Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence

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ABSTRACT

Background This review aimed to synthesize qualitative evidence for barriers and facilitators to effective implementation of screening and brief intervention for alcohol misuse in adults and children over 10 years.

Methods A search of medical and social science databases was carried out and augmented by hand-searching of reference lists and contents of key journals. Qualitative evidence was synthesized thematically.

Results A total of 47 papers varying in design and quality were included in the review. Most evaluated implementation in primary care settings. Implementation was reported to be limited by lack of resources, training and support from management, as well as workload. The appropriateness of context in which discussions take place was reported as an acceptability factor for patients and practitioners. Health professionals require sufficient knowledge about alcohol guidelines and risk in order to implement screening and intervention to those most in need.

Conclusions Whilst brief screening and brief intervention have been shown to be effective in some settings, this review has identified a number of barriers and facilitators to implementation. Adequate resources, training and the identification of those at risk without stereotyping are the main facilitators in primary care. More research is needed to assess implementation in other settings.

Keywords alcohol consumption, health services, public health

Introduction

Alcohol misuse (at a level below diagnostic criteria for alcohol abuse or dependence) is associated with significant health and social harms. In order to reduce levels of alcohol consumption and negative impacts of drinking, brief interventions are being delivered with individuals that have been identified as positive for alcohol misuse as defined by screening tools such as the Alcohol Use Disorders Identification Test (AUDIT), which was developed originally by the WHO for use in primary health care settings. Use of the AUDIT screening tool has now extended to include other settings. A range of brief interventions are available, which typically use a client-centred approach and are based on theories of behaviour change. The defining characteristics of screening and brief intervention are that a non-specialist (for example a general practitioner or nurse) is able to explore a potential problem and negotiate healthy lifestyle options with the patient in order to motivate behaviour change.

This paper reports on synthesis of evidence relating to barriers and facilitators to implementation of screening and brief intervention. A range of study methods was considered including reviews, randomized controlled trials (RCTs), surveys and qualitative studies.

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Methods

Search strategy

Searching for relevant literature was carried out in 2008 by an information specialist using an emergent rather than exhaustive search strategy. This method was developed in order to achieve maximum specificity in the context of complex review questions such as those addressing public health topics. The method entailed close working between the information specialist and reviewer, with the reviewer identifying relevant terms which were further explored by the information specialist.

The following electronic databases were searched. The databases were selected in order to cover both medical, health and social science topics: Medline via OVID; CINAHL via OVID; PsycInfo via OVID; ASSIA via CSA and the Social Science Citation Index and Science Citation Index via Web of Knowledge. Searches were not limited by date or language at the search stage. Papers were considered up to May 2009, with publication of included papers dating between 1997 and 2008.

From sourced articles, further searches were carried out using key phrases, words and authors. In particular, work that might provide qualitative information on implementation was targeted in three search iterations, which used the following keywords in varied combinations: Practitioner, professional, doctor, patient, intervention, brief intervention, minimal intervention, training, alcohol, drinking (not water), drinking behaviour*, screening, accept*, cop*, manage, treat, qualitative, interview. Details of the full search strategy are available upon request.

Inclusion/exclusion criteria

Papers that were included in the review addressed screening and/or brief intervention with alcohol users over the age of 10 years. The review protocol excluded papers that focussed on educational interventions and school-based interventions due to their inclusion in recent UK guidance. Reports of interventions of >30 min in duration, or that were carried out by specialists were excluded. Inclusion of evidence was not restricted by study type, though there was a focus on study designs that elicited the views of professionals and users, or that included relevant process evaluation information. Whilst there was no language restriction, all retrieved papers were published in the English language.

Identification of retrieved papers

In order to identify the barriers and facilitators to the effective implementation of an intervention, data were derived from exploratory studies as well as from RCTs that included a discussion of implementation issues. Evidence was drawn from a range of study types including qualitative research that used interviews and focus groups to obtain the views of patients and professionals on screening and brief intervention for alcohol misuse. Other useful data were retrieved from surveys that aimed to explore intervention feasibility and patient satisfaction as well as implications of carrying out the intervention.

Quantity of available evidence

Searches undertaken to address the review questions relating to barriers and facilitators to implementation of brief intervention yielded a total of 323 abstracts for screening; 201 abstracts were rejected upon examination. As the overall quantity of evidence generated relating to barriers and facilitators was large, priority was given to studies that were most relevant to the research question in order to best inform current UK practice. Of 122 full papers retrieved, 75 were excluded after close scrutiny. Two systematic reviews, 6 RCTs, 25 cross-sectional studies and 14 qualitative studies (47 papers in total) were included in the review of barriers and facilitators to implementation.

Settings

A total of 22 included studies originated in the UK. Thirty-five of the papers were set in primary care, indicating a scarcity of research activity in other settings that have the potential to be effective in promoting healthy behaviours in relation to alcohol. These include emergency care, secondary care and probation centres. Details of included studies are set out in Table 1.

Data extraction and analysis

Relevant data were extracted from all 47 included papers, which were also assessed for quality and double checked (M.J.; R.J.). Narrative summaries were grouped by setting as well as study type to aid explanatory accounts. Thematic analysis was carried out with the qualitative data extracted from each included paper.

Results

Quality

Twenty of the studies were judged to be of very good quality and 24 were of good quality. Three papers were judged to be of poorer quality in terms of relevance and reporting of methods. Quality assessment in this context is therefore not a fixed judgement, as the same papers could be judged differently for other reviews. ‘Poor quality’ papers were included for their contribution where better quality
Table 1 Included studies in the review of barriers and facilitators to the implementation of screening and brief intervention

<table>
<thead>
<tr>
<th>Study and country</th>
<th>Setting</th>
<th>Study population</th>
<th>Barriers/facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aalto et al.42 (Finland), Survey</td>
<td>Primary Care</td>
<td>41 GP practices; 1011 patients screened as early phase heavy drinkers.</td>
<td>Low training rates and knowledge of screening tools/brief intervention.</td>
</tr>
<tr>
<td>Aalto et al.43 (Finland), Survey</td>
<td>Primary Care</td>
<td>Nurses and physicians</td>
<td>Lack of training in both nurses and GPs; nurses required more training than did GPs.</td>
</tr>
<tr>
<td>Aalto et al.5 (Finland), Survey</td>
<td>Primary Care</td>
<td>1000 patients (consecutive)</td>
<td>Patients are positive about being asked about drinking. Drinking is discussed less often than users expect.</td>
</tr>
<tr>
<td>Aalto et al.29 (Finland), Focus groups</td>
<td>Primary Care</td>
<td>GPs n = 18; Nurses n = 19</td>
<td>Lack of guidance for nurses in carrying out brief intervention.</td>
</tr>
<tr>
<td>Aalto et al.31 (Finland), Survey</td>
<td>Primary Care</td>
<td>Patients: n = 1203</td>
<td>Time spent discussing drinking with users is short; typically less than 4 min.</td>
</tr>
<tr>
<td>Aalto et al.44 (Finland), Survey</td>
<td>Primary care: All (3193) physicians in Finland</td>
<td></td>
<td>GP own relationship with alcohol could be a barrier to discussion with users.</td>
</tr>
<tr>
<td>Adams et al.17 (New Zealand), Survey</td>
<td>Primary care</td>
<td>161 GPs</td>
<td>Access to financial support and training are important incentives for GPs.</td>
</tr>
<tr>
<td>Adams et al.21 (USA), RCT</td>
<td>Primary care</td>
<td>4 sites; 21 physicians; 7 nurses; 1 resident; 344 patients</td>
<td>The extent of brief intervention implementation is increased through training. However the appropriateness of implementation may not be increased.</td>
</tr>
<tr>
<td>Aira et al.20 (Finland), Semi-structured interviews</td>
<td>Primary Care</td>
<td>4 centres; n = 35</td>
<td>Low training rates and knowledge of screening tools/brief intervention. GPs lacked time to carry out drinking assessments. GPs reluctant to discuss drinking unless signs of risk are apparent.</td>
</tr>
<tr>
<td>Anderson et al.5 (UK), Survey</td>
<td>Emergency Care</td>
<td>84 units; 2 individuals (one medical, one nursing), from each</td>
<td>Under-activity of practitioners in managing hazardous drinking. Practitioner views that ED setting unsuitable for screening and intervention.</td>
</tr>
<tr>
<td>Anderson et al.25 (Cross-national), Survey</td>
<td>Primary Care</td>
<td>340 GPs</td>
<td>Role insecurity among GPs remained following training implementation.</td>
</tr>
<tr>
<td>Babor et al.16 (USA), Cluster RCT</td>
<td>Primary Care</td>
<td>Practices from 5 Managed Care Organizations</td>
<td>Implementation facilitated by prior experience and management stability.</td>
</tr>
<tr>
<td>Beich et al.18 (Denmark), Focus Groups and interviews</td>
<td>Primary Care</td>
<td>Patients &gt; 18 years n = 24</td>
<td>GPs report lack of training in counselling skills. Additional workload can lead to stress in practitioners. Practitioners concern that users may be offended by discussing drinking. GPs reluctant to carry out BI with younger people. Primary care physicians have limited time to carry out recommendations for preventing alcohol misuse. Qualification in addiction medicine is associated with better detection of problem drinkers. Advice is most likely to be given to certain groups, e.g. males.</td>
</tr>
<tr>
<td>Beich et al.45 (Denmark), Systematic review</td>
<td>Multi-national primary care</td>
<td>Patients screened for drinking behaviour</td>
<td></td>
</tr>
<tr>
<td>Berner et al.24 (Germany), Survey</td>
<td>Primary Care</td>
<td>58 practices</td>
<td></td>
</tr>
<tr>
<td>Best et al.46 (UK), Interviews</td>
<td>Probationary setting</td>
<td>14 Forensic Medical Examiners</td>
<td>Forensic Medical Examiners (FMEs) report lack of training in assessment of drinking behaviour and lack of time to carry out assessments. FME views that the probationary setting is unsuitable for screening and intervention.</td>
</tr>
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Continued
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| Brooker et al.47 (UK), Interviews + | Emergency Care | 17 Nurses | Implementation of brief intervention not as consistent in ED as in primary care  
Nurses’ views in ED are not consistent in terms of delivering holistic or specialist care |
| Deehan et al.26,27 (UK), Survey ++ | Primary Care | 5560 GPs | GPs report lack of training in counselling skills |
| De Guzman et al.37 (USA), Qualitative: Interviews + Desy and Perhats7 (USA), Process Evaluation + | Setting not specified All 25 receiving Medicaid. | 25 mothers with HIV, AIDS or at risk of HIV infection.  
2 nurses from each site  
3265 patients screened | A good relationship between user and practitioner facilitates discussion of drinking behaviour  
Emergency Department professionals report lack of support financially and managerially |
| Goldberg et al.46 (USA), RCT + | Academic, general medicine clinic | 1328 patients | Use of specialists does not necessarily facilitate attendance by users |
| Graham et al.49 (USA), Survey − | Emergency Care | 569 members of Michigan College of Emergency Physicians | Lack of time is a reported barrier to implementation in Emergency Departments |
| Heather9 (UK), Delphi survey ++ | Primary Care | 79 Experts (health professionals, alcohol workers, researchers and academics) | Consensus of experts was that practitioner training would facilitate awareness raising regarding detection of drinking problems  
Implementation is facilitated by an appropriate context for discussion, e.g. clinics and new registration sessions, and by utilizing specialists for brief intervention |
| Heim et al.35 (UK), Survey + | Community | Community; Pakistani, Indian and Chinese young people in Greater Glasgow | In Indian communities there is a reported lack of understanding of potential drinking problems. In Pakistani communities fear of reprisal can mean that drinking is hidden |
| Huntley et al.30 (UK), Survey ++ | Emergency Care | ED patients | In emergency departments, clinical inertia was identified as a potential barrier to implementation |
| Hutchings et al.19 (UK), Focus Groups ++ | Primary Care | 4 Primary Care teams  
2 GP and 2 nurse groups  
6 patient groups | Some nurses report training as an incentive to carrying out alcohol work  
Nurses reported ‘overload’ of preventive work  
Implementation is facilitated by an appropriate context for discussion, e.g. clinics and new registration sessions  
Users are generally positive toward screening  
Discussion of drinking behaviour is facilitated by a good relationship between user and practitioner |
| Johansson et al.8 (Sweden), Focus Groups − | Primary Care | 26 nurses | Nurses reported time constraints a barrier to carrying out alcohol work  
Implementation is facilitated by an appropriate context for discussion, e.g. during arranged appointments  
Advice on drinking is provided less frequently than other health promotion advice  
Advice is most likely to be given to certain groups, e.g. males |
| Johansson et al.8 (Sweden), Survey + | Primary care | 39 centres; 4862 patients | The extent of brief intervention implementation is increased through training  
However the appropriateness of implementation may not be increased |
<p>| Kaner et al.4,22 (UK), RCT + | Primary care | 128 GPs | |</p>
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| Kaner et al.³²,³³ (UK), Survey ++ | Primary Care | 430 GPs | Under-activity of practitioners in managing hazardous drinking  
GPs report limited time to carry out discussions on drinking |
| Same study as Lock¹⁵ | Primary care | 84 GP practices | Brief intervention is more likely to be carried out with certain populations, e.g. those that are unemployed |
| Kaner et al.²³ (UK), RCT ++ | Primary Care | 212 patients | Nurses receiving training were more likely to carry out interventions, but not necessarily appropriate management  
Anxiety regarding giving misdirected advice was a reported barrier among nurses  
Enlisting the help of receptionists increased the rate of screening |
| Kaner et al.²⁰ (UK), Interviews + | Primary Care | 29 GPs | GP own relationship with alcohol could be a barrier to discussion with users  
Inconclusive evidence that SES impacts upon uptake of BI |
| Littlejohn³⁴ (UK), Systematic review + | | 18 studies. | |
| Lock et al.¹⁴ (UK), RCT ++ | Primary Care | 84 receptionists | Receptionists’ attitudes toward screening programmes are less positive than those of practitioners  
Lack of routine despite strong evidence for effectiveness  
Routine clinics are viewed as a less threatening environment for discussions of drinking  
Nurses are perceived as having more time to carry out alcohol work |
| Lock¹⁵ (UK), Focus Groups ++ | 8 practices | 31 patients | Patient’s attitudes to and experiences of alcohol and BI in primary health care  
Negative reactions from users  
Discussion of drinking behaviour is facilitated by a good relationship between user and practitioner |
| Lock¹⁵ (UK), Survey ++ | Primary care | 128 practice nurses | Advice is most likely to be given to certain groups, e.g. males  
Routine clinics are viewed as a less threatening environment for discussions of drinking  
Nurse views that alcohol is an emotive topic to discuss |
| Same study as Kaner et al.³² | | 177 patients drinking above cut-off | |
| McManus et al.¹⁴ (UK), Before/after study | General Hospital | 15,498 patients (Routine Data) | Advice is most likely to be given to certain groups, e.g. those from Hispanic and Black populations  
GPs difficulty in identifying with heavy drinkers |
| Miller et al.¹⁸,¹⁹ (USA), Survey (part of RCT) + | Primary Care | 162 patients | Users are generally positive toward screening  
Time constraints in addressing drinking with each patient |
| Mukamal³³ (USA), Survey + | Primary care | 15,498 patients (Routine Data) | |
| Rapley et al.¹³ (UK), Interviews ++ | Primary care | 29 GPs | |
| Rush et al.¹⁹ (Canada), Qualitative; Focus Groups and Interviews ++ | Primary care | Focus groups: $n = 12$  
Interviews: $n = 12$ | |
| Schermer et al.³² (USA), Survey + | Emergency Care | 3 sites | Surgeons viewed the ED setting as appropriate for screening and brief intervention  
Patients viewed the ED setting as appropriate for screening and brief intervention |
| Schermer et al.³² (USA), Survey + | Trauma Centres | 315 surgeon responses | |

[Table 1 Continued]
evidence was not available, for example in specific settings or with particular populations.

**Settings**
A majority of the studies reviewed were carried out in primary care, where implementation of research and practice is more advanced. There was evidence that many service providers in primary care as well as emergency care settings are not currently engaging in the provision of screening and brief intervention, despite its well-evidenced effectiveness.4–7

Other potential settings that might implement interventions for alcohol misuse include secondary care, probation centres and colleges, but more research is needed to establish feasibility and acceptability of establishing the intervention given the differences between service user populations and work practices.

Identified barriers and facilitators to intervention implementation were present at organizational, provider and patient level. These are presented as separate themes in the following section with the understanding that levels overlap in the sense that they each have an impact on the other.

**Organizational factors**

**Context of delivery**

There was evidence that the context of intervention delivery could facilitate implementation of screening and/or brief intervention, as acceptability for patients is a major factor in take up. Patients and professionals were reported to indicate that carrying out screening and brief intervention in well-being clinics or registration sessions provided an appropriate environment in which lifestyle issues are commonly addressed, and nurses could be more involved.8–14 Patients tended to report caution about the visibility of their consultations, preferring to see a general practitioner or practice nurse rather than a specialist.15 Practice nurses were regarded as having more time for discussion, whilst general practitioners (i.e. family doctors) were considered to be more knowledgeable.15

**Support**

Barriers to engagement in screening and brief intervention were found to be associated with several organizational factors. The most important factors were lack of financial incentives or managerial support,7,16,17 as well as management of staff workloads that might limit the extent to which practitioners are able or willing to take on additional responsibilities.8,10,18–20 Consistent evidence suggested that providing access to staff training facilitated the implementation rate of brief intervention,4,16,17,21–27 particularly when courses cover skills relevant to the appropriate detection and management of individuals at risk of heavy drinking.24

Some studies have explored the impact of administrative support in facilitating screening in general practice. Delegating work such as handing out questionnaires can save time,26 though receptionists were not found to have as positive an attitude toward involvement in this type of work without adequate re-imbursement28 or toward changing their role,8 as were clinicians.

**Staff factors**

**Attitude to health promotion activity**

Despite organizational barriers to implementation, providers generally report positive attitudes toward the inclusion of health promotion programmes into primary care, with nurses often involved in implementing screening and brief intervention, albeit with reservations about their knowledge in this area. As Lock et al.28 suggest, implementation may be facilitated by involving all relevant staff in discussions from the planning stage onwards. However, a barrier to implementation was found in that a minority of health care professionals did not see the delivery of brief interventions as a part of their role. Some professionals, particularly in emergency departments referred patients to specialists.

There was evidence of barriers in terms of perceived lack of knowledge and confidence in imparting advice. Practitioners were often confused by, or unaware of current guidelines, particularly in view of the multiple definitions relating to alcohol measures and strengths.29 Nurses were anxious not to misdirect advice,23 with some practitioners finding drinking a difficult topic to raise,12,14 in case of upsetting patients. Whilst service user aggression was rare, providers might remember such incidents and attempt to avoid a re-occurrence.12,18 In emergency departments, clinical inertia was identified as a potential barrier to implementation,30 despite positive attitudes of surveyed junior doctors. Inertia may be due to perceived lack of time or lack of faith in formal screening tools compared with professionals’ own judgement.

**Health promotion activity**

Advice on drinking behaviour was provided less frequently than for other lifestyle behaviours, such as exercise, diet and smoking, and less often than patients expected.

Discussion about drinking typically lasted <4 min31 and detection rates for ‘at-risk’ drinkers were as low as one in three,24 possibly due to a reluctance to ask patients about their drinking unless there are clear signs of risky drinking behaviour. Detecting ‘at-risk’ individuals13 accurately
requires a specific knowledge base that takes into account actual levels and patterns of consumption for different groups within society without stereotyping particular groups.

Training
Training was found to be more acceptable to nurses when delivered by a nurse.\(^{14}\) Being receptive to the aims of training as well as being committed to alcohol interventions was found to facilitate success.\(^{25}\) However, there is some evidence that even after training, some professionals do not carry out interventions appropriately\(^{22}\) and some remain unmotivated.\(^{7}\) This may be due to other factors, for example organizational barriers.

Patient factors
Patient characteristics
A barrier to equitable access to interventions by patients was found in the association of particular individual characteristics with either a lower or higher likelihood of being approached by practitioners to discuss drinking behaviour. In particular, those most likely to be approached were males,\(^{6,8,11,24,26,27}\) those who were unemployed\(^{32}\) and, in the USA, people of Black or Hispanic ethnic origin.\(^ {33}\) There was no association found between socioeconomic status and implementation of brief intervention.\(^ {34}\) Beich et al.\(^ {18}\) found that general practitioners were reluctant to bring up the topic of drinking with young people as they felt that they would be likely to grow out of the habit of hazardous drinking.

A survey by Heim et al.\(^ {35}\) showed cultural differences in attitudes toward drinking and satisfaction with service provision. The Chinese population surveyed drank less and were satisfied with services, whilst the Indian community tended to under-report alcohol misuse and be dissatisfied with services. The reasons for dissatisfaction were not reported.

Timing of the intervention
Once alcohol misuse is detected, Williams et al.\(^ {36}\) conclude that patients need to be counselled as soon as possible to facilitate intervention success. If further appointments are required, early discussion is particularly important. Appointments made in the emergency department were reported to be attended by 35% of patients, with attendances dropping by over half for appointments made for 2 days ahead or more.

Tailoring interventions to patient needs
There was suggestion from experts\(^ {9}\) that brief intervention should be tailor-made to meet the needs of individual patients rather than standardized across all groups in order to facilitate implementation. There was also evidence from patient and professional views that a good rapport between patient and professional was helpful in discussing sensitive topics such as drinking behaviour.\(^ {10,37,13}\)

Patient participation
In terms of participation, the majority of patients expressed positive attitudes toward screening\(^ {10,38}\) and discussing drinking.\(^ {6}\) However, one barrier that some professionals had encountered was a negative reaction from some users in terms of embarrassment and unease, with some patients changing general practitioner.\(^ {12,18}\)

Discussion
Main findings of this study
Forty-seven studies with varied designs and mixed quality were identified as relevant for our exploration of barriers and facilitators to the implementation of screening and brief intervention for alcohol misuse.

Most of the studies reviewed were carried out in primary care, where implementation of research and practice is more advanced. Whilst some research has been carried out in emergency care settings, the evidence base is less well developed. There are major differences between primary care and emergency care settings in terms of service user characteristics and working practices. Patients seen in emergency care settings are more likely to have misused alcohol immediately prior to their visit, they are also often acutely ill or severely traumatized, possibly unconscious, thus making staff decisions about the appropriateness of screening and discussing alcohol at point of contact more problematic. Referral procedures are therefore more likely to be negotiated, which create a barrier in terms of time lapse.\(^ {36}\) However, where appropriate, brief intervention in emergency care provides for some a ‘teachable moment’.\(^ {36}\) Other potential settings such as secondary care, probation centres and colleges require more research to establish feasibility and acceptability of intervention implementation.

From available evidence, implementation of brief interventions was facilitated or limited by organizational, provider and service user factors. The evidence shows that patients prefer to discuss alcohol related issues with their GP or nurse rather than a specialist; this is in line with the aim of brief interventions. However, the extent to which this can be
implemented in practice may be restricted by existing workload as well as limited resources and support.

Whilst evidence was found of a positive attitude among staff toward the general aim of carrying out health promotion work, practitioners may not implement screening and brief intervention in a standardized way across groups. It is important to be aware of epidemiological evidence regarding those groups that drink most heavily, but there is a related risk of inadvertently creating health inequalities and missing individuals at need. For example, recent surveys show that both males and females in higher managerial employment drank far more frequently than those without employment.38

Patients appear to expect more discussion around alcohol consumption with practitioners, yet real or perceived lack of knowledge and fear of upsetting patients present barriers to such discussion. Wellbeing clinics and check-ups appear to be a more acceptable context for screening and brief intervention, due to the emphasis on health promotion, rather than consultations, where the patient presents with a particular, usually non-alcohol related, condition.

**What is already known on this topic**

There is consistent systematic review evidence that brief interventions are effective in primary care settings.39 Routine assessments with young people and adults are carried out as part of health promotion work developed by Primary Care Trusts and supported by the Department of Health.40 Brief interventions are also considered to be potentially effective in settings such as emergency care, secondary care and custody suites.41

**What this study adds**

Evidence from qualitative data has provided explanations for why screening and brief intervention may or may not be effective in different settings. Implementation requires adequate support in terms of training and resources. The context of the discussion is important for patient acceptability. Providers need to be aware of the signs of alcohol misuse and which individuals to approach without stereotyping ‘at-risk’ groups.

**Limitations of this study**

Evidence relating to young people under 15 was not identified since, despite the inclusion of these age groups in searches, the review protocol excluded papers that focussed on educational and school-based interventions. A separate review of these interventions was conducted to support guidance for schools (http://www.nice.org.uk/nicemedia/live/11666/36327/36327.pdf).

Time restraints limited the option of exploring qualitative data to build a theory. Purposive sampling was utilized for expediency and key recent and high-quality literature was deemed to be sufficient evidence. However, it is possible that a review of qualitative studies only (rather than surveys, RCTs and reviews) could have provided a less broad but deeper analysis of barriers and facilitators.

**Conclusion**

A review of qualitative evidence shows that screening and brief interventions for alcohol misuse can be effective. There has been more activity in terms of research and health promotion in this area in primary care than any other setting. Evidence shows that primary care, and especially wellbeing clinics and new patient registration sessions provide a potentially acceptable context for patients to discuss drinking behaviour. For screening and brief intervention to be implemented effectively, adequate financial and managerial support is required in terms of training opportunities and covering workload. Practitioners require sufficient confidence and knowledge to address drinking behaviour appropriately with at risk individuals, without stereotyping particular groups.

**Funding**

This review was funded by the National Institute for Health and Clinical Excellence (NICE) as part of their programme of public health guidance development. This paper represents the authors’ views and not the views of NICE.

**References**


