementation of BIs. For example, endorsement by a dedicated management team is important for engaging and supporting the uptake of BIs by primary care workers (Babor, Higgins-Biddle, Dauser, Higgins, & Burleson, 2005).

The working environments of primary care professionals must support and encourage the use of BI if they are to be incorporated into everyday practice (Babor & Higgins-Biddle, 2000). Anderson and colleagues (2003) defined a supportive BI working environment as one which provided primary care workers with access to screening and counselling materials, training in BIs and help in dealing with difficult situations.

In identifying other organisational supports, the importance of on-site support agents and facilitators (e.g., a specialist drug and alcohol worker) has also been highlighted, as has the value of a shared-care model of operation (Roche et al., 2002). Specialist workers form an integral part of the primary healthcare team as they have the capacity to provide generalist workers with the support and guidance required to deliver effective AOD BIs and they can also serve as a pathway for onward referral (Heather, Dallolio, Hutchings, Kaner, & White, 2004).

As noted, developed, stable, and resourceful organisations provide a strong foundation for BI implementation. One reason for this is that these enablers have been found to result in increased role security, that is, the degree to which primary care professionals feel able to deliver BIs (e.g., 'I feel I can appropriately advise my patients about drinking and its effects'; Anderson et al., 2003). Indeed, role security has been identified as an important factor for the successful implementation of BIs in primary care; primary care professionals who report high role security are more likely to manage, and intervene with clients who engage in hazardous drinking and/or have alcohol related problems (Anderson et al., 2003).

Furthermore, it has been found that primary care workers (particularly general practitioners) who have low levels of role security feel less inclined to incorporate BIs into their clinical routine. For example, Anderson and colleagues (2004) found that the provision of training and support increased screening and BI activity only for those practitioners who already felt secure and committed in working with problem drinkers. For those who had low role security and therapeutic commitment at baseline, training and support did not increase their rate of BI delivery and actually worsened their perceived role adequacy and attitudes towards working with drinkers. Therefore, in order to encourage the use of BIs in primary care, organisations need to implement support strategies that address not only practitioners' skills in delivering BI, but also the barriers associated with low role security and therapeutic commitment.

4.4.1.4 PRACTICE NURSES

Practice nurses (i.e., nurses who are employed by general medical practices) are in an ideal position to deliver BIs in primary care settings given their involvement in health promotion work and their repeated contact with clients (Lock, 2004b). Nevertheless, it has been reported that practice nurses deliver BIs to very few individuals with AOD related problems (Lock & Kaner, 2004). This may be attributed to the fact that very little has been done to develop and define the role of practice nurses in terms of AOD BIs, even though nurses themselves describe such interventions as being a legitimate part of their work (Hyman, 2006; Lock, Kaner, Lamont, & Bond, 2002).

Nurse-led BIs are equally effective in reducing alcohol consumption (for up to 12-months) as those delivered by physicians, and are delivered at approximately two-thirds the cost (Babor et al., 2006). Furthermore, with appropriate training and support, nurses have been found to deliver a higher proportion of BIs to hazardous drinkers, compared to licensed medical practitioners (73.1% vs. 57.1%, respectively) (Babor et al., 2005). It has also been found that general practitioners who receive assistance in delivering BIs from a practice nurse are more likely to implement BIs into their clinical practice (Kaner, Lock et al., 1999).

Despite these encouraging findings, nurses continue to be regarded as an under-utilised resource in the area of BI in primary care settings (Johansson, Akerlind, & Bendtsen, 2005).

In 2001, the Australian Government provided $104.3 million funding to a Nursing in General Practice Initiative over a four-year period, with $12.5 million dedicated specifically to the training and professional support of practice nurses. As a result, Australia experienced an increase in the number of practice nurses employed in primary care settings (Jolly, 2007). With a greater number of practice nurses being employed, organisations have the opportunity to capitalise on their ability to conduct effective BIs, and with the appropriate training and support, practice nurses could act as a great enabler to BI implementation in primary care.

KEY POINTS

- Direct strategies of BI dissemination (e.g., telemarketing) are a necessary first step for their successful implementation in primary care settings, but such strategies should not be used in isolation and need to be accompanied by multifaceted implementation models that incorporate components such as training and support.
- Workforce development provides one avenue for addressing the barriers to BI implementation. This may involve the utilisation of training strategies that are multifaceted and combine both educational components and continuing office-based support.
- Supportive, stable, and resourceful organisations provide a strong base for BI implementation.
- Low levels of role security can result in primary care professionals feeling reluctant to incorporate BIs into their everyday clinical practice.
- Practice nurses are in an ideal position to conduct effective BIs and have been shown to be a cost-effective resource; however, they continue to be under-utilised in primary care settings.

4.4.2 PROGRAM DELIVERY DESIGN FACTORS

Program delivery design factors comprise: competing health priorities; lack of practitioner skills and awareness; negative practitioner attitudes; and innovative models for BI delivery.

4.4.2.1 COMPETING HEALTH PRIORITIES

Time constraints and competing demands are among the most commonly identified barriers to the implementation of AOD BIs (Bero et al., 1998). It has been argued that practitioners may not have the capacity to implement AOD BIs into their general practice because AOD related problems must compete with a range of other health priorities that are identified during patient-centred consultations, for example, high blood pressure, diabetes, and depression (Holmwood, 2002). Primary care professionals, particularly general practitioners and A&E clinicians, perceive screening and BIs to be a major addition to their daily workload and find them awkward to implement during the course of a normal consultation (Beich et al.,

2002). A recent study conducted in an Australian A&E setting evaluated the attitudes of emergency staff towards performing alcohol screening and delivering opportunistic BIs (Weiland, Dent, Phillips, & Lee, 2008). Despite having a positive attitude towards the routine delivery of BIs in emergency settings, all participants identified a lack of time as being the main barrier to BI implementation.

It has been argued, however, that time-related concerns "fail to give appropriate weight to the importance of alcohol use to the health of many patients and overestimates the time required" (Babor and Higgins-Biddle, 2001, p. 7). According to Babor and Higgins-Biddle (2001), screening takes between two and four minutes and can be integrated into a routine medical history interview. They also state that scoring and interpretation of a screening tool (e.g., the AUDIT) can occur in less than one minute and only a small proportion of those who complete the screen will actually require a BI (5%-20%), which should take no longer than 15 minutes to complete. Thus, given that AOD use is a major risk factor for many of the health problems that are encountered in primary care, it is argued that the value of a BI should not be overshadowed by any practitioner ambivalence to deliver the intervention based on the time involved (Babor & Higgins-Biddle, 2001)

4.4.2.2 PRACTITIONER SKILLS AND AWARENESS

The failure of primary care workers to routinely deliver BIs has been attributed to a number of factors but none more so than a lack of knowledge and skills, insufficient training and a shortage of subsequent support (Heather et al., 2004). Numerous studies have demonstrated that even though primary care workers feel they have a legitimate role in intervening with clients who experience AOD problems, they feel ill equipped to do so (Aira, Kauhanen, Larivaara, & Rautio, 2003; Kaner, Heather, McAvoy, Lock, & Gilvarry, 1999).

In an attempt to identify the barriers associated with BI implementation, Aalto et al. (2001) investigated the skills, knowledge, and training needs of primary care nurses and physicians in relation to alcohol-specific BIs. It was found that the majority of participants, particularly nurses, felt a need for further training in the area of BIs because they were not familiar with the content and/or structure of such interventions. In fact, only 18% of participants (45 out of 250) felt their knowledge was sufficient to deliver competent BIs to hazardous drinkers.

A lack of practitioner awareness regarding the definition of early stage, hazardous drinking has also been highlighted. In a qualitative study conducted by Aalto, Pekuri, and Seppa (2003a) it was found that nurses and general practitioners were confused about what constituted hazardous or harmful drinking and they found it difficult to differentiate it from alcohol dependence. This uncertainty and lack of understanding may explain findings in a related study, in which less than half of self-reported problem drinkers were asked about their

alcohol consumption and/or advised to reduce or cease their drinking behaviour (D'Amico, Paddock, Burnam, & Kung, 2005).

4.4.2.3 PRACTITIONER ATTITUDES

As suggested above, the implementation and utilisation of AOD BIs in primary care is likely to be influenced by various practitioner factors, including their interest in and attitude towards working with clients with AOD related problems and delivering BIs. While both general practitioners and nurses agree that AOD specific counselling and health promotion are part of their role, numerous studies have indicated that they are unlikely to undertake this area of work (Beich et al., 2002; Funk et al., 2005; Lock & Kaner, 2004). Reasons for this have been found to include: scepticism about the effectiveness of BIs (Aira, Kauhanen, Larivaara, & Rautio, 2004); fear of losing rapport with clients (Lock et al., 2002); and anxiety about discussing lifestyle issues, particularly in relation to alcohol use (Kaner, Heather, Brodie, Lock, & McAvoy, 2001). Furthermore, both general practitioners and nurses have indicated that they feel reluctant to initiate a conversation about alcohol without a 'legitimate clinical reason', such as an alcohol-related symptom or finding (Aalto et al., 2003a).

Nevertheless, in a qualitative study conducted by Beich et al. (2002) general practitioners indicated that they did feel comfortable giving their clients systematic advice on alcohol, if they had developed a robust doctor-patient relationship. However, the practitioners in this study also indicated they felt reluctant to follow-up on alcohol-related problems because they felt that they were intruding into their clients' private life. Some doctors also expressed the opinion that alcohol use is too sensitive and difficult a topic to discuss with clients (particularly in comparison to smoking). As a result, they are reluctant to raise the issue during consultations (Aira et al., 2004).

Medical practitioners have also been noted to hold negative, stereotypical views about individuals who experience AOD problems (Roche et al., 2002). According to Roche and Freeman (2004), general practitioners commonly perceive clients with AOD issues as "difficult, aggressive, demanding, manipulative, deceitful, and unmotivated and unwilling to change" (p. 13). Consequently, practitioners are reluctant to respond to clients with AOD-related issues and engage in AOD BI activity (Roche & Freeman, 2004).

It has been found that practitioners' attitudes can also influence the effectiveness of BI-related training and its potential to increase BI uptake in primary care settings. A longitudinal study, investigating changes in primary care professionals' BI activity over a three-year period, found that although guidelines, on-site training and ongoing support was provided, no changes in activity were found between baseline and three-year follow-up (Aalto, Pekuri, & Seppa, 2003b). In an attempt to understand why this occurred, the researchers drew on data pertaining to the primary care professionals' attitudes, skills and knowledge (Aalto, Pekuri, &

Seppa, 2005). It was found that, even though the implementation strategy used was successful in increasing practitioner knowledge regarding BIs, their attitudes and skills did not appear to develop positively. Thus, it was concluded that where the implementation strategy failed was in addressing the emotional responses of primary care workers (e.g., encouraging positive attitudes and increasing motivational skills).

Therefore, it seems that future research and training efforts regarding BI implementation could focus on improving the attitudes and motivations of healthcare professionals in regards to AOD BIs. Encouraging positive attitudes and increasing motivational skills will no doubt be a challenging endeavour and should be seen as a long-term process (Nilsen et al., 2006).

4.4.2.4 INNOVATIVE MODELS

In order to help address and overcome the many barriers associated with AOD BI implementation in primary care, Heather et al. (2004) argued that the development of strategies which assist and encourage primary care professionals to incorporate screening and BIs into their daily practice, are needed. In a review of the literature Bero and colleagues (1998) described such strategies as encompassing: multifaceted interventions, continuing medical education, routine audits and feedback, and computerised decision support systems.

The feasibility of the latter strategy, computerised decision support systems, was investigated in a double-blind, randomised controlled trail conducted by Kypri and colleagues (2004). This study involved the implementation of a web-based, electronic screening and brief intervention (e-SBI) program in a university health service. The program was designed to reduce hazardous alcohol consumption for students by providing personalised and constructive feedback in response to a self-completed alcohol assessment.

Individuals who completed the e-SBI program reported significantly lower total alcohol consumption, lower heavy episode frequency, and fewer personal problems, compared to controls. These outcomes were found to persist for six weeks but were no longer evident (with the exception of fewer personal problems) at six-month follow-up. It was concluded that the e-SBI program was able to reduce hazardous drinking in university students (to a similar extent as practitioner led BIs) while also providing them with a non-intrusive, non-threatening and anonymous means of reducing their hazardous drinking behaviour. Moreover, the authors concluded that such a program could easily be implemented into primary care settings. As this research is specific to problematic alcohol use, further research is required to determine the effectiveness of computerised screening and BI programs in relation drugs other than alcohol (e.g., amphetamines).

KEY POINTS

- Primary health professionals have difficulty implementing AOD BIs into their daily practice because of many competing health priorities and limited time availability.
- Due to a lack of BI skill and awareness, primary care workers have identified a need for increased training in the area of AOD BIs.
- The attitudes and motivations of primary care workers need to be addressed during BI implementation as they can greatly impact the rate of BI delivery.
- Innovative models, particularly self-completed computer based screening and BI programs, can address some of the barriers associated with BI implementation as they can assist primary care professionals with incorporating screening and BIs easily into their daily practice.

4.4.3 CLIENT FACTORS

Individual factors include: client attitudes and client demographic characteristics.

4.4.3.1 CLIENT ATTITUDES

As stated in a previous section of this review, primary care workers often feel reluctant to question clients about their AOD use and deliver BIs as they fear that rapport will be lost (Lock et al., 2002). However, in a study exploring client attitudes towards alcohol-related BIs (Lock, 2004a) the opposite was found. That is, clients indicated they would be very receptive to alcohol-related advice if it were delivered by a health professional with whom they had developed good rapport. Furthermore, clients identified general practitioners as their preferred health professional to deliver a BI, and considered BIs to be a legitimate part of the general practitioner's role.

In addition, clients have been found to view their primary care worker as a trustworthy, approachable and reliable source of information and, as a result, feel comfortable about being questioned about sensitive issues, such as alcohol consumption (Lock, 2004a, 2004b). Babor and Higgins-Biddle (2001) also stated that clients appreciate it when primary care workers take an interest in alcohol-related issues that may be affecting their health. While these findings are encouraging, they are contrasted by recent evidence that relates to substances other than alcohol. In a qualitative study conducted by Mugavin et al. (2007) regular drug users felt that treatment providers lacked knowledge of drugs and held negative attitudes towards AOD users. It was reported that these concerns discouraged drug users from seeking AOD treatment from primary care workers, particularly general practitioners.

4.4.3.2 CLIENT DEMOGRAPHIC CHARACTERISTICS

The provision of BIs in primary care is influenced not only by practitioner characteristics (e.g., attitudes, motivations and experience), but also client demographic characteristics. Client gender, employment status, and education status influences the rate of BI delivery in primary care settings (Kaner et al., 2001). Practitioners are more likely to deliver BIs to risky drinkers who are male, unemployed, and technically trained. Clients least likely to receive an alcohol related BI were female, students, and university-educated. These findings, particularly those in relation to gender, are consistent with the general characteristics of the treatment population, with greater numbers of males engaging in risky alcohol consumption, compared to females (Australian Institute of Health and Welfare, 2005).

Interested in determining whether client characteristics influenced nurse-led BIs, Lock and Kaner (2004) conducted a study involving practice nurses in primary care settings. Although nurses were also more likely to deliver BIs to male risky drinkers, the clients' occupational or educational status did not influence the provision of BIs. These findings suggest that non-clinical factors, such as client demographic characteristics, are important considerations when planning effective implementation strategies.

KEY POINTS

- Clients view BIs to be a legitimate part of their health workers role and perceive general practitioners to be the most appropriate health professional to deliver an alcohol-related intervention.
- General practitioners are more likely to deliver alcohol-related BIs to clients who are male, unemployed, and technically trained. Clients who are least likely to receive a BI are females, students, and university-educated.

4.5 SUMMARY

BIs can play a valuable role in reducing hazardous AOD use, with a large evidence base supporting their use in relation to hazardous alcohol consumption. Primary care settings have been identified as the ideal setting in which to deliver AOD BIs, largely because of their involvement in health promotion and prevention and also because a high proportion of the population utilise such services each year. Nevertheless, it is has been reported that the majority of clients who are seen by primary care workers are not asked about AOD issues and are often not offered BI treatment, even when it is warranted. This lack of BI activity in primary care is commonly attributed to poor implementation strategies, which often fail to address the enablers and barriers associated with BI implementation.

This review identified several enablers and barriers to BI implementation, which were related to system design, program delivery design, and client factors. Some of the enablers, which were identified included: direct dissemination strategies; workforce development; multifaceted training techniques; supportive, stable, and resourceful organisations; innovative models (e.g., online BI programs); and positive client attitudes towards the provision of BIs. In contrast, some of the barriers were found to include: low levels of role security; under-utilisation of practice nurses; competing health priorities and limited time availability; lack of BI awareness, knowledge, and skills; negative practitioner attitudes; and insufficient training and subsequent support.

In order to facilitate the implementation of BIs in primary care settings and encourage their acceptance among healthcare professionals, it seems that the aforementioned barriers need to be acknowledged and addressed. This may occur via a number of avenues including, the dissemination of AOD BI guidelines, increased and improved training for primary care workers, promotion of BI effectiveness, and more research that focuses on primary care workers' attitudes towards and commitment to implementing AOD BIs into their daily clinical practice. After all, if such strategies are developed and the associated barriers addressed, an effective model of BI implementation in primary care is likely to be developed and successfully utilised.

5 BRIEF INTERVENTIONS IN PRIMARY CARE: KEY INFORMANT PERSPECTIVES

This section draws on key informant interviews (N=17) to address the research questions. Key informants included primary care professionals working in general practice, community health services, hospitals, specialist AOD, mental health and dual diagnosis services, pharmacies, and a specialist youth health service.

5.1 CURRENT PREVALENCE

Project findings indicate that the implementation of AOD BI across the Victorian primary care sector is limited. As outlined in the methodology, significant effort was undertaken to identify individuals and organisations utilising BIs. While the methodological process for identifying and recruiting this group to the project was sound, very few of the 67 individuals contacted delivered AOD BI themselves or knew of others doing so. Interestingly, a significant proportion of those contacted did report delivering elements of BI, such as information, advice and referral as part of standard client work, but did not identify this work as a BI.

As it became increasingly evident that practitioners rarely implement AOD BI, the reasons for low BI uptake across the primary care sector were explored. A number of barriers to BI implementation were identified and are outlined below. Examination of these system level, program level and individual level barriers provides some context for the isolated instances of purposeful BI delivery that are occurring. An overview of current BI practices across the sector is provided, with identification of evidence-based practice and innovation that has developed in some settings, despite barriers to implementation. Those enablers that facilitate the delivery of AOD BIs in the Victorian primary care sector are outlined, followed by a discussion of how to enhance AOD BI uptake across the primary care sector. The conclusions draw on evidence from the literature and key informant interviews to comment on future directions in relation to AOD BI in primary care.

5.2 BARRIERS

As documented in the literature, a number of structural, organisational and individual factors can act as barriers to AOD BI implementation in primary care settings. These include insufficient workforce development regarding AOD BIs, inadequate system supports, time constraints, and negative practitioner attitudes (Nilsen et al., 2006). Key informants reported that these and other barriers contributed to low BI implementation in the Victorian primary care context. As outlined below, barriers were identified at the system level, program level, and individual level.

5.2.1 SYSTEM LEVEL BARRIERS

System level barriers to BI uptake pertain to limited workforce knowledge of BIs and a lack of dedicated funding.

5.2.1.1 LIMITED WORKFORCE KNOWLEDGE OF BIS

There was general consensus among key informants that a clear understanding and theoretical knowledge of BIs was important for BI uptake in primary care settings. However, most key informants indicated that many primary care workers did not have an adequate understanding of BIs. A poor understanding of BIs is not a feature unique to the Victorian workforce, as inadequate levels of BI knowledge and awareness have also been reported in the international literature (Aalto et al., 2001). In some cases, Victorian primary care workers were delivering elements of BI, such as information and advice, without conceptualising such work as a BI. Even among those who delivered BIs in a more formal and deliberate way, conceptualisation and implementation varied widely (n=6).

> *You often hear people speak of BIs with confidence but their ideas of them are quite variable.*
>
> *I would say that most staff may not have a great theoretical understanding of BIs….staff may be doing it without even realizing that is what it is called.*

This workforce development issue is indicative of limited knowledge of AOD issues across the primary care sector. Despite acknowledgement that primary care clinicians should have the capacity to appropriately identify and address AOD issues among clients, few recognise the physical and psychological problems associated with hazardous AOD use. Limited AOD knowledge was attributed to the varied professional backgrounds and qualifications represented across the primary care sector, and a lack of formal AOD training. Such workforce development issues ultimately limit the capacity of staff to intervene effectively with clients experiencing problematic substance use (n=8).

Key informants commented on the lack of BI training currently available to primary care workers in Victoria. Workforce development in AOD BI, and ongoing support by experienced and credible educators, could increase health workers' knowledge of, confidence in, and delivery of BIs (n=3).

5.2.1.2 LACK OF INCENTIVES

Key informants reported that current funding conditions did not support the routine delivery of BIs in primary care and financial support was required to promote the consistent delivery of BIs. Without adequate incentives, services would continue to struggle to incorporate BIs into organisational policies and mainstream practice. Financial support could drive systemic and organisational change and staff acceptance of AOD BIs as a legitimate clinical activity (n=10).

The absence of systematic reporting mechanisms that acknowledge where AOD BI practice does occur was identified as another barrier to staff uptake. Without methods of recording BI implementation, there was little incentive to provide such interventions (n=3).

> *It is frustrating for workers because sometimes we can't get a pat on the back for that and a tick for that.*

5.2.2 PROGRAM LEVEL BARRIERS

Empirical studies have demonstrated the effectiveness of AOD BIs when delivered in primary care settings (e.g. Babor & Grant, 1992; Fleming et al., 2002; Kaner et al., 2007). However, it is also reported that healthcare workers are reluctant to deliver BIs in practice (Funk et al., 2005; Weiland et al., 2008). Key informants identified a number of program level barriers which impede staff uptake of AOD BIs in Victorian primary care settings. These barriers include negative staff attitudes, time constraints and lack of management support.

5.2.2.1 NEGATIVE STAFF ATTITUDES

Negative staff attitudes towards AOD BIs were identified as a major barrier to the implementation of BIs in Victorian primary care settings. Consistent with the literature, key informants reported that some primary care workers were concerned that exploring AOD issues might disrupt the development of rapport with clients (Lock et al., 2002). Others viewed the AOD issues of their clients as 'somebody else's problem', requiring specialist skills and knowledge beyond their primary care role (n=7).

> *For external agencies, outside of drug and alcohol, one of the major barriers is that they don't see it as their primary role or as part of core business.*

> *They would much more prefer to refer someone over to the AOD service for them to do it.*

Clinicians' personal bias against individuals who misuse AOD also impeded the uptake of BIs. This was thought to be particularly problematic among clinicians with stereotypical views of drug users (n=5).

> *Certainly in rural areas where there tends to be an older population of GPs – they tend to have quite serious type views of people with D&A problems so there isn't a lot of enthusiasm to screen for or look for drug and alcohol problems.*

> *For some workers, when they think of people with substance use disorders they think of the worst scenario, most dependent-type person who probably burnt them at some time. Like a GP will think of a monster who demands more benzos; they don't tend to recognise the larger cohort, the cohort where the most personal and financial costs are, i.e. those that would qualify for abuse rather than dependence.*

Despite the extensive evidence base for BIs, and the positive experiences of those engaged in BI delivery, key informants reported that scepticism about the effectiveness of AOD BIs was common across the primary health care sector. While the low profile of BIs relative to other interventions may explain this broader scepticism, the workforce development needs identified above are the most likely contributor to negative attitudes. Across the sector, lack of knowledge and understanding creates 'fear of the unknown', reluctance and scepticism (n=3).

5.2.2.2 TIME CONSTRAINTS

Key informants identified time limitations and competing health priorities as the greatest barrier to BI implementation. This comes as little surprise in a sector in which clients may present with immediate needs. The literature notes that primary care staff often perceive BIs to be a major addition to their daily workload (Beich et al., 2002) and this was consistent with key informant reports that primary care staff view BIs as 'more work, rather than more effective work'. It was important to convey to staff that BIs are brief, and should be embedded in normal practice. Key informants noted that linking BIs to standard screening and assessment practices facilitated smooth and efficient BI implementation. In some cases, this entailed developing a combined assessment/BI tool that scored a client's AOD risk and directed clinicians to administer appropriate BI interventions (n=6).

5.2.2.3 LACK OF MANAGEMENT SUPPORT

Management support is critical to the successful implementation of BIs in primary care settings. According to the literature, a top-down approach is essential to incorporate BIs into everyday practice (Babor & Higgins-Biddle, 2000). Key informants concurred, highlighting the need for strong endorsement of BIs by management. Implementation of BIs requires 'a whole service response, not just a clinician's response'. Managers can raise and maintain the profile of BIs by keeping BIs on the agenda at staff meetings and clinical reviews, promoting the effectiveness of BIs across an organisation, encouraging BI uptake among staff and monitoring implementation (n=3).

> *The crucial thing is what the manager is like. If the manager can see the benefits and is oriented towards providing the most effective service that they possibly can, it is very easy. But if the manager is going to be difficult about it you know it is not going to fly – it is going to be much harder to get it running with the staff.*

5.2.3 INDIVIDUAL LEVEL BARRIERS

The implementation of BIs in primary care settings is influenced not only by practitioner factors but also by various client-related barriers (Lock, 2004a, 2004b). According to key informants, clients' readiness and motivation to change, attitude towards AOD interventions, physical, emotional and mental health, cultural background, and literacy and numeracy skills

can impact on the delivery of a BI. Key informants also indicated that clients' level of intoxication can also be a barrier for BI delivery (n=6).

> *I suppose the alcohol or the drug problem itself can make a person difficult, and can make them less attractive to the reception staff, especially if they present substance-affected. So those sorts of issues in themselves can make it difficult (to deliver an AOD BI).*

5.3 MODELS OF AOD BI IN VICTORIAN PRIMARY CARE SETTINGS: AN OVERVIEW

It is within a state-wide context of limited knowledge and practice across the primary care sector that isolated instances of AOD BI delivery have occurred. This section provides an overview of models of AOD BI implementation in Victorian primary care settings, drawing on key informant data. The fifteen[3] models of BI, which are presented as case examples in Appendix 3, are characterised by their diversity, rather than their homogeneity. They reflect the range of practice occurring across those few primary care sites proactively delivering AOD BIs in Victoria. It is worth noting that the case examples are more likely a reflection of BI practices per se, as opposed to 'good practice' in BI delivery. The absence of evaluation of the models hinders such judgements. Notwithstanding the lack of evaluation, some of the BI models identified in this project do appear to represent innovative responses, and at the very least reflect sector leadership through their purposive delivery of AOD BIs. The diversity of the models of AOD BI is presented below, with attention to AOD BI settings, clients, models and innovative practice.

5.3.1 AOD BI SETTINGS

The primary care settings in which AOD BIs were occurring varied widely. Primary care settings included general practice, community health services, hospitals (metropolitan and regional), a specialist youth service, and a pharmacy. Stand-alone specialist AOD, specialist mental health and specialist dual diagnosis services also delivered BIs, although more commonly these were delivered through one of the generalist primary care settings identified above. Examples of such settings included:

- Specialist AOD service located within community health services
- Specialist AOD service connected to a hospital
- Specialist mental health service within a hospital
- Specialist mental health service connected to general practice

The providers of AOD BIs within these settings included:

- GPs
- Nurses (nurse practitioners, ED and ward nurses, psych nurses)
- AOD specialists (AOD mental health clinicians, ABI workers, clinical nurse consultants, withdrawal nurses, case managers)

[3] Two key informants were not currently delivering, or managing staff delivering, BIs.

- Allied health professionals (Mental health clinicians, social workers, welfare workers, pharmacists, paediatricians, occupational therapists, care co-ordinators)
- Harm reduction workers (Needle and Syringe Exchange Program (NSP) staff
- Intake workers, duty workers, triage staff

One key informant highlighted the great potential of AOD BI delivery within the primary care settings. In contrast to the specialist AOD environment, the primary care sector affords access to a much larger population of clients experiencing problematic use before their use becomes significant, entrenched and dependent. The provision of early intervention through evidence-based practice such as AOD BIs enhances opportunities for population-level responses (n=1).

5.3.2 AOD BI CLIENTS

AOD BI clients typically reflected the focus of the service, rather than the nature of the BI itself. AOD BIs were provided to both adults and young people (n=7), families (n=2), youth (n=2), and adults only (n=1). Adults with AOD or mental health issues were the target group of four settings[4].

5.3.3 AOD BI MODELS

Consistent with the literature (Poikolainen, 1999), AOD BIs delivered in Victorian primary care settings included very brief interventions and extended BIs. Most commonly, both forms of BI were provided (n=12), although in some cases only very brief interventions were provided (n=4)[4]. All key informants reported that the models of AOD BI utilised in their setting/s comprised assessment, intervention and referral phases[5] (n=15). The features of each phase are outlined below.

5.3.3.1 ASSESSMENT PHASE

Assessments ranged from brief to comprehensive, exploring general health through to specific AOD, mental health and welfare issues. A number of key informants reported using validated screening tools such as AUDIT (alcohol only) and ASSIST (9 substances including alcohol and tobacco) for assessment, albeit abridged or adapted versions (n=3). Others reported conducting informal assessments based upon discussions with the client (n=3). Screening and assessment occurred at one or more points across the treatment contact: at initial intake, at first treatment session and throughout treatment. The assessment typically informed the intervention phase.

[4] The total number here exceeds N=15 as one key informant worked across multiple settings.

[5] Assessment, intervention and referral phases have been delineated as separate processes in this discussion for clarity. However, it is acknowledged that these elements are part of an overall intervention and occur in concert with one another, rather than in isolation.

5.3.3.2 INTERVENTION PHASE

5.3.3.2.1 VERY BRIEF INTERVENTIONS

The intervention phase typically drew on the results of the assessment to provide feedback to clients and inform the treatment provided. Clients assessed as having moderate or high risk AOD issues generally received more intensive interventions than low risk clients.

Very brief interventions varied in length from 2-3 minutes to 30 minutes, with shorter versions more typical in hospital or GP settings. Very brief interventions were seen as opportunistic interventions suitable for clients in crisis, clients with immediate needs or clients unlikely to return for further treatment (n=6).

The intervention phase of very brief interventions generally involved:

- Providing verbal information and advice (n=15)
    - Discussing the harms of substance use (e.g. risks of binge drinking; n=9)
    - Discussing harm minimisation strategies (e.g. safer drinking practices, safe injecting practices, relapse prevention; n=9)
    - Discussing treatment options (n=4)
- Providing written information (e.g. AOD fact sheets; ADF withdrawal pamphlets; safe drinking guidelines; information packs, service information, DirectLine contact numbers, decisional balance sheet, drinking decisions pamphlet; pharmacy self-care cards regarding safer injecting practices; n=9)
- Delivering Motivational Interviewing (n=4)
- Identifying and setting client goals (n=3)
- Working to build rapport and engage clients (n=3)
- Discussing the Stages of Change and identifying where the client fits (n=2)
- Addressing immediate needs (e.g. mental health, housing, sexual health, etc; n=2)
- Using the FRAMES approach (n=2)
- Developing care plans, including hospital discharge plans and recommendations (n=2)
- Organising treatment commencement (n=1)
- Utilising ancillary teaching aids such as videos and DVDs (n=1)

Two key informants reported that the provision of written material was often inappropriate for their clients due to their low literacy skills and the incidence of ABI and intellectual disability. In these cases, verbal information in conjunction with pictorial information was considered helpful (n=2).

5.3.3.2.2 EXTENDED BIS

Consistent with the literature (Babor & Higgins-Biddle, 2000), extended BIs occurred across multiple sessions (3-5 sessions) of 20-30 minutes each (n=8). In addition to the features of very brief interventions identified above, extended BIs typically involved:

- A focus on therapeutic elements such as motivational interviewing, CBT and psychotherapy (n=3)
- Assertive follow-up by phone (n=2)
- Providing decisional balance exercises and homework for clients (n=1)
- Supportive counselling (n=1)
- Case counselling (n=1)
- Liaising with existing community supports (n=1)

Two key informants noted that extended BIs were helpful for dual diagnosis clients who often require more time to absorb information and achieve individual AOD-related goals. Such clients can receive multiple extended brief interventions addressing particular issues (n=2). This reflects an expanded approach to the extended BI model based on the provision of longer term counselling.

Although there are several features common to very brief interventions and extended BIs, such as the provision of information and advice, key informants noted that extended BIs can be distinguished by the focus on client engagement, goal setting and inclusion of therapeutic elements (see Table 2 for a more comprehensive comparison between very brief interventions and extended BIs).

5.3.3.3 REFERRAL PHASE

The referral phase included formal and informal referrals both within services and to external services. Referrals were made via formal referral processes, informal verbal referrals and the provision of written service information. Some key informants reported facilitating linkages with other services by making appointments for clients or accompanying them to treatment. Key informants noted the importance of having good existing relationships with other services in order to facilitate smooth referral processes (n=6).

Referrals were made to:

- GPs (n=3)
- AOD specialist services, including AOD counsellors, DirectLine and NSPs (n=6)
- Mental health services, including counsellors, psychologists and psychiatrists (n=4)
- Local hospitals (n=2)
- Housing services (n=1)

Table 2: Features of very brief AOD interventions and extended AOD BI in Victorian primary care settings

Very Brief Intervention	Common Features	Extended Brief Intervention
Single session, opportunistic intervention that ranges from 2-3 minutes to a maximum of 30 minutes	Verbal and written information and advice around AOD use, harm minimisation, and treatment options	Multiple session intervention (3-5 sessions) ranging between 20-30 minutes in length
Use of the FRAMES approach – Feedback, Responsibility, Advice, Menu of change strategies, Empathy, Self-efficacy	Focus on rapport building and client engagement	Focus on therapeutic elements, such as motivational interviewing, CBT, and psychotherapy
In hospital settings, developing a discharge plan	Identify the client's immediate needs and set goals (including the commencement of treatment)	Developing care plans, liaising with existing supports, and assertive follow-up
Utilising ancillary teaching methods, such as DVDs	Motivational interviewing	Client activities (e.g., decisional balance exercises)
	Identifying the client's position in the stages of change model	
	Formal and informal referrals to relevant services	

5.3.4 BI AND DIFFERENT DRUG TYPES

Key informants generally concurred that BIs were suitable across all substance types, inclusive of alcohol and amphetamines. Clinical priority was to assess the individual needs of the client and tailor the intervention according to the client's specific substance use and severity. Key informants were also cognisant of a client's readiness to change and adapted the intervention and referral phases accordingly. For example, motivational interviewing is better suited to a pre-contemplative client than CBT (n=16). Refer to Appendix 4 for a list of amphetamine resources for clinicians.

5.3.5 INNOVATIVE PRACTICE

One model of AOD BI stood out as innovative by virtue of its work towards implementing alcohol BIs. This model, which incorporated a dedicated BI champion, a specific funding stream and use of computer-assisted technology, facilitated excellent BI uptake across the service.

5.3.5.1 NORTHEAST HEALTH, WANGARATTA (WANGARATTA HOSPITAL)

This regional hospital has developed an innovative model of AOD BI for implementation across the hospital through dedicated project funding provided by regional DHS. Within the time limited environment of a hospital setting, very brief interventions are delivered (max. 5 minutes). Key features of this model include:

- A focus on alcohol BI
- Initial implementation in the ED but later rolled out across wards
- Promotion among staff regarding alcohol harms and effectiveness of BIs
- Training of nurses to provide 5 minute BI
    - In high throughput wards, all staff trained in BIs
    - In low throughput wards, 3-4 champions trained in BIs
- Development of a 20 page take-home alcohol information pack for clients
- Use of adapted AUDIT for screening linked to AOD BI
- Initial paper-based screening and BI upgraded to computer-prompted screening and BI.
    - DHS provided additional funding to put the AUDIT screen and an automated BI on the hospital IT system, Orion. Wireless laptops travel between clients and prompt nurses to conduct AUDIT screening and a BI. AUDIT is automatically scored and advises nurses of the appropriate BI response required.
    - Data can be downloaded and analysed by project officer for feedback to staff, management and others.
    - A further proposal to conduct a computer-generated BI is also underway. It is proposed that, following autoscoring of the AUDIT screen, staff will provide headphones to clients and activate a BI computer link to deliver the appropriate information. The use of a computerised support system will free

up more staff time and has been shown to be effective in producing short-term reductions in alcohol consumption (Kypri et al., 2004).

- Approximately 9,000 alcohol BIs have been conducted in the 17 months since project implementation
- A critical feature of the project is support from ward managers. Rollout was successful in all wards where management were supportive of project and followed-up staff who were not conducting screening and BI.

Further information on this model of AOD BI is available in case example #1 in Appendix 3.

5.4 FEATURES OF GOOD PRACTICE IN BI

5.4.1 CLIENT ENGAGEMENT

The clinician and the client really need to be engaged very early for it to be effective.

Engaging clients in treatment is central to good practice in BI implementation, just as it is across the AOD sector (Roche et al., 2002). According to key informants, engagement is facilitated when clinicians treat clients with respect and empathy, are non-judgemental, identify and respond to the specific needs of the client, and earn their trust. Key informants reported that engagement is important in establishing a relationship with clients because it increases the likelihood that a client will return for further treatment when, and if, required. Engagement enhances communication between the clinician and their client, improves the effectiveness of information transfer so that relevant AOD information, such as that pertaining to harm reduction strategies, are more likely to be absorbed by clients (n=12).

5.4.2 ASSESSMENT

Assessment was identified as an important element of a BI. Key informants conceptualised assessment or brief screening as part of the BI itself, which is consistent with the literature (Lee et al., 2004). Assessments typically occurred via validated and adapted screening tools and were helpful in forming the basis of a discussion with a client about AOD issues. This discussion included feedback to a client about their current level of risk, potential harms and strategies for harm reduction (n=9).

5.4.3 TIMELINESS OF INTERVENTION

The timeliness of treatment was identified as central to good practice in BI delivery. Prompt service responsiveness and BI delivery were particularly important where clients were presenting in crisis. The provision of timely treatment in these circumstances provides key opportunities to provide important information and education, respond to immediate needs and deliver positive treatment experiences. Positive treatment experiences enhance the likelihood of future client contact (n=6).

Client stability can influence the delivery of BIs in many primary care settings. Those working within hospital settings reported that some clients seen in emergency departments were not suitable for BI delivery until their health and medical needs had stabilised. This often meant postponing BIs and accessing clients in general medical wards.

5.4.4 LINKAGES

Good linkages facilitate timely and appropriate responses from professionals with specialised expertise. A number of key informants noted that professional networks allowed enhanced

referral and support processes to both clients and services themselves. Some networks developed within organisations while others were established with external services (n=6).

5.4.5 GOAL-ORIENTED INTERVENTION

A number of key informants reported that goal setting was an important component of BIs. Goals were developed in collaboration with clients based on their needs and typically focussed on reducing the harms of current substance use. Goals needed to be achievable and accompanied by harm minimisation strategies which reduced risk (n=5).

5.4.6 WORK ACCORDING TO STAGES OF CHANGE MODEL

> *You sort of work out where the person is in the stages of change, working out the appropriate intervention and the appropriate level on which to pitch it, and the appropriate treatment. That is my major thing because if you get it wrong at that point it can really backfire.*

Client readiness to change was important to the delivery of an appropriate BI. A client's stage of change influences the treatment approach, language and information provided by clinicians. Information must be pitched at the right level, depending on a client's pre-contemplative or contemplative status (n=5).

5.4.7 PROVISION OF WRITTEN INFORMATION

Key informants reported that the provision of written information to clients regarding AOD use was an important element of a BI. Such information included leaflets, booklets and fliers. The use of written information to promote staff use and uptake of BIs was also seen as helpful, with two key informants reporting the successful use of these strategies. This included placing the BI pamphlet in client files and displaying fliers across work settings to remind staff to deliver BIs (n=3).

5.4.8 QUALITY STAFF

Three key informants reported that the positive qualities and attributes of good AOD clinicians were a key component of good BI practice. The qualities and attributes deemed important included: the ability to talk to clients on their own level, be non-judgemental, sympathetic and engaging, and motivational in their clients interactions. According to key informants, such features enable clients to develop a robust relationship with health service staff and make them more receptive to the information presented during a BI (n=3).

5.5 ENABLERS OF GOOD PRACTICE IN BI DELIVERY

The features of good practice in BI identified above are supported by a number of enablers, most of which are closely linked to uptake issues. The most significant enabler is a workforce with capacity to deliver BIs as part of a range of AOD interventions. Workforce capacity was predicated on appropriate training and development to impart greater understanding of BIs and their effectiveness, and shift negative attitudes towards such interventions. Central to these efforts was normalising the role of BIs as an essential component of primary care work (n=9). Specific implications for the sector, particularly as they pertain to the uptake of BIs, are outlined below.

5.6 IMPLICATIONS FOR THE SECTOR: INCREASING BI UPTAKE

5.6.1 TRAINING

According to key informants, increasing the uptake of BI delivery among primary care staff was primarily a matter of training. Staff training should focus on promoting the effectiveness of BIs in reducing harmful AOD use among clients. In hospital settings, the capacity of BIs to reduce re-admissions to emergency departments was identified as an effective way of framing the positive impact of BI. Training should also encourage staff to view BIs as a legitimate part of their primary care role, explain how to deliver a BI, and empower staff to deliver BIs (n=11).

Key informants commented on a number of training approaches to enhance uptake. Some reported that training should occur with all staff at employment intake/orientation, while others felt that targeted training of identified BI champions would be more effective. Training could occur as part of in-service education or via external courses, TAFE, undergraduate and graduate courses. Key informants called for regular training, after hours training and group training. Training needed to be matched to the knowledge skills of attendees and seek feedback from participants for ongoing improvement (n=9).

Two key informants noted that BI training for primary care staff should be part of broader efforts to enhance AOD knowledge across the sector. This could occur via routine staff placements in neighbouring AOD specialist agencies and greater attention to AOD issues in TAFE curriculum. As noted in the literature (Anderson et al., 2004), the importance of providing multifaceted training strategies, which combine both education and continuing office-based support, was also highlighted by one key informant (n=3).

5.6.2 BI CHAMPIONS

> *I think it would probably benefit from a champion, someone talking positive, going around talking to people and informing them of the effectiveness and the value of BIs.*

Many key informants supported an approach that utilised BI champions as a means of promoting AOD BI uptake in primary care. Champions would be drawn from interested individuals and provided with comprehensive training. Champions would deliver secondary consultation, work towards raising BI awareness and increasing BI uptake in their organisations and beyond. The credibility of such individuals within their workplace and the sector was reportedly a key factor in getting other staff to engage with champions and implement change (n=5).

The use of existing positions that already service multiple primary care sites was identified as a potential source of BI support. In one Victorian health region, a mental health sector liaison worker proactively monitors AOD screening and BI implementation across 13 sites. Similar multi-site roles may provide opportunities for identifying and engaging BI champions to work across parts of the primary care sector (n=1).

5.6.3 ORGANISATIONAL SUPPORT

A multi-pronged and strategic approach to workplace change was reportedly the best way to increase the uptake of BI delivery by primary care staff. This required strong managerial support, embedding AOD and BI practice into organisational policy, providing training and mentoring for staff and mandating BI delivery. This is consistent with the literature which identifies organisational support, stability and leadership and being important enablers to the successful implementation of BIs (Babor et al., 2005). Processes which engage staff in the planning and rollout of BIs also assist in enhancing uptake (n=3).

> *Policy is the most potent driver of implementing and making change – routinely screening and providing BIs as a treatment pathway is a powerful driver.*

Cultural change across organisations takes time. One key informant reported that, in their organisation, effecting such change in relation to BI took approximately eight months (n=113).

5.6.4 LINK TO ASSESSMENT

Linking a BI with screening and assessment processes already in place across services was identified as another effective method of facilitating staff uptake of the intervention. A number of key informants reported linking the BI with paper-based and computer-assisted screening tools to encourage their use. Following completion and scoring of the screen, the clinician is guided through to the appropriate BI. In doing so, the linked BI supports the uptake of AOD screening by providing structure and information to those clinicians concerned about how to proceed should an AOD screen be positive for harmful use.

We built in flow charts on the back of the assessment forms so when someone scores positively you know what to do next. You need very clear pathways for the person administering the screen and how to follow it. Otherwise they feel that they are holding it all and they don't know what to do with it and there will be a real reluctance to do the screen unless they are very clear with what they do with it after that.

6 CONCLUSION

This project, undertaken by Turning Point Alcohol and Drug Centre in 2007/08, sought to review the delivery of AOD BI across Victorian primary care settings. Commissioned by the Victorian Department of Human Services' Drugs, Policy and Services Branch, the review aimed to define models of AOD BIs as documented in the literature, report on the effectiveness of these models, and describe examples of good AOD BI practice in Victorian primary care settings, including enablers and barriers to implementation. The review would also provide direction for the development and implementation of models of AOD BI. The review methodology incorporated a literature review, semi-structured interviews with 17 key informants, the development of case examples and liaison with a Steering Committee.

The literature indicates that AOD BIs are valuable interventions well suited to primary care settings. The health promotion activities of primary care services, which can reach large numbers of clients, are consistent with the delivery of BIs. Despite this, low levels of AOD BI delivery in these settings have been documented. Poor BI uptake among primary care services has been attributed to low levels of role security, under-utilisation of practice nurses, competing health priorities, lack of BI awareness, knowledge and skills, negative practitioner attitudes, and insufficient training and support. In contrast, enablers of BI uptake included direct dissemination strategies, workforce development, multi-faceted training techniques, supportive, stable and resourceful organisations, innovative models and positive client attitudes to BIs. Key messages from the literature pertain to better dissemination of AOD BI guidelines, increased and improved training for primary care workers, promotion of BI effectiveness and further research into attitudinal impediments to AOD BI uptake among workers.

Consistent with the literature, AOD BI delivery among Victorian primary care providers is limited. Significant liaison with the sector identified only a few providers reporting purposive AOD BI practices. In some cases, the assessment, intervention and referral phases of BIs were occurring but were not identified as BIs. Key informants reported that system level barriers to BI implementation included limited workforce knowledge of BIs and a lack of incentives. Program level barriers included negative staff attitudes, time constraints and lack of management support. Individual (client) level barriers pertained to clients' readiness to change, attitude towards treatment, level of intoxication, physical and emotional state, cultural background, and literacy skills.

A number of models of AOD BI were identified in Victorian primary care settings and the literature, including very brief interventions and extended BIs. The diversity of the 15 identified models of AOD BI across settings and providers is remarkable. A feature common to all the models is the three-phased BI, incorporating assessment, intervention and referral. Assessments vary from comprehensive to very brief screens. Intervention phases range from 2-30 minutes over a single session for very brief interventions to 20-30 minutes over 3-5

sessions for extended BIs. Very brief interventions and extended BIs always include the provision of information and advice, with extended BIs engaging in greater therapeutic work with clients. Innovative AOD BI practice was documented in one setting.

Key informants reported that 'good practice' in AOD BIs was defined by the presence of a number of features. These included client engagement, assessment, timely and goal-oriented intervention, linkages, consideration of the stages of change and the provision of written information. Enablers of good BI practice were closely tied to uptake issues enhanced by workforce training, identification of champions to promote BI delivery, organisational support, and the linking of BIs to assessment processes.

Significant work is required to increase the delivery of AOD BIs across the primary care sector. The limited purposeful delivery of AOD BIs should be addressed through workforce development, awareness raising activities, and system- and organisation-level support for the training, uptake and delivery of BIs. It might also entail the inclusion of BI delivery in primary care position descriptions. Establishing networks of BI champions to sustain knowledge-sharing activities and promote the integration of these activities into mainstream treatment, education and training is critical to facilitating a cultural and attitudinal shift across the workforce. Innovation in the delivery of AOD BIs should be acknowledged and rewarded to promote leadership and good practice.

As one key informant noted, the greatest potential impact of BI uptake is not at the specialist AOD level but across primary care settings. The latter affords an opportunity to provide early intervention to a much greater population of clients experiencing problematic use before their use becomes significant, entrenched and dependent. By intervening early in harmful AOD use via effective practices such as BIs, the capacity to have a marked impact on clients is enhanced. In the context of under-utilisation in the primary care sector, work towards enhancing the uptake of AOD BI warrants immediate and ongoing attention.

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8 APPENDIX 1 – PARTICIPATING KEY INFORMANTS

Michael Aufgang

Rodger Brough

Ros Burnett

Jim Burns

Peter Cash

Gary Croton

Colin English

Dot Henning

Dean Hyland

John Parkinson

Dianne Roberts

Clare Roczniok

Steve Voogte

Tracey Wieland

Veronica Yates

9 APPENDIX 2 – KEY INFORMANT INTERVIEW SCHEDULE

1. What is your experience with AOD BI in primary care? In which setting is your experience based?

GP A&E Dept CHC Pharmacy AOD MH

2. How does a client get to the point where they receive a BI at your service? i.e. What were the processes from intake to receiving a BI? *(Via triage/duty worker /reception/ A&E*)

3. Who delivers the AOD BI?

4. What does an AOD BI involve at your service? Identify oral or written information/advice, identify subject matter, and formal/informal referral/s (to which service)?

a. It sounds like a *(very brief/extended)* BI is used at your service. Does this sound correct?

5. (Only where appropriate) Extended BIs are also noted in the literature. Do you deliver these? Do you know of others who use extended BIs?

6. (For services only) How did you get staff to take on BI delivery? (e.g. Training, directive, BI champion)

(For individual providers) How did you come to be providing BIs? (e.g. Training, info)

7. In your view, what are the features of good practice in BI?

a. Are there particular strengths in the way BIs operate at your service?

8. What are the enablers of good practice in AOD BI? (At systems level, organisational level, program level, individual level)

9. What are the barriers to good practice in AOD BI? (At systems level, organisational level, program level, individual level)

10. Do AOD BIs need to differ in any way for alcohol and amphetamine users?

11. How can we increase the uptake of AOD BIs (explore own and other settings)? (e.g. Identify and skill up BI champion/leader/promoter, identify through ADIS?)

10 APPENDIX 3 - MODELS OF AOD BI: CASE EXAMPLES

The models of BI implementation presented in this section are drawn from semi-structured interviews with 15 of the 17 key informants[6]. Key informants were current providers of AOD BIs across a number of primary care settings, including hospitals, community health centres, and general practice, as well as specialist AOD, mental health and dual diagnosis services. The models reflect the complexity of the primary care sector in which practitioners often work across multiples settings, deliver specialist treatment within generalist primary care settings, are embedded in, attached to, or separate from, other organisations.

The 15 models of BI implementation presented below are characterised by their diversity, rather than their homogeneity, reflecting the range of BI practice occurring in the Victorian primary care sector. For a discussion of some of the commonalities across the models, refer to section 5.3.

[6] Two key informants were not delivering BIs at the time of interview. A total of 67 potential key informants were contacted, of whom only 17 were delivering BIs.

10.1 PRIMARY CARE SETTINGS

10.1.1 HOSPITALS

CASE EXAMPLE # 1 – AN INNOVATIVE MODEL OF ALCOHOL BI

Service setting	• Regional Hospital - Emergency Department (ED) and wards
Client group	• All Adults and young people (16 + years) who present to hospital
Type of BI provided	• Very brief intervention only (time limited context)
Pathway to BI	• Clients receive an assessment and BI in wards across hospital, including the ED • In the ED setting the client receives a BI if they are stable and not in significant pain, otherwise they are captured in medical wards when they are moved out of ED • In the day surgery and overnight medical and surgical ward, assessment and BI are delivered during normal admission process • In the critical care ward, BIs are conducted via ED, theatre or wards (although very few occur here)
Who provides BI?	• Hospital nurses
What does the BI entail?	**Assessment:** • An adapted AUDIT screen (adapted and abridged version) is conducted across hospital **Intervention:** *Very brief interventions* • BIs have a maximum duration of 5 minutes – 'short and sharp' • The AUDIT screen and an automated BI have been incorporated into the hospital's IT system; wireless laptops travel between clients and prompt nurses to conduct an AUDIT screen and BI • The AUDIT is automatically scored and nurses are advised of the appropriate BI response required • An AUDIT score of 8-15 results in a BI and provision of a 15-20 page paper-based information pack • An AUDIT score of 16+ results in a BI, an information pack and advice to contact local CHS for AOD counselling • The BI provides information and education regarding acceptable levels of drinking, the harmful effects of alcohol, and strategies to reduce risk of alcohol use • Wireless technology is used to identify clients who haven't yet had an assessment and automatically links nurses to the BI and other interventions, appropriate to AUDIT score **Referral:** • Clients who score above 16 on the AUDIT are advised to contact the local CHS for AOD counselling

Implementation	• Promotion among staff regarding alcohol harms and effectiveness of BIs
	• Nurses trained to provide 5 minute BIs
	  ○ In high throughput wards, all staff are trained in BIs
	  ○ In low throughput wards, 3-4 champions are trained in BIs
	• Initial paper-based screening and BI was upgraded to computer-prompted screening and BI
	• DHS provided additional funding to put the AUDIT screen and an automated BI on the hospital IT system, Orion.
	• Data can be downloaded and analysed by project officer for feedback to staff, management and others
	• A critical feature of the project is support from ward managers; rollout of the project was successful in wards where management support was received and staff who did not conduct screening and BI were followed up
	• Approximately 9,000 alcohol BIs have been conducted in the 17 months since project implementation
	• A further proposal to conduct a computer-delivered BI is also underway

Features of model	• Assessment • Linkages • Quality staff

CASE EXAMPLE # 2[7]

Service setting	• Metropolitan Hospital - ED and wards
Client group	• Adults and young people
Very brief and/or extended BI?	• Very brief intervention (5-10 mins) • BI up to 20mins • Extended BI - multiple sessions (20-30 mins) in outpatient setting
Pathway to BI	• Clients attend ED and are triaged • Nurses or doctors contact clinical nurse consultant (CNC) directly by phone when AOD issues are identified (CNC is located on site from 8:30am) • If clients admitted overnight, they are listed in a book for CNC • CNC sees clients in hospital or contacts them by phone if they have already left the hospital • Clients may receive BI at triage stage (in ED clinic), in ED proper or in wards if too unwell or transferred
Who provides BI?	• Clinical nurse consultant and doctors
Type of BI	**Assessment:** • AUDIT assessment (alcohol only) is conducted as part of the BI formal assessment or assessment embedded into conversation **Intervention:** *Very brief interventions* • 5-10 min including assessment, intervention and the development of a discharge plan • Utilises FRAMES approach is used • Information and advice is provided re harm minimisation and relapse prevention • Verbal and written material is provided, including decisional balance sheet, drinking decisions pamphlet, harm minimisation documentation, and client documented plan to change *20 minute BI* • This is extension of very brief intervention with more motivational interviewing *Extended BI* • Clients can return to be seen by CNC or doctors as outpatients at a clinic, on-site at the hospital • Extended BIs are framed to clients as 'support', 'reviews', 'monitoring', and 'check-ups', rather than 'counselling'. • Extended BIs entail identifying and exploring AOD use and developing strategies which work for the clients

[7] This case example has not been validated by the key informant.

	• Case counselling provided • CBT techniques are used in a relapse prevention framework • Clients return because familiar with hospital and staff. • This clinic work is unfunded **Referral:** • Referrals provided, clients linked with agencies/workers, assertive follow-up of clients
Features of model	• Assessment • Client engagement • Linkages

CASE EXAMPLE # 3

Service setting	Three service settings: • Regional Hospital • Primary Mental Health Care • General Mental Health Care
Client group	• *In hospital setting:* young people and adults • *In primary mental health*: persons receiving treatment at their local General Practices for high prevalence mental health disorders (Anxiety & Depression) • *In general mental health*: persons receiving specialist mental health treatment
Type of BI provided	• *In hospital setting:* Very brief interventions • *In mental health care settings*: Both very brief and extended BIs
Client pathway to BI	• *In hospital setting*: o All presentations are screened using AUDIT; clients scoring 8-15 receive a BI and clients scoring in high range receive referral to specialist AOD • *In primary mental health*: o Clients with anxiety and depression are referred by their GP to a visiting Integrated Primary Mental Health worker o Presenting clients are routinely screened for a co-occurring alcohol use disorder by the IPMHS clinician o Those screening positive for risky alcohol use receive a BI and those assessed as alcohol dependant receive referral to specialist AOD services • *In general mental health:* o All presentations to local specialist mental health services are screened using ASSIST; the goal is for BIs to be provided to all persons who screen positive for risky substance use
Who provides BI?	• *In hospital setting*: nurses and doctors • *In primary mental health*: mental health clinician • *In general mental health:* the case manager who detects the substance use problem
Type of BI	**Assessment:** • An AOD assessment is conducted for all clients across all three primary care settings; routine screening and assessment is critical to the success of BIs **Intervention:** *Very brief interventions* • BIs can be opportunistic, single session interventions in both mental health and hospital settings • BIs are delivered using the FRAMES approach • Both verbal and written information is provided about safety, harm minimisation, recommended drinking levels etc

	• Clients are given information and advice about AOD use and mental health disorders • Useful and effective strategies to deal with issues are identified *Extended brief interventions* • Extended BIs include the same elements as very brief interventions, however, they are provided over multiple sessions • Extended BIs are particularly relevant for people with serious mental illnesses as they provide an opportunity for engagement and they can address mental health issues. **Referral:** • In hospital and primary mental health settings, clients who are assessed as high risk or alcohol dependant receive referral to specialist AOD services
Features of model	• Assessment • Client engagement • Written information

10.1.2 GENERAL PRACTICE

CASE EXAMPLE # 4

Service setting	• General Practice
Client group	• Adults, young people and families
Type of BI provided	• Very brief interventions • Extended brief interventions
Client pathway to BI	• Clients present to service reception via self-referral, informal/peer referral, or external sources such as DirectLine and makes appointment • BIs don't generally occur in the initial consultation; clients may not respond to information presented during a BI if they are not stabilised • A BI is more like a progress review where client goals and treatment options are discussed and relapse prevention is addressed
Who provides BI?	• GP
What does the BI entail?	**Assessment:** • Prior DirectLine assessment; and/or • GP conducts a general medical examination where AOD issues are identified and explored **Intervention:** *Very brief interventions* • 5-10 min BI • Discuss treatment options (such as pharmacotherapy) • The BI should be goal-oriented - determine client goals; • Verbal information and advice is provided • In some cases, ancillary teaching aids such as videos and DVDs are used *Extended brief interventions* • Same elements as very brief interventions with addition of supportive counselling and psychotherapy, education re mental health issues, mental health care plan development, and goal setting **Referral:** • Referral to psychologist, psychiatrist or counsellor, as appropriate
Features of model	• Assessment • Client engagement • Goal-oriented intervention • Linkages • Quality staff

CASE EXAMPLE # 5

Service setting	• General Practice
Client group	• Adults and young people
Type of BI provided	• Very Brief Interventions (2-3 minutes) in GP setting
Client pathway to BI	• Client makes an appointment to see the GP; client may be seen by a practice nurse prior to consultation with the GP (although AOD issues are not usually assessed by the nurse) • Client history is taken by GP and if an AOD problem is uncovered, a BI is conducted • Often the client does not attend with AOD use as the major presenting problem; the AOD problem may be identified during assessments for other problems (e.g., sleeping problems or depression). In this case, the BI is more opportunistic in nature and is conducted when an AOD problem is identified
Who provides BI?	• GPs
What does the BI entail?	**Assessment:** • Informal assessment is conducted; AOD issues (e.g. levels of use, psychological/physiological problems) are identified in client notes and while assessing clients for other health problems **Intervention:** *Very brief interventions* • 2 to 30 mins • BIs are often opportunistic • verbal information and advice is provided • Clients are provided information re recommended drinking levels, the psychological and physiological effects of their use, harm minimisation strategies, and the contact details of other services • Discuss treatment options • Consider where the client is re stages of change **Referral:** • Referrals to specialised services (e.g. AOD counselling) occur, as required
Features of model	• Timeliness of intervention • Assessment • Client engagement • Work according to stages of change model

10.1.3 COMMUNITY HEALTH SERVICES

CASE EXAMPLE # 6

Service setting	• Community Health Service
Client group	• Adults, young people and families
Type of BI provided	• Very brief interventions • Extended brief interventions
Client pathway to BI	• Clients present via external referral or self-referral • Client attends reception and an appointment with the appropriate health service staff is arranged • An initial AOD assessment is completed, after which a BI is provided
Who provides BI?	• AOD counsellors • Withdrawal nurses • NSP staff
What does the BI entail?	**Assessment:** • An assessment is conducted during the client's first appointment **Intervention:** *Very brief interventions* • 10 to 30 minutes duration • Opportunistic in nature; they are delivered in crisis situations and provide an opportunity to met the client's immediate needs and engage the client in treatment and/or refer to other services • Provide verbal and written information and advice re AOD use (e.g. alcohol guidelines), harm minimisation and risk management • Motivational interviewing provided • Focus on engaging the client *Extended brief interventions* • Same elements as very brief interventions, but extend over multiple sessions • Focus on establishing goals • May involve assertive follow-up via phone to track the client's progress. **Referral:** • Referral to local hospital or other relevant services when assistance with withdrawal is required • Important to maintain a good network of referral destinations (e.g. hospitals, GPs) as BIs are a team effort, both within the agency itself and the wider community
Features of model	• Timeliness of intervention • Assessment • Client engagement • Goal-oriented intervention • Linkages

CASE EXAMPLE # 7

Service setting	• Community Health Service
Client group	• Young people aged 12-24 years
Type of BI provided	• Very brief interventions (1 session) are conducted at intake or during treatment • Extended BIs (usually around 5 sessions)
Pathway to BI	• Clients present to service via external or informal/peer referral • Intake worker and clinicians assess the client's needs and may provide a very brief intervention.
Who provides BI?	• Intake workers, dual diagnosis clinicians, members of the AOD team, and the withdrawal nurse.
What does the BI entail?	**Assessment:** • Informal assessment is conducted at intake to identify the clients issues • Formal assessment (e.g. AUDIT, ASSIST, K-10) is only conducted where client returns for further treatment support • Throughout treatment, client AOD use is explored e.g. substance types, frequency, and longevity of use **Intervention:** *Very brief interventions* • Very brief interventions occur in first session and are used opportunistically • Verbal and written information re harm minimisation strategies, health implications of substance misuse and general health information. *Extended brief interventions* • Same elements as very brief interventions, but over 5 sessions. • May incorporate motivational interviewing • Each session of the extended BI addresses different subject areas, such as health implications, social implications and legal implications of substance use/abuse. **Referral:** • Referrals provided to within-agency supports
Features of model	• Assessment • Client engagement • Work according to stages of change model

CASE EXAMPLE # 8

Service setting	• Specialist AOD withdrawal service within a regional community health service (CHS)
Client group	• AOD-dependent adults
Type of BI provided	• Very brief intervention • Extended brief intervention
Client pathway to BI	• Clients referred from GPs, local hospital, mental health workers, and/or self-referred • Intake worker undertakes brief assessment and BI regarding immediate needs and safety issues • Client is allocated to a worker and an appointment scheduled with withdrawal nurse • 45 min psychosocial assessment and 30 minute BI delivered by withdrawal nurse
Who provides BI?	• Rural withdrawal worker and intake worker
What does the BI entail?	**Assessment:** • A brief assessment occurs at intake and a more detailed, psychosocial assessment is conducted during the first appointment with the withdrawal nurse **Intervention:** *Very brief interventions* • Involves education/discussion regarding psychoactive drugs, withdrawal, dual diagnosis issues, and suicidality • The stages of change model is explained to the client and the client is asked to identify where they fit within the model • ADF withdrawal materials/pamphlets provided • Focus on rapport building • Withdrawal options outlined and most suitable option organised. *Extended brief interventions* • Extended BIs involve providing education as above, as well as working on model of change with pre-contemplative/contemplative clients. • Client is supported to make the decision to undergo withdrawal • Client is asked to participate in decisional balance exercises and is given homework to take away. • Typically takes the client 2-3 sessions to make a decision to commence withdrawal treatment **Referral:** • Referred to home-based withdrawal, rural hospital withdrawal or AOD-specialised withdrawal unit
Features of model	• Timeliness of intervention • Assessment • Client engagement • Work according to stages of change model • Linkages

CASE EXAMPLE # 9

Service setting	• Specialist AOD counselling service within rural CHS
Client group	• Adults
Type of BI provided	• Very brief interventions • Extended brief interventions
Client pathway to BI	• Client sees intake worker who clarifies and prioritises issues and refers client, as appropriate. • BI can occur at intake or during treatment
Who provides BI?	• BIs also provided via the breadth of community health services available, including: AODTS programs, home-based withdrawal, detox, infectious diseases nurse, NSP, CCCC, pharmacotherapy clinic, ABI worker, relapse prevention groups, ABI worker, family support group, allied health services, GPs, counselling and family support services, psychologists and nurses
Type of BI	**Assessment:** • AOD assessment conducted at intake for all new clients • Ongoing verbal assessments occur during treatment **Intervention:** *Very brief interventions* • BIs provided at intake provide relevant information and education to clients (often in crisis and with immediate needs) *Extended brief interventions* • During treatment, ongoing verbal assessments assist in identifying issues which require internal or external referrals for the client, e.g. safety issues, homelessness, safe injecting, education, relapse prevention group. • Motivational Interviewing, Cycle of Change, Choice Theory, and CBT are delivered during treatment. **Referral:** • Clients referred to external agencies including ED, housing agencies, NSPs, and/or mental health services
Features of model	• Assessment • Linkages

10.1.4 YOUTH SERVICE

CASE EXAMPLE # 10

Service setting	• Youth health service co-located within multiple service environment
Client group	• Youth at risk of or experiencing homelessness
Type of BI provided	• Very brief interventions • Extended brief interventions
Client pathway to BI	• Clients drop in for service via external, internal or informal/peer referral • Clients attend reception and directed to see health service staff • Assessment, includes AOD BI conducted with all new clients
Who provides BI?	• GPs, clinical nurses, nurse practitioner, social worker, and paediatrician • All staff are experienced in providing BIs as part of a general health assessment
What does the BI entail?	**Assessment:** • All new clients undergo an assessment where their AOD use is explored (i.e. substance type/s, frequency and level of use) **Intervention:** • Verbal information and advice is provided, particularly on harm minimisation and how to reduce AOD use • Information and advice re alcohol use and safety, especially re young women • BIs delivered in context of a range of possible needs relating to mental health, sexual health, housing etc. • Written material is rarely provided due low literacy skills and confidentiality issues **Referral:** • Referrals to other services/workers co-located within the agency • Ongoing support is available for repeat clients
Features of model	• Assessment • Client engagement • Linkages

10.1.5 PHARMACY

CASE EXAMPLE # 11[8]

Service setting	• Pharmacy
Client group	• Young people and adults in crisis
Type of BI provided	• Very brief interventions
Client pathway to BI	• Clients present to pharmacy to collect pharmacotherapy, other forms of medication, clean syringes, and/or general health advice • Clients may also discuss issues with dispensary assistant who refers the client to the pharmacist to identify and address key issues • BIs are often delivered in crisis situations
Who provides BI?	• Pharmacist
What does the BI entail?	**Assessment:** • Informal assessment; issues are identified via discussion with clients **Intervention:** *Very brief interventions* • Discuss safety and risk issues, for example, safe drinking practices and the risks of binge drinking • BI involves verbal information and advice about prevention, help, and referral • In some cases, written material is provided including relevant service information and/or pharmacy self-care fact cards regarding safe-injecting practices. **Referral:** • Referral to GPs, AOD counsellors, and DirectLine; • Good partnerships with GPs and other health workers enable better referrals
Features of model	• Timeliness of intervention • Client engagement • Written information • Linkages • Quality staff

[8] This case example has not been validated

10.2 SPECIALIST SERVICES

10.2.1 SPECIALIST AOD SERVICES

CASE EXAMPLE # 12

Service setting	• Specialist AOD service
Client group	• Adults, young people and families
Type of BI provided	• Very brief interventions • Extended brief interventions (max 5 sessions)
Client pathway to BI	• Clients present to service via formal referral (e.g. COATS, child protection, community health), informal referral via friends and family, referral from DirectLine, and/or self-referral. • Clients schedule an appointment, attend reception and are then seen by the duty worker for screening and identification of key issues • The client is assigned a counsellor and given a new appointment • In the first session with the counsellor, the client is assessed, provided with information and a AOD BI may be delivered
Who provides BI?	• All AOD staff including: psychologists, social welfare workers, Certificate IV graduates, workers with graduate and post-graduate counselling qualifications, primary care staff and addiction medicine specialists
What does the BI entail?	**Assessment:** • An assessment is conducted by the counsellor for all new clients **Intervention:** *Very brief interventions* • Oral and written information is provided • Some pictorial material is provided due to low literacy skills, ABI and intellectual disability issues among some clients. • Information and advice re safety and risk issues (especially re alcohol), needles, injecting risks, liver function, medication contra-indications, overdose, and suicide • Useful for single sessions *Extended Brief Interventions* • Same elements as very brief interventions but over 3-5 or more sessions **Referral:** • Clients referred to external agencies if further support required
Features of model	• Assessment • Client engagement • Goal-oriented intervention • Work according to stages of change model

CASE EXAMPLE # 13

Service setting	• Specialist AOD service connected to local metropolitan hospitals
Client group	• Adults and young people
Type of BI provided	• Very brief interventions

Pathway to BI	• Clients mostly enter hospital via ED and are triaged, although some admitted directly to wards for planned surgery
	• Some clients leave prior to treatment but are followed up by care co-ordinator via phone the following day and BI may be offered
	• ED clients screened for AOD issues by doctors and nurses during medical assessment and at triage (initial assessment is completed by the nurse)
	• Where doctors or nurses identify AOD issues, they:
	  ○ Contact the care coordinator (verbal, or via pager) who contacts head office of AOD service, which contacts the clinical nurse consultant (CNC), or
	  ○ Directly contact CNC via head office
	• The CNC attends hospital location to deliver BI to client or provides secondary consultation to doctor, nurse or other treating team staff (e.g. social worker)

Who provides BI?	• Care co-ordinators (only based in ED), social workers (more common in the wards), CNC, Addiction Medicine Physician and Registrar, hospital nurses and doctors
Type of BI	**Assessment:** • An AOD assessment is conducted during general medical assessments and at triage **Intervention:** *Very brief interventions* • BI is provided as part of an hour-long interview which includes assessment, the provision of information and advice, referral and recommendations for discharge plan • Personalised verbal information and advice is given re harm minimisation, AOD-related harms, medical risks, and overdose • Written information is also provided via leaflets/brochures with service and DirectLine information • Some motivational interviewing provided • Staff may also liaise with the client's community GP and existing community supports. For example, community AOD services may be contacted, in the presence of the client, to obtain appointments prior to discharge from hospital • CNC can recommend prescribed anti-craving medications via Addiction Medicine Specialist or treating medical team **Referral:** • At least 1 referral is provided
Features of model	• Assessment • Client engagement • Linkages

10.2.2 SPECIALIST MENTAL HEALTH SERVICE

CASE EXAMPLE # 14

Service setting	• Public Mental Health (MH) Services
Client group	• Adults with severe mental health issues
Type of BI provided	• Very brief interventions • Extended brief interventions
Pathway to BI	• Clients present to service via external (GP, ED, police) referral, self referral, or informal/peer referral • Client is triaged and an assessment conducted. The client could receive a very brief intervention at this point by the triage worker. • If client is recognised as needing treatment, the client's case will be managed for a short time by the acute support team, with support from the dual diagnosis specialist. If continued care is required, they are then referred to a case manager, with support from the dual diagnosis specialist, or are placed under the direct care of dual diagnosis specialists, where a full psychiatric assessment and substance use assessment occurs. Extended BIs usually occur at this point.
Who provides BI?	• Triage workers, case managers, dual diagnosis specialists, psych nurses, social workers, occupational therapists
Type of BI	**Assessment:** • A general assessment is conducted at triage • A full psychiatric assessment and substance use assessment occurs when the client is seen by a dual diagnosis specialist **Intervention:** *Very brief interventions* • 5-20 minutes • Provision of oral and written information and advice, including pamphlets on general drug information (e.g. the effects of alcohol, speed, ecstasy) and handbooks on dual diagnosis. • May involve some motivational interviewing *Extended brief interventions* • Usually provided by the dual diagnosis specialist • Maximum of 5 sessions over a 3 month period (up to 20-30 minutes each) • Sessions are conducted when the client is stable enough to understand the information provided • Discuss harm prevention, risk taking, • Provide motivational interviewing • Client may engage in repeated cycles of extended BIs, for example, the first five sessions may involve information and advice around harm minimisation. Four to five months later, the client may receive 5 sessions of extended BIs around cannabis and amphetamine use, etc. - the BI is tailored around the clients presenting needs

	Referral: • Provide referrals to other relevant services
Features of model	• Timeliness of intervention • Assessment • Client engagement • Goal-oriented intervention • Work according to stages of change model • Quality staff

10.2.3 SPECIALIST DUAL DIAGNOSIS SERVICE

CASE EXAMPLE # 15

Service setting	• Specialist dual diagnosis service
Client group	• Adults with AOD and/or mental health issues
Type of BI provided	• Very brief interventions • Extended brief interventions
Client pathway to BI	• Client presents to agency and the triage clinician identifies substance use and mental health issues • Appropriate referral within the agency is made • Treating clinician conducts AOD assessment and BI • It is useful to use BIs in the initial sessions, especially if the clinician thinks the client will not present for further assessment. However, it is not always appropriate to deliver BI in first session so it may be offered in subsequent consultations.
Who provides BI?	• The first line clinician (i.e. AOD counsellors and psychologists)
What does the BI entail?	**Assessment:** • An AOD assessment is conducted for all new clients; client is given verbal and written feedback about their assessment score **Intervention:** *Very brief interventions* • Delivered in AOD and MH settings • 5 to 10 minutes • Clients are provided with information regarding the risks of AOD use, the impact of substance use on mental health, harm minimisation and general health information. • Fact sheets around drugs and mental health are provided. • BIs vary according to assessment score. For moderate and high risk clients, BIs are more intensive than those for low risk clients. *Extended Brief Interventions* • Extended brief interventions differ across the MH and AOD sector. • In the AOD sector, extended BIs involve multiple sessions (approx 30 mins) of structured information. The information provided is often around different subject areas, for example, harm reduction, risks related to alcohol, amphetamines, injecting etc • In the Mental Health sector, extended BIs have a therapeutic element and involve collaborative therapy for people with both AOD and MH issues. Examples include a 10-week program which draws on the principles of CBT. May also involve developing a collaborative care journal, scheduling appointments, mood and medication monitoring etc. **Referral:** • Appropriate referrals within the agency occur
Features of model	• Assessment • Client engagement • Linkages

11 APPENDIX 4 - AMPHETAMINE RESOURCES

The tables presented below list a range of amphetamine resources available to clinicians, free of charge. Resources such as these may be provided to clients during a BI, and are tailored to a variety of audiences, including amphetamine users, their family and friends, Indigenous Australians, and young people[9].

Table 3: Amphetamine resources for a general audience

Title	Publisher	Format	Availability
How drugs affect you: Amphetamines	Australian Drug Foundation, February 2006	Pamphlet	Single free copy: DrugInfo Clearinghouse (Victoria only) Multiple copies available for purchase: ADF Bookshop
How drugs affect you: Ice (crystal methamphetamine)	Australian Drug Foundation, February 2007	Pamphlet	Single free copy: DrugInfo Clearinghouse (Victoria only) Multiple copies available for purchase: ADF Bookshop
"Ice" (crystal methamphetamine hydrochloride)	DrugInfo Clearinghouse, July 2003, revised April 2006	Fact sheet	Online: DrugInfo Clearinghouse

Table 4: Amphetamine resources for family and friends

Title	Publisher	Format	Availability
Dealing with party drug use: A guide for parents	Australian Drug Foundation, February 2004	Booklet	Single free copy: DrugInfo Clearinghouse (Victoria only) Multiple copies available for purchase: ADF Bookshop
What parents should know about ICE (Crystal methamphetmine)	Victorian Department of Human Services, October 2007	Pamphlet	Online: Victorian Government Department of Human Services Limited free quantities (up to 25 copies): DrugInfo Clearinghouse (Victoria only)

[9] The resources listed here were sourced from The DrugInfo Clearinghouse website: (http://www.druginfo.adf.org.au/article.asp?ContentID=Amphetamine-relatedresources)

Table 5: Amphetamine resources for Indigenous Australians

Title	Publisher	Format	Availability
Speed: At what cost?	Victorian Aboriginal Community Controlled Health Organisation	Pamphlet	Online: Koori DrugInfo Bulk orders: Victorian Aboriginal Community Controlled Health Organisation
Speed: At what cost?	Victorian Aboriginal Community Controlled Health Organisation	Poster	Limited free quantities (up to two copies): DrugInfo Clearinghouse (Victoria only) Bulk orders: Victorian Aboriginal Community Controlled Health Organisation

Table 6: Amphetamine resources for self-help

Title	Publisher	Format	Availability
A users' guide to speed	National Drug and Alcohol Research Centre, 2001	Booklet	Single free copy: DrugInfo Clearinghouse (Victoria only) Multiple copies available for purchase: ADF Bookshop
Crystal: Info for the gay, lesbian, bisexual and transgender community	ACON, December 2005	Booklet	Online: ACON Limited free quantities (up to 10 copies): DrugInfo Clearinghouse (Victoria only) Bulk orders: ACON
On thin ice	National Drug and Alcohol Research Centre, 2006	Booklet	Online: National Drug and Alcohol Research Centre Limited free quantities (up to five copies): DrugInfo Clearinghouse (Victoria only)

Table 7: Amphetamine resources for young people

Title	Publisher	Format	Availability
Speed. You don't know who made it. Or what's in it.	Australian Government Department of Health and Ageing, 2005	A3 poster	Online: Australian Government Department of Health and Ageing Limited free quantities (up to two copies): DrugInfo Clearinghouse (Victoria only) Bulk orders: Australian Government Department of Health and Ageing