

Department of Health Promotion & Protection

**Environmental Scan Exploring Systemic
Barriers for Screening & Brief Intervention
for Primary Health Care Providers**

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Finding the solution is simple when you know how

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Executive Summary

Introduction

Screening and brief intervention are recognized as proven and effective secondary prevention strategies for substance use and problem gambling in primary health care settings. Given that primary health care providers are preferred by patients for discussing addiction issues, as well as the effectiveness and cost benefits of screening and brief intervention, it has been suggested that they be included as a key role of primary health care providers. The effectiveness of these interventions have been well documented in the literature; however, some have criticized that this has been done in ideal research conditions and does not account for the systemic barriers faced in the ‘real world’ primary health care environment.

The purpose of this report is to present a synthesis of the findings from an environmental scan conducted to explore the systemic barriers for screening and brief intervention for primary health care providers. The environmental scan consisted of a review and synthesis of the academic and grey literature as well as interviews to gather the perspective of key informants and discuss the systemic barriers for screening and brief intervention for substance use and problem gambling in the Nova Scotia primary health care environment.

Methodology

Environmental Scan

Telephone and face-to-face interviews were conducted with key informants including: 1 Director of Continuing Medical Education (also a fee-for-service family physician); 1 Past President of the Nova Scotia College of Family Physicians (also a fee-for-service family physician); 1 Family

Practice Nurse (FPN); 4 Addictions Services staff (Antigonish, Middleton, Lunenburg, Shared service area for DHA 4, 5 and 6); 1 Health Psychologist; 1 District Manager - Addiction Services; 1 Emergency Room Social Worker; and 1 Emergency Room Discharge Planning Nurse.

Literature Review

A literature review of the systemic barriers to screening and brief intervention was conducted. The review included studies and documents from the academic and grey (e.g., government reports, etc.) literature. The information collected was reviewed and synthesized.

Considerations

Although this exploration of the systemic barriers for screening and brief intervention among primary health care providers captured information from multiple stakeholders and sources, there are considerations that should be noted. The exploration was conducted to the extent that the resources would allow. As such, this report presents the findings from a literature review which was not intended to be an exhaustive review, but rather to inform areas of exploration for the interviews. The timeline and resources also only allowed for a limited number of one-on-one interviews with key informants. Given these considerations, readers should exercise caution in over generalizing the results and findings from this environmental scan. Despite this, input was obtained from multiple sources (i.e., there was triangulation of data sources and methods) which helps to ensure the credibility and trustworthiness of the findings. It is important to note that the findings from the key informant interviews complemented the findings of the literature review.

Findings

Perspectives on Addiction

Views of Addiction Overall

- ◆ There is often a judgment around people who have an addiction as primary health care providers may judge the likelihood of an addiction based on what they assume a person with an addiction would look like (profile).
- ◆ Addiction is commonly judged as a problem or flaw of the individual and there remains a perception (among providers and society overall) that substance abuse is a choice of the individual and a 'habit' that can be overcome with willpower. The societal stigma of addiction causes some hesitation among primary health care providers to address addiction.
- ◆ There is a lack of understanding among providers around the complexity of addiction and the associated health effects.

Views of Addiction Services

- ◆ A strength of Addiction Services is that it is community based and provides services 'out in the community'. The Satellite Offices are especially important and valued for people accessing services in rural and non-urban communities across Nova Scotia.
- ◆ Services such as detox and treatment are valued and Addiction Services staff are seen as highly knowledgeable. The various provincial strategies addressing addiction (e.g., Alcohol Strategy) are a positive step provincially.
- ◆ A lack of communication is a significant challenge associated with Addiction Services as providers rarely receive follow-up, outcome or progress information when patients are sent/referred to Addiction Services. Communication is lacking around changes to services or

service availability. There is an interest among providers to receive recommendations/guidance for next steps to ensure continuity of care and support.

- ◆ There is a lack of awareness regarding many of the services provided by Addiction Services. The Service is predominantly viewed among primary health care providers as providing detox services, and the role of Addiction Services across the spectrum from prevention to treatment is not well known among providers.
- ◆ Addiction Services should play a greater leadership role in being a resource for primary health care providers; supporting and providing guidance in addressing addiction; proactively sharing current research and best practice; and promoting available resources and tools.
- ◆ Although providers are thankful for the services offered, Addiction Services is often undervalued. Further, providers have encountered a lack of accessibility to Addiction Services programs and services, and an inability to quickly and easily contact the Service directly (e.g., a direct line for providers).
- ◆ Strengthening linkages with Mental Health Services to better address concurrent addiction and mental health issues is needed.

Systemic Barriers to Screening & Brief Intervention

☞ Lack of Time

- ◆ A lack of time due to high patient volume is a barrier to screening and brief intervention. There are also concerns as to the ‘briefness’ of brief intervention and a belief that addressing addiction requires a longer process than a short intervention session with a patient.
- ◆ As opposed to physicians, nurses and other providers may be better suited to perform screening and brief intervention as they often have longer patient interactions; however, they may not have the same perceived level of authority and impact on the patient as a family physician.

- ◆ The literature suggests that overcoming the lack of time barrier may include providing supports to physicians through the use of nurse practitioners/family practice nurses. Nurses tend to have longer patient interactions and provide screening and brief interventions which are more cost effective. Patients also often feel more comfortable discussing issues of addiction with a nurse rather than with their family physician, who is often viewed more as an ‘authoritarian’.
- ◆ Research suggests that technology may be used to overcome the obstacle of lack of time by way of electronic surveys/questionnaires which could be completed by patients prior to their appointment.

☞ Lack of Remuneration

- ◆ A lack of remuneration is a major barrier to screening and brief intervention among family physicians. In the fee-for-service environment, there is little incentive to engage in screening and brief intervention addressing addiction as it is generally viewed as an area that takes significant time to address in the clinical setting. As such, screening and brief intervention are not routinely addressed unless it is part of the presenting health issue. It was suggested by some that a means to addressing this barrier is to re-examine the way in which family physicians are compensated. Other suggestions included implementing a billing code for a ‘health and wellness’ annual check-up that would allow sufficient time and appropriate compensation for performing screening and brief intervention addressing health risk factors in general. This would also allow physicians to see, screen and provide brief interventions for patients who are not regularly seen.
- ◆ Researchers have also suggested that financial re-imburement may encourage providers to include screening and brief intervention in their clinical practice. The literature also notes that physicians are more apt to ask questions related to addiction when it is seen as part of general lifestyle screening (where the substance is not the focus of the appointment) as well as when a patient exhibits negative health symptoms related to substance use.

☞ Lack of Priority

- ◆ Physicians often prioritize patients' acute presenting problem, therefore, screening and brief intervention is often not addressed. Addiction is uncommonly addressed unless the patient's presenting problem includes symptoms of addiction. As such, high risk behaviours associated with addiction may be overlooked unless related to the presenting problem.

☞ Lack of Training to Address Addiction

- ◆ A lack of knowledge around brief intervention and addressing addiction is a barrier. Screening tools often stop short in supporting providers beyond the screening stage and increasing training around the 'next steps' in brief intervention is critical to addressing this barrier (e.g., motivational interviewing, etc.).
- ◆ In order for training around addiction and brief intervention to be successful, it must be practical for the primary health care setting(s) and be delivered by those with whom primary health care providers can relate (e.g., other physicians), rather than specialists from Addiction Services. The area of addiction should also be a greater component of the medical school curriculum to enhance knowledge and skills for screening and brief intervention.
- ◆ Research suggests that primary health care providers feel there is a need for increased medical school and CME training around addictions. With the increased recognition regarding the benefits of screening and brief interventions in primary health care settings, several training resources are available to support primary health care providers.

☞ Lack of Availability & Use of Tools

- ◆ A lack of tools is a barrier to screening and brief intervention, especially outside of alcohol and smoking screening. Although tools and resources are likely available, these are not effectively promoted or communicated to providers (an area in which Addiction Services could take a leadership role).

- ◆ There is a disconnect between the availability and the use of tools. In order to facilitate the use, tools should: be short; produce results which are easily interpreted; include next steps for post-screening; be promoted (to the public and providers); be available in multiple formats; be gender and age specific; and be valid and developed through a consultative process.
- ◆ The literature provides several examples of tools which are effective and accurate for assessing the use and/or degree of dependence on various substances and gambling (e.g., CAGE, AUDIT, FAST, HIS, ASSIST, etc.).
- ◆ Screening tools make use of ‘pen and paper’ screening which is not part of standard clinical protocols or general practitioner culture. Physicians typically diagnose via empirical observation and verbal questioning around symptoms.

∞ Lack of Comfort in Addressing Addiction

- ◆ A common barrier to screening and brief intervention is a lack of comfort and confidence in addressing addiction. Comfort levels are often substance specific.
- ◆ There is a high level of comfort among providers in screening and brief intervention for smoking due to the cultural/societal shift around smoking as a health concern as well as the media promotion and public education around the negative health consequences of smoking.
- ◆ After smoking, alcohol is most likely to be addressed in screening and brief intervention. However, alcohol is more ‘socially acceptable’ given that it is legal and widely used among the general population, which can create some discomfort addressing a substance which has been “normalized” and not predominately viewed as a health concern.
- ◆ Screening and brief intervention is rarely conducted for prescription drugs as providers are often unsure what constitutes ‘normal’ use versus abuse of these drugs.
- ◆ According to the literature, primary health care providers are least likely to engage in screening and brief intervention with illicit drugs and gambling. Gambling is not often addressed because it is non-symptomatic. If a gambling or illicit drug problem is identified, providers are often unsure of the next steps involved in addressing these types of addictions.

☞ Lack of Patient Disclosure

- ◆ Providers often believe that they will not get honest answers from patients if they were to screen for addiction. The lack of patient disclosure is linked to fear of judgment and stigma should patients disclose their problems around substance use and gambling. The lack of patient disclosure is often substance specific, with smoking likely to receive greatest disclosure over other substances and gambling.

☞ Media & Government Interest around Substance Use and Gambling

- ◆ The media is viewed as a systemic barrier preventing screening and brief intervention (e.g., positive associations and ‘normalization’ of excessive alcohol consumption, etc.).
- ◆ Addressing addiction is also challenging given government interests and economic ‘benefits’ of substance use and gambling, such as taxes on cigarettes, alcohol, lottery tickets, etc.

☞ Lack of Interest or Role

- ◆ A barrier to screening and brief intervention is the lack of interest around addiction and a perception that this field is outside of the role of a primary health care provider. It is loosely viewed as a ‘specialized’ service. Although primary health care providers appreciate their role in the screening aspect of addressing addiction, there is some discomfort in the ‘intervention’ of brief intervention as this is generally viewed as being outside of their expertise and should be referred to an addiction specialist.

Conclusion

This report presented the results of an environmental scan including a literature review and key informant interviews. The report highlights numerous barriers to screening and brief intervention as well as recommendations to address these barriers. In the majority of cases, there are no simple solutions to address these barriers as they require a shift in the health care system. In some cases, the barriers are beyond the health care system and are issues at a cultural/societal level. However, the benefits and opportunities of screening and brief intervention in primary health care settings are well documented. Therefore, efforts to overcome these systemic barriers and promote screening and brief intervention have the potential to have a positive impact on addiction in Nova Scotia.

Introduction

Background

Substance abuse and problem gambling are linked to numerous physical, social and emotional health issues such as chronic diseases and mental health illnesses (e.g., cancer, cardiovascular disease, anxiety, depression, etc.), injury, violence, financial problems, family/relationship issues, etc.¹⁻³. Screening and brief intervention are increasingly being recognized as proven and effective secondary prevention strategies for substance use (e.g., alcohol, smoking, illicit drugs, etc.) and problem gambling in primary health care settings⁴⁻⁷. Fleming (2004/2005)⁸ describes screening and brief intervention (in the context of alcohol use) as “*screening [and] an interview process by which practitioners can identify at-risk drinkers...followed by [a] one time or repeat short counseling sessions...designed to help the patient reduce their drinking and minimize related problems*” (p.57).

☞ Screening & Brief Intervention in Primary Health Care

Given that primary health care professionals (e.g., family physicians, social workers, nurse practitioners, family practice nurses, etc.) are the preferred providers by patients for discussing substance issues⁹, as well as the effectiveness and cost benefits⁵ of screening and brief intervention, it has been suggested that they be included as a key role of primary health care providers^{9, 10}. As described by the Ministry of Health (New Zealand)¹¹ “*there is the opportunity in primary care settings to provide an integrated package of service provision and to intervene at an early stage in the harm continuum, with screening and assessment... This will require workforce development in primary care settings on screening and brief and early intervention*” (p.20).

It has been suggested that screening and brief intervention are effective in theory but less so in practice¹². The effectiveness of these interventions have been well documented in the literature; however, some have criticized that this has been done in ideal research conditions and does not account for the barriers faced in ‘real world’ practice¹². These systemic barriers have challenged the use of screening and brief intervention in primary health care settings and have prevented the effective engagement of primary health care providers working in ‘real world’ settings. The literature suggests that these barriers are both practical and attitudinal from the providers, the patients and the health care system itself^{12, 13}.

Purpose of the Report

The purpose of this report is to present a synthesis of the findings from an environmental scan conducted to explore the systemic barriers for screening and brief intervention for primary health care providers. The environmental scan consisted of a review and synthesis of the academic and grey literature, as well as interviews to gather the perspective of key informants (e.g., family physicians, emergency room physicians, family practice nurses, social workers, Addiction Services staff, etc.) and discuss the systemic barriers for screening and brief intervention for substance use and problem gambling in the Nova Scotia primary health care environment.

Methodology

The following section describes the methodology used to explore the systemic barriers of screening and brief intervention initiatives among primary health care providers. The methodology for the interviews is presented, as well as the literature review procedures.

Environmental Scan

Telephone and face-to-face interviews were conducted between July and September 2008 with 10 key informants from across the province. The following key informants were interviewed as part of the information gathering process:

- ◆ 1 Director of Continuing Medical Education (also a fee-for-service family physician)
- ◆ 1 Past President of the Nova Scotia College of Family Physicians (also a fee-for-service family physician)
- ◆ 1 Family Practice Nurse (FPN)
- ◆ 4 Addiction Services staff (Antigonish, Middleton, Lunenburg, Shared service area for DHA 4, 5 and 6)
- ◆ 1 Health Psychologist
- ◆ 1 District Manager - Addiction Services
- ◆ 1 Emergency Room Social Worker
- ◆ 1 Emergency Room Discharge Planning Nurse

Literature Review

A literature review of the systemic barriers to screening and brief intervention was conducted. The review included studies and documents from the academic and grey (e.g., government reports, etc.) literature. The information collected was reviewed and synthesized.

Data Analysis

Data collection was completed by experienced research consultants from Research Power Inc. and a lead researcher then analyzed and compiled the data from the interviews and literature review into the final report. Each interview lasted approximately 45 to 60 minutes and were audio-recorded and then transcribed verbatim. An interview guide was developed by the research consultants to guide the interview discussions. A copy of the interview guide is presented in Appendix A. Once transcribed, the interview data was coded, that is, broken into meaningful pieces related to emerging themes and categories. Coding was done using the qualitative software package NVivo (version 7), which is frequently used in qualitative health research. Sub-themes that illuminated the data in ways not provided by the main codes/themes were created as needed and attached to the main themes.

Trustworthiness of the Findings

Trustworthiness of the findings was assured through several methods including:

- ♦ Independent and systematic coding and data analyses;
- ♦ The use of direct quotations from interviews with key informants to substantiate the findings; and
- ♦ Peer review and debriefing between the research consultants conducting the analyses.

Qualitative methods, including interviews, are exploratory in nature and thus provide rich and valuable insight into people's views and feelings, but is not intended to be generalized or

quantified. Verbatim quotations from respondents are used throughout the report to illustrate the findings.

Considerations

Although this exploration of the systemic barriers for screening and brief intervention among primary health care providers captured information from multiple stakeholders and sources, there are considerations that should be noted. The exploration was conducted to the extent that the resources would allow. As such, this report presents the findings from a literature review which was not intended to be an exhaustive review, but rather to inform areas of exploration for the interviews. The timeline and resources also only allowed for a limited number of one-on-one interviews with key informants. Given these considerations, readers should exercise caution in over generalizing the results and findings from this environmental scan. Despite this, input was obtained from two sources (i.e., there was triangulation of data sources and methods) which helps to ensure the credibility and trustworthiness of the findings. It is important to note that the findings from the key informant interviews complemented the findings of the literature review.

Findings

The following section presents the findings from the exploration of the systemic barriers to screening and brief intervention for primary health care providers. The interview and literature review results are presented and organized into two main categories: 1) perspectives on addiction; and 2) the systemic barriers to screening and brief intervention. When available, findings from the literature review are presented in textboxes throughout the report (references are presented in Appendix B) and also in a section on recommendations for addressing barriers as described by the literature.

Perspectives on Addiction

The following section presents the findings from the environmental scan related to perspectives on addiction including views of addiction overall and the strengths and challenges/areas of improvement for Addiction Services as a service.

∞ Views of Addiction Overall

During the interviews, key informants were asked general questions around primary health care providers' views of addiction. Discussions revealed perceptions of judgment and assumptions as well as stigma.

Judgment & Assumptions

During the interviews, some key informants indicated that there is often a judgment around people who have an addiction. Key informants noted that although they themselves do not judge people with an addiction, there are some primary health care providers who judge the likelihood of an addiction based on what they assume a person with an addiction would look like, or the typical

Literature:

Roche & Freeman (2004)¹² found attitudinal barriers by family physicians prevent them from engaging in screening and brief intervention. These barriers include perceptions that patients with addictions are manipulative, difficult, aggressive, deceitful, demanding, unmotivated and unwilling to change.

addiction ‘profile’. For example, if a person was elderly or well put together, it was indicated that some providers would assume that addiction is not a likely issue and therefore would not engage in screening and brief intervention.

[Providers think if] you look [a certain] way, ‘I’m going to ask about your drug and alcohol [use]. [But if] you look well put together [or], you’re a grandmother, [the perception is] ‘I’m not going to ask you, I’ll assume that you’re not using.’

I think we tend to miss the seniors who sit in their apartment and drink daily, but aren’t necessarily having outward harmful effects from it. I think those are the ones that we tend to miss.

...assumptions often dictate what [providers ask about addictions]. I don’t think many people would think to ask people in their sixties if they use crack, but the number of crack users we’re seeing in their sixties blows me away.

Stigma

Several key informants noted that a stigma exists around addiction as they are commonly judged as a problem or flaw of the individual. Some felt that there remains a perception (among providers and society overall) that substance abuse is a choice made by the individual and a ‘habit’ that can be overcome with willpower. It was noted that there is a lack of understanding among providers around the complexity of addiction and the associated health effects. It was noted that the societal stigma of addiction causes some embarrassment or hesitation to address addiction among primary health care providers. Further, the societal stigma may cause non-disclosure by patients who fear they will be judged by their primary health care provider. This was especially true in rural contexts where patients were more likely to know or run into their physicians in social settings.

... there's always that idea that clients don't have enough willpower to stop, or why do they use, and different questions like that, which become a matter of willpower. I think there's certainly a misconception about the personal reasons for people using and not really understanding the complexity of addictions.

I think that the problem [with addictions] in general are minimized and that there is a lot of stigma attached to it.

I think having a substance use disorder is something with a lot of stigma attached to it, and so there's a bit of embarrassment sometimes in just raising the questions.

I think having a substance use disorder is something with a lot of stigma attached to it... I think being in a rural context, one has more than one relationship with one's physician. You're just as apt to see a physician at a house party as you are in the office, and so some of the questions that involve stigma become even more difficult to raise.

☞ Views of Addiction Services

Strengths

During the interviews, key informants were asked what they felt the strengths of Addiction Services were. They identified community based services, knowledgeable staff, and provincial strategies that were well defined. These are described in greater detail below.

Community Based

Several providers indicated that a strength of Addiction Services is that it's community based. Many felt it was positive that the services were 'out in the community'. The value of the Satellite Offices were noted as being especially important and valued by people accessing the services in rural and non-urban communities across Nova Scotia. It was noted that having community outreach workers and clinical therapists working directly in the community has enabled trust and familiarity to be built with community members. Some highlighted that it has been (and in some cases continues to be) a challenge shedding the 'clinical' view of Addiction Services to one which is more community based.

I think the best thing about [the] service is that [it's] out into the community. ... [They have] clinical therapists in Liverpool, and Caledonia, and Chester, and Bridgewater, and Lunenburg, and I think there's even someone that goes up to New Germany. So [it's] good to have them] working in a rural community, transportation is a huge issue for a lot of these people.

I think [they are] in a nice position, just due to the nature of how [it's] set up. [They are] out in the community, [with the] satellite offices. [They are] known in the community... I think [they're] in a nice position to really be involved in the community.

I think being more accessible to our community was a challenge. I think we were often in hospitals, so we would come across as sterile and sickness-based, illness-based. So I think the challenge [had been] to really get out there [in the community] and be accessible to everyone in the community... to being more centrally located, or to not to have the clinical atmosphere about it.

Self-Referral Services & Knowledgeable Staff

A few noted during the interviews that they valued having access to services such as detox and treatments that were self-referral based. The knowledgeable staff of the Service was also consistently noted as a key strength.

I value the fact that [Addiction Services] are there, and that if I have someone who needs detox for alcohol or drugs, that I have a number that I can call and say, help me out with this one. Or give me some advice as to what I can do. Generally you give the patient their number, they can self-refer. ...So I'm happy they're there.

Well I think that [the people who work for the Service are] very good professionals in the addiction treatment area, and they do a great job ... I value their help.

Provincial Strategies

A number of key informants highlighted the various provincial strategies addressing addiction (e.g., Alcohol Strategy) as a strength and a positive step provincially.

I really think that one of the strengths has to do with the present strategies that are being written. I think the alcohol strategy is a huge move forward.

Challenges & Areas of Improvement

A lack of communication and follow-up; awareness regarding the full range of services offered; a lack of a leadership role; being an undervalued service; accessibility; as well as a lack of linkages with Mental Health Services were identified as challenges and areas of improvement for

Addiction Services. These challenges and areas of improvement are described in greater detail in the following section.

Lack of Communication & Follow-up

It was consistently noted by key informants that a lack of communication was the greatest challenge associated with Addiction Services. Several informants indicated that they rarely received follow up, outcome or progress information when they sent/referred patients to Addiction Services programs and services. A few noted that communication was lacking around changes to services or service availability. Many indicated that an area of improvement should be to standardize communication post referral to the Service ensuring information is captured in patients' charts at the primary health care level. Some noted that this would entail implementing supports to facilitate this process (e.g., allocation of staff time). Further, along with an update on the patient's treatment plan/progress, a few expressed an interest in receiving recommendations or suggestions for next steps for the family physician and other providers to ensure continuity of care and support.

It's like [the patients] go into a big black hole, you never hear back what's been done or what treatment was initiated. Communication [is a challenge].

I think that [Addiction Services is] seen as a bit of a black hole, if you send a referral, who knows what's going to happen with it. [There is no] procedure to send information back. Whereas if someone were to send the referral to Mental Health Services, they would receive a report back whereas with Addiction Services ... we don't have the formalized procedures for sending back regular information on patients who are referred.

... if I sent [a patient] to [Addiction Services] ...There's no flow back as I would with other specialties, turn around and expect recommendations so that if "Charlie" falls off the wagon, here is [some recommendations] that you might do to get him back on track....I've been at this for 30 years, I don't recall ever getting any communication from Addiction Services.

... [Addiction Services] had the closure and we got an e-mail a day before the closure happened, and then after they've reopened, I think it was the day before, there was a newspaper story where [it said] there was a fund available for transportation to have people from the Capital District to move to detox in other districts, but that wasn't relayed to Emergency Room staff.

I think providing some time for Addiction Services workers to write reports back to referral agents. ... It's not built into our day ... if we could [have designated time] so that writing those reports back was seen as a priority with us, I think that would make a difference.

Lack of Awareness of Services

During the interviews, key informants noted that they were unaware of many of the services provided by Addiction Services, such as prevention services, tobacco intervention programs and supports, women's treatment services, etc. Some noted that the Service is predominantly viewed among primary health care providers as providing detox services. Several felt that the role of Addiction Services across the spectrum from prevention to treatment was not well known among providers. In some areas, a liaison worker has been hired and it is hoped that communication, and promotion of the range of services provided, may be improved through this new position. It was also recommended that the Addiction Services website be updated and explicit around the services provided.

I don't think [providers are] really fully aware of what [Addiction Services] do.they know that we do detox.. I don't know that they know that we have smoking cessation groups in probably 10 different areas around our service area, that we run groups that are targeted to women, or that we have clinical therapists ... I don't think people really realize what we do.... I think that our liaison worker will ensure as well, that people know exactly what we do.

[Addiction Services] is still called Drug Dependency to some [providers around] here, and primary care physicians. I don't think [they have] done a particularly good job of messaging who [they] are, and messaging the scope of the work that [they] do. I think the majority of the population, including primary care providers view the service as only detox.

I'm not quite sure [providers] fully understand exactly what we do, and how we do it, and why we do it. I think there's a perception out of that we just bring people in and dry them out for alcohol. I think they have very little knowledge of it, and it's probably more based on their experience with our services.

Lack of Leadership Role

Several interview participants indicated that Addiction Services was currently not playing a strong enough leadership role. Some felt that the Service could take on a greater leadership role in being a key resource for primary health care providers providing support, recommendations and advice around addressing addiction in the primary health care setting. The resources available through Addiction Services are often under-utilized, not promoted or outdated. Further, some indicated that leadership opportunities exist in terms of assisting the implementation of

provincial strategies, as well as taking an active role in sharing current research and best practice addressing substance use and problem gambling. Some spoke positively of efforts, such as the *Changing Minds* series, which a number of key informants felt helped to decrease the stigma associated with addiction.

I just don't think [providers] utilize [Addiction Services] the way they should. ... [in the] emergency department, they really don't know how to adequately treat a person in alcohol withdrawal, and they don't pick up the phone [to Addiction Services] to say, we've got so and so, and what should we do? Where we would be able to give them that information. So there eight detox units, every one has the same protocols that we use for particular drugs ... in our area – I've made sure that they all have copies of those, but they don't utilize them.

Resources would be my other criticism as well, in terms of written resources. [Addiction Services] have the pamphlets, the drug information sheets that have been outdated for years, but they just keep saying they're in the process of updating. ... They don't have much in the way of resources.

I think the upcoming national strategy, and looking at drug strategies, I think [Addiction Services] can provide some leadership there. [For example promotion around] alcohol as carcinogenic and its impact on women and breast cancer. That hasn't happened at the addiction level, so I would really like to see [Addiction Services] take some leadership... If Addiction Services begins to look at research as part of [their] mandate, or just even conversations with people who are doing research, more partnerships, I think that would be a good thing. Particularly with developing best practices, I think addressing the knowledge gap is vital.

Undervalued Service

It was noted by some key informants that providers were thankful for the services offered but also felt as a service Addiction Services was undervalued. Limited funding allocated to the Service was felt to be symbolic of the value placed on the issue of addiction overall by the health system at large.

...we hold our nose and say, 'boy, I'm so glad we have [Addiction Services], but I'm glad that it's over on the other side of the city'. So I think there's an appreciation for it...like 'I'm glad we have some place to send these people'. So I think it's appreciated, but I think it's under-valued.

[In terms of] resources, Addiction Services is always referred to as the 'poor cousin' in the health care system, which is demonstrated by the fact that they're in a condemned building right now.... [it's an example of] the government not seeing it as a priority in terms of services.

Lack of Accessibility

Some key informants noted during the interviews that a challenge of Addiction Services was a lack of accessibility to programs and services. Many expressed frustration with the inability to quickly and easily contact the Service directly (e.g., a direct line for providers).

... It's viewed as being very, very lacking in accessibility. Health care professionals when we call, there's no direct line for us to get through to, it's difficult to access [Addiction Services]... the most common [service] I use is for detox, and that's a challenge. There's no direct line.

I think that among health professionals there is apathy towards trying to access care, like what's the point, we can't get them in anyway. ...To build up that buy-in, you're going to have to get faith in the system, and people don't have faith in the system at this point. So you're going to have to show that we can access the services we need to, and it's not difficult [for example], health care providers [could] have a direct line. That would be a huge thing in Emergency, a direct line straight through, so it's easy, one step access.

Lack of Linkages with Mental Health Services

It was noted by a number of key informants that people with addictions often have concurrent mental health issues. Therefore, it was suggested that an area of improvement was strengthening linkages with Mental Health Services.

Another common problem is being integrated with Mental Health. ..They go hand-in-hand. Patients have the problem of having co-existing conditions, and they go to access Addiction Services and are told, you need to go to Mental Health, and Mental Health turns them away until they get their addiction issue under control.

Systemic Barriers to Screening & Brief Intervention

The following section presents the systemic barriers to screening and brief intervention as identified by key informants during the interviews. When available, textboxes on the right hand side present the findings from the literature review and linkages to the barriers identified by key informants. Recommendations for addressing barriers as identified by the literature and key informants are also noted throughout. The following barriers were identified and are described in greater detail below: lack of time, lack of remuneration, lack of priority, lack of availability and use of tools, lack of training, lack of comfort, lack of patient disclosure, media and government interests around substance use and gambling as well as lack of interest.

☞ Lack of Time

During the interviews, key informants consistently noted a lack of time as a barrier to screening and brief intervention. Several indicated that physicians, including family physicians and emergency room physicians, lacked the time to engage in screening in brief intervention due to high patient volume (e.g. busy waiting rooms, taking up beds in the emergency room, etc.). Further, some interviewees questioned the ‘briefness’ of a brief intervention and felt that addressing addiction requires a longer process than a short intervention session with a patient. It was often noted that nurses and other providers (e.g., social workers), as opposed to physicians, may be better suited to perform screening and brief intervention as they often have longer appointments with patients which could accommodate addiction screening and brief intervention. However, it was noted that although nurses and other providers may have more time to engage in screening and brief intervention, they may not have the same perceived level of authority and impact on the patient as the family physician.

Literature:

- Studies suggest that a lack of time is a key barrier to screening and brief intervention by primary care providers^{15, 16, 17, 19}.
- Studies suggest the lack of time is due, in part, to patients presenting with acute issues requiring time and immediate attention^{16, 17, 19}.
- A lack of time is commonly cited as a barrier by primary care providers due to misconceptions surrounding the length of time and effort required to conduct screening and a brief intervention^{14, 16}.

...once you've identified the problem, I don't think there is any quick and easy fix. So as a family physician, 'if there's no quick and easy fix and I can't fix it'.

...if you've got a waiting room full of patients, time would be a barrier. The screening probably not so much of an issue, but the intervention piece. And honestly, there's usually nothing brief about it. Once you uncover [an addiction]...there is no briefness to it.

... if you're hearing it from your doctor...I think the majority of the population would take that more serious than if it came from a social worker or a nurse....A lot of [the screening] questions could be asked by nurses. I think nurses have more time than physicians often. ...there's no reason why the nurses can't do the warm up and learn how to initiate the conversation, and ask things ... have the physicians take over from there if there's a need to do that.

Literature Recommendations for Addressing a Lack of Time

The literature suggests that overcoming the lack of time barrier may include providing supports to physicians through the use of nurse practitioners/family practice nurses in screening and brief interventions. Physicians who receive training and are supported by a nurse are significantly more likely to provide screening and brief interventions than those who receive information or guidelines on brief interventions alone²¹. Nurses have been found to be capable of providing effective screening and brief interventions which help to decrease the time burden on physicians⁷. It has been suggested that the use of nurses rather than physicians may also be beneficial to patients who often feel more comfortable discussing issues such as substance use and problem gambling with a nurse with whom they could relate to rather than with their family physician who is often viewed more as an ‘authoritarian’¹⁷. Further, patient visits with family practice nurses or nurse practitioners are typically longer than those with physicians, therefore allowing additional time to be spent screening and engaging in brief interventions¹⁷. A literature review by Roche and Freeman (2004)¹² suggests that nurse screening and brief interventions also cost 10% to 42% less than physician interventions and are of the same quality of care.

It has been recommended that technology be used to overcome the obstacle of a lack of time. Moyer and Finney (2004)²² provide examples of various computer programs designed to help physicians screen patients for substance use and gambling problems. These types of programs often take the form of electronic surveys/questionnaires which may be completed by patients prior to their appointment. This saves time and enables the physician to review and provide brief intervention if appropriate.

∞ Lack of Remuneration

A lack of remuneration is a major barrier to screening and brief intervention among family physicians. In the fee-for-service environment, there is little incentive to engage in screening and brief intervention addressing addiction as it is generally viewed as an area that takes significant time to address in the clinic setting. As such, screening and brief intervention are not routinely addressed unless it is part of the presenting health issue. It was suggested by some that a means to addressing this barrier was to re-examine the way in which family physicians are

compensated. Other suggestions included implementing a billing code for a ‘health and wellness’ annual check-up that would allow sufficient time and appropriate compensation for performing screening and brief intervention addressing health risk factors in general. This would also allow physicians to see, screen and provide brief interventions for patients who are not regularly seen (e.g., teenagers, young adult males, etc.).

The first major barrier is the way physicians are paid. Physicians are paid to provide periodic health intervention, acute care interventions. ... if family physicians were paid more hourly or salaried ... [then they] I don't have to generate an income by seeing how many [patients they can see]. ... [there is] no credit because there are no billing codes. [Physicians] don't get any credit for the screening and health intervention that we do on a day-to-day, hour-to-hour basis.

... there should be a visit that is strictly health and wellness. Let's look at your lifestyle, do you exercise, what do you eat, are you doing any substances, are you drinking too much... there are some people, particularly the men quite honestly. At least the women are coming in for their pap... but the men in particular I find, you never see them....If [physicians are] on salary, then they have more time.

I think that if the doctors were on salary the time would be less of an issue ...they just push [patients] through so quickly, if they got a salary and they only saw X number of people a day they might have more time to address other issues. Very often you'll see signs in the doctor's office, these days you can only address two issues today. Make another appointment if you have something else to discuss.

Well in Nova Scotia, in 30 years, it has never been appropriate to do annual check ups. For your kids, once they pass the age of five, there is no standard to turn around and say, they should be in the doctor's office once a year... I know that in Ontario they have a code for your annual health care, a health examination. In Nova Scotia, they don't.

Literature Recommendations for Addressing Lack of Remuneration

Primary health care providers have suggested that their comfort around screening and asking questions related to substance use and problem gambling has increased and seen as more appropriate when it's part of patient's generally lifestyle screening (e.g., yearly check up, hypertension screening, diabetes clinics, etc.) where the substance and use of the substance are not the focus of the appointment¹⁷, hence, the utility of a billing code for an annual checkup. Researchers have also suggested that financial re-imburement may encourage providers to include screening and brief intervention into their clinical practice^{15, 27, 28}. Further, providers comfort and willingness in asking questions related to substance use is heightened when the patient exhibits negative health symptoms related to substance use as providers perceive that their questions in this case are ‘justified’¹³.

☞ Lack of Priority

A few providers also felt that the lack of time was linked to a lack of priority around addiction.

It was noted that physicians (e.g., emergency room, family physicians, etc.) often prioritize the patient's acute presenting problem such that screening and brief intervention is a low priority and often not addressed. Several interviewees noted that addiction is rarely addressed in the primary health care setting

Literature:

- Given that patients often present in primary care settings for more acute issues, providers often are concerned that questions around addictions would be inappropriate, intrusive and insulting to patients^{16, 17}.
- Brady et al. (2002)²⁰ found that physicians reported patients being annoyed when issues such as their alcohol consumption were raised as they were most interested in having their presenting problems addressed.

unless the addiction is overt and a health concern. It was noted that addiction is often only addressed if the patient's presenting problem included symptoms or side effects of addiction. As such, the high risk behaviours associated with addiction may be overlooked unless they are the direct result or cause of the presenting problem (e.g., car accident from intoxication, etc.). Some noted that the high risk behaviours are ignored as they are viewed as the result of a 'decision' of the individual.

...if a client has a presenting problem that needs to be addressed immediately, [screening and brief intervention] probably just doesn't even come into consideration It's more dealing with the immediate needs of the client at that time.

The client presenting in an emergency department usually is requiring something in acute care, and needs some sort of immediate care. It might not be the place to do [screening and brief intervention] immediately, that's for sure.

... a lot of the problems around addictions are chronic. They're chronic health care problems... in the Emergency Department it's basically fix whatever's going on and out the door.

☞ Lack of Training to Address Addiction

A number of key informants identified a lack of knowledge around brief intervention and addressing addictions as a barrier. They indicated that providers were uncertain as to the ‘next steps’ involved in addressing addiction once one was identified through screening. Some felt that screening tools stopped short in supporting providers beyond the screening stage and many key

Literature:

- Studies have identified inadequate training, lack of knowledge, skills and confidence around screening and brief intervention as the most common barriers preventing primary care providers from carrying out brief interventions^{10, 14-19}.
- In the case of substances such as alcohol, there is confusion and lack of awareness among many physicians as to what constitutes misuse such that intervention is needed²⁶.
- Only 18% of surveyed primary care nurses and physicians felt they had enough knowledge to provide brief interventions and only 12% had participated in any brief intervention training¹⁴.

informants felt that increasing training around the ‘next steps’ in brief intervention would be critical to addressing this barrier. A few felt that training on current techniques and skills on how to address addiction such as motivational interviewing would also be beneficial. However, it was emphasized that in order for training around addictions and brief intervention to be successful, it must be practical for the primary health care setting and context. It was recommended that training opportunities be delivered by those with whom primary health care providers could relate (e.g., other physicians who currently use screening and brief intervention in their practice), rather than specialists from Addiction Services. Further it was also suggested that education and professional development be provided using a variety of formats (e.g., workshops, online learning opportunities, etc.) to accommodate and best suit a wide range of providers and primary health care contexts (e.g., emergency room, fee for service environment, alternative payment plans, interdisciplinary teams, etc.). Several key informants felt that the area of addiction should be a greater component of the medical school curriculum which would include enhanced knowledge, screening and brief intervention skill development.

Knowledge would be another barrier, and what to do about [an addiction]. If you uncover a problem, what are you going to do about it? If you have nothing to offer [the patient], then you feel helpless, and you don't feel good, you've uncovered something, now you have to do something about it [and you] don't have the knowledge or skills to do it.

I don't think there's anything in med school about [screening and brief intervention], so [providers] are unfamiliar [and] if they do ask the questions, what do they do next? I'm not sure that we've done the best job we can by [just] saying, here's a screening instrument. I think addictions needs to be taught in the different schools. ... we haven't done as good a job as we can [with] professional development, and helping [providers] knowledge base to catch up with what's happening in addictions today.

... the education [and training] has to be done in a way that's meaningful, and that respects the context in which [primary health care providers] work. So having someone from Addiction Services come in and tell a family physician and/or a family practice nurse physician [will be ineffective.] What we need is like people, other primary care providers talking about how they've integrated this into their practice so it makes it more real, and it's more practical, and respects the context in which we work. ... But [physicians] don't want to listen to specialists, and I think we need to look for champions in the primary care field who are doing a good job, and have discovered strategies that work [around screening and brief intervention] so that they're sharing those with their colleagues.

[Addiction training] needs to be available in many ways. So it needs to be available as education online for those who can access it that way, in writing, in personal seminars, so there have to be multiple ways [of different providers] accessing it to get the information.

Literature Recommendations to Address Lack of Training

Research suggests that primary health care providers feel there is a need for increased formal training (e.g., university medical education and training) and continuing medical education related to substance use and gambling problems to facilitate the engagement and use of brief intervention among primary health care providers^{14, 18}. With the increased recognition regarding the potential for screening and brief interventions in primary health care settings, several training resources have been developed to support primary health care providers such as:

- ◆ *Training Physicians in Techniques for Alcohol Screening & Brief Intervention.* Author: The National Institute on Alcohol Abuse and Alcoholism's (NIAAA)
- ◆ *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care.* Author: Babur, T.F. & Higgins-Biddle, J.C. (World Health Organization)

- ♦ *Drink-Less Program* (package of materials to assist primary health care workers screen for alcohol related problems and offer appropriate advice to patients) Author: University of Sydney & the World Health Organization
- ♦ *Alcohol Screening and Brief Intervention: A Training Program of Veteran Service Providers*. Australian Government- Department of Veterans' Affairs.

Studies suggests that some of the most effective health care provider training strategies for screening and brief intervention include: skills-based role playing (e.g., interviewing techniques, rehearsals, etc.); performance feedback (e.g., feedback regarding practice performance, patient outcomes, etc.); clinical protocols and guidelines (e.g., guidelines in *Brief Intervention For Hazardous and Harmful Drinking: A Manual for Use in Primary Care*); clinic based education; and training by credible experts^{8,14}.

Although training is a recognized facilitator in the use of screening and brief intervention, Roaches and Freeman (2004)¹² caution that a number of obstacles exist in the use of training and learning opportunities for primary health care providers. Barriers which prevent the participation in learning opportunities include a lack of time, faculty expertise, funding support, training sites, institutional support, and competing educational needs and priorities among physicians and nurses¹².

☞ Lack of Availability & Use of Tools

Several key informants identified the lack of tools and resources as a barrier to screening and brief intervention. Some interviewees highlighted the CAGE tool as one that was widely used and available for alcohol, but were

Literature:

- Screening tools make use of 'pen and paper' screening which is not part of standard clinical protocols or general practitioner culture (i.e., diagnosis via empirical observation and verbal questioning around symptoms)¹².

unaware of tools for other substances and addictions. Although it was recognized that tools and resources are likely available, it was noted that these are **not effectively promoted or communicated** to providers. A few interviewees noted that this was an area in which Addiction Services could take a leadership role. Further, many key informants highlighted a disconnect

between the availability and the use of tools. Further, it was noted that when tools are used, there is not always an understanding of the scoring among providers.

Well when you're talking about if there are tried and tested tools, questions that we should be asking patients, [physicians] don't have those. I don't know if [tools have] been communicated to primary care providers or not. I've not seen anything in the last three years, but if there are tools available, [there is a need to] find ways to get those out in a way that's meaningful. Because [physicians] are a little overloaded with information, so we do need to be careful when things are sent out, to provide them in a meaningful way.

I hear the health care providers saying they don't have [tools and resources] and asking for [them]. So [providers are] looking for some leadership from [Addiction Services] around what are those screening [tools].

There are no screening tools available in the Emergency Department that I'm aware of. Certainly none that are being used by the nurses and physicians.

My problem is that if I utilize the screening tools, there's not enough awareness of them [with other providers], so if I say, bed two just scored a 19 on the AUDIT that has no meaning for anybody.

Lack of Use

Key informants were also asked what were some key elements to consider should a new screening and brief intervention tool be developed. These are summarized in the following table along with supporting quotes.

Table 1: Key elements of a Screening and Brief Intervention Tool

Theme	Description	Quote
Short	<ul style="list-style-type: none"> • Tool should be very short and concise • Tool should include a limited (4-5) number of questions 	<ul style="list-style-type: none"> • <i>Four, maybe five questions but no more. Physicians for example, or any other primary care health provider really doesn't have the time to go into [a] 35 question [survey]</i>
Simple Interpretation of Results	<ul style="list-style-type: none"> • Simple calculation to determine whether or not an issue has been identified 	<ul style="list-style-type: none"> • <i>I think it would have to be very intuitive in terms of the analysis. A lot of screening scales, there's 12 questions and you have to add up 12 numbers to get a score and [providers] won't do that.</i>
Next Steps	<ul style="list-style-type: none"> • Tool should guide the provider through next steps once an issue is identified (e.g., referral, steps for brief intervention, etc.) 	<ul style="list-style-type: none"> • <i>Some of [the tools] at the bottom once you've got your score, it is helpful to know, okay, so where do we go next?</i>
Public Awareness	<ul style="list-style-type: none"> • Tool/questions should be publicly promoted or displayed to build familiarity/ acceptance of the questions • Promotion could encourage patients to be proactive and discuss addictions with physicians 	<ul style="list-style-type: none"> • <i>... the whole aspect of self-management and patients taking responsibility. So if there's some kind of public awareness. ... putting some onus on the patients to manage their own health.</i> • <i>...in the United States, the drug companies ... have tapped into the selling of self-advocacy... commercials about drugs ' you should ask your doctor'. So let's take that and use it for a health promotion ...advocate for your doctor to ask [addictions] questions.</i>

Theme	Description	Quote
Promotion	<ul style="list-style-type: none"> • Tool needs to be promoted among providers (e.g., short, easy to use, etc.) to build provider support, buy-in and use. 	<ul style="list-style-type: none"> • <i>If the tool is created, as far as it getting good uptake by the physicians, is going to take some work that it's promoted in an effective way</i> • <i>I think that doctors listen to doctors, so you'd have a much better uptake if you've got the champion within the physician community, than you would if you had somebody from Addiction Services or Department of Health, or Health Promotion and Protection trying to [promote the tool].</i>
Multiple Formats	<ul style="list-style-type: none"> • Availability of the tool in multiple formats including linked to electronic health records or paper style questionnaire for inclusion in the patient chart 	<ul style="list-style-type: none"> • <i>I think it would have to be a paper that could be part of the chart... If I'm doing an AUDIT [right now] it doesn't go on the chart.</i> • <i>We probably could do some work with the electronic record. Set up alerts and reminders, and to have the tools put online so that they're easily accessible.</i>
Gender & Age Specific	<ul style="list-style-type: none"> • Tool should be specific to each gender (e.g., tolerances, etc.) and age/ stage of life (e.g., adolescences, adults, seniors, etc.) 	<ul style="list-style-type: none"> • <i>... there are different cut-off rates for women ... so you'd have to put the cut-off rate higher... 51 percent of the population is female, and so I don't see any sense in getting a male screening instrument if it's not going to pick up women's substance use.</i>
Valid	<ul style="list-style-type: none"> • Tool needs to be researched and tested to ensure validity 	<ul style="list-style-type: none"> • <i>... it has to be valid. Anybody can throw a couple of questions together, but whether or not it's really telling us something important and useful about someone's use of alcohol or drugs, or involvement in gambling is quite another thing. So I think it has to be a researched tool. ...we have to have a valid tool.</i>
Consultative Process	<ul style="list-style-type: none"> • Tool should be developed in consultation or collaboration with primary health care providers to ensure it meets their needs and to facilitate buy-in 	<ul style="list-style-type: none"> • <i>... if you were developing such a [tool], consult with family practice nurses and family practice physicians to get feedback.</i> • <i>I think that certainly Addiction Services have a primary role [in developing the tool]. [But] if you're developing a tool, certainly I would be asking Acute Care staff, because they certainly would have their own perspective of clients. Certainly the physicians, nurse practitioners, anyone who has a lot of immediate, upfront contact [with patients]</i>

Literature Recommendations for Lack of Tools

Several short, easy to use tools have been developed to overcome this barrier and help primary health care providers detect and screen for problematic substance use and gambling [12]. Commonly used tools which have been found to be accurate and effective for assessing the use and/or degree of dependence on various substances [12] are presented in the table on the following page.

Table 2: Tools to Assess, Screen & Detect Substance Use Problems

Target Substance	Tool	Description
Alcohol	CAGE	Quick scan to detect alcohol abuse
	Alcohol Use Disorders Identification Test (AUDIT)	Accurately predicts patient's future related harm from alcohol (e.g., illness, hospitalization, social issues, etc.)
	Fast Alcohol Screening Test (FAST)	Abbreviated version of the AUDIT tool, with a high degree of sensitivity to detect alcohol problems
Smoking	Heaviness of Smoking Index (HSI)	Measurement of nicotine dependence
Multiple Drugs	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	Comprehensive measure of drug use for a variety of drugs such as alcohol, tobacco, prescription drugs and illicit drugs
Problem Gambling	Center for Addiction and Mental Health Short Gambling Screen	Short questioning to alert possible gambling concerns

☞ Lack of Comfort in Addressing Addiction

A barrier commonly noted by key informants was a lack of comfort and confidence to address addiction. As previously described, key informants felt that primary health care providers do not engage in screening because they are not trained in providing brief intervention or follow up care in the event that an addiction were to be identified through screening. As such, addiction issues may be often avoided or ignored in the primary health care setting. It was suggested that Addiction Services could take a leadership role in providing supports to primary health care providers around behaviour change techniques.

Literature

- Discomfort around discussing addictions with patients has been found in the literature as obstacles to screening and brief intervention^{16, 23, 24}.
- Many physicians find it challenging to raise issues related to addictions with their patients²⁵ fearing losing, interfering or spoiling their relationships with patients^{16, 17, 23-25}.
- Discomfort has been linked to a lack of skills to engage in preventative health care²³.

Patients are usually pretty good about it. It's often the health professional's discomfort. It's often the health professional that is afraid to ask the question, because they're afraid of what answer they might get, and they're not confident in their ability to deal with whatever the answer might be. So it's better just not to ask...

Several key informants noted that this barrier was substance dependent. The following section describes the 'lack of comfort barrier' according to substance including smoking, alcohol, prescription drugs, and illicit drugs and gambling.

Comfort Addressing Smoking

The majority of interviewees described a high level of comfort among primary health care providers in screening and providing brief intervention for smoking. Many attributed the comfort in asking questions and addressing smoking cessation to the cultural/societal shift around smoking as a health concern. Many noted that media promotion and public education around the negative health consequences of smoking has facilitated comfort and open discussion around smoking. It was also noted that in some settings, such as the emergency department, smoking is overtly tolerated or ‘supported’ whereas other substances such as alcohol, is treated negatively.

[Are primary health care providers comfortable providing screening and brief intervention] I would have to say probably not, with one exception, I think the exception would be smoking. I think that smoking has been really mass-marketed in health, as opposed to the other addictions. I would think that of all the addictions ... I do think that with smoking, there's been enough exposure.

I think it's a lot more socially acceptable for patients, they [are likely to] be asked questions about their cigarette use as opposed to [illicit] drug, alcohol, prescription drug abuse.

Comfort Addressing Alcohol

Several interviewees indicated that after smoking, alcohol is most likely to be addressed in terms of comfort in screening and brief intervention. Although providers felt there was some comfort addressing alcohol, it was noted that alcohol is more ‘socially acceptable’ given that it is legal and widely used among the general population and some providers may be uncomfortable addressing a substance which has been “normalized” and not predominately viewed as health concern.

I think it's a cultural shift. I think there are certain drugs that are acceptable and certain drugs that aren't acceptable. Barely 20 years ago, tobacco use was very normalized, but the particular problem in society has changed radically. I think alcohol is viewed somewhat like we viewed tobacco 20 years ago. But further work needs to be done around educating the population. ...So I think there's a huge cultural fact here,

Primary health care providers are pretty well educated around the harms of tobacco. They might be less likely to use it with alcohol, and I think more further work needs to be done around that.

Comfort Addressing Prescription Drugs

A number of interviewees indicated that screening and brief intervention was rarely conducted for prescription drugs. Some noted that addressing prescription drug abuse was challenging as many providers are unsure what constitutes ‘normal’ use versus abuse of these drugs.

I know the whole issue of prescription drugs is just so difficult to address, those patients are often seen as such challenges and so draining on the health care professional. Usually, because the reason why they're on the medications in the first place is chronic pain, which is very hard to substantiate or unsubstantiated. There's just so many gray areas, you have to rely so much on the patient and it's hard to distinguish between what's required and what's necessary, versus an addiction.

Illicit Drugs & Gambling

Key informants generally indicated that primary health care providers were least comfortable or likely to engage in screening and brief intervention with illicit drugs and gambling. Some informants noted that gambling was especially not addressed because it was often non-symptomatic and was uncommonly the presenting problem faced by family physicians or physicians and nurses in the emergency room. Further, it was noted if a gambling or illicit drug problem is identified, providers are often unsure of the next steps involved in addressing these types of addictions.

Literature:

- In 2000, more than half of physicians surveyed indicated that they had low confidence in their ability to raise and address issues such as gambling problems with their patients¹⁰.
- Physician confidence in screening and intervening tends to be especially low for patients dealing with illicit drug related problems compared to smoking¹².

Other addictions aren't even recognized in the Emergency Department. Take gambling, that's rarely recognized or identified unless a family member brings it up. ...I think that the screening is a small piece of it, because then what do you do with the information you've collected? I think certainly people are more accustomed to and more comfortable dealing with smoking. [In the Emergency Room], I'm not sure I've ever heard somebody question somebody's gambling-related activities, I don't think it's ever come up in the Emergency Department, because it's not overt. It's not something you recognize easily unless somebody brings it to your attention.

...I would say that people are more comfortable screening for alcohol use, and certainly I think it would be a rare family physician that would not inquire about smoking. I think people are less likely to ask about recreational drugs.

☞ Lack of Patient Disclosure

It was noted by several interviewees that primary health care providers often perceive that they would not get honest answers by patients if they were to screen for addiction. Some

Literature:

- McCormick et al. (2006)²³ found that patients often disclose information regarding drinking (both in response to questions and without prompting); however, primary care providers often do not explore these disclosures (e.g., change the subject, downplay the significance of their patients' drinking, etc.).
- Contrary to the belief that providers will encounter resistance or negative reactions by patients, physicians who used brief intervention for problem gambling found patients to be receptive to questions¹⁹.

attributed the lack of disclosure by patients to the fear of judgment and stigma they may face should they disclose their problem around substance use and gambling. Similar to other barriers, the lack of patient honesty was thought to differ by substance. A few interviewees felt that providers would get honest answers around smoking but not with other substances such as alcohol and drugs or gambling.

.it's also a sense of, am I going to get an honest answer? The odd time in an interview someone will say, well I'm not going to lie to you doc, I do such and such. But the vast majority of people are not going to tell you about their intimate personal lives, whether it be sexual, whether it be from the perspective of using illicit drugs.

Alcohol is probably less asked [by providers] and probably you get less honest answers too. That's probably why it's not asked, because you don't expect to get the full story anyway. ... there's so much public stigma related to addiction, so we can ask patients, but we don't always get an honest answer.

...[Another barrier is] the level of comfort, [patients] are probably relaxed telling [providers] how much they smoke; they're less relaxed telling how much they drink, and they're not going to tell how much illicit drugs they use.

I'm sometimes struck by patients that will sometimes admit to an addiction that they've had for years, that they don't want to tell [their family doctor about] because they don't want [their family doctor] to know, they don't want [their family doctor] to think badly of them. It's a stigma, and I think for some patients, if they've had a relationship with their family doctor for a long time, they don't want the physician u to be disappointed ...[or they] didn't want you to think badly of [them].

☞ Media & Government Interest around Substance Use and Gambling

During the interviews, several key informants highlighted the media as a systemic barrier preventing screening and brief intervention. For example, some highlighted the positive association and 'normalization' of excessive alcohol consumption as a contributor to the social acceptance of excessive alcohol use and the stigma of addressing it by primary health care providers. A few also noted that addressing addiction was challenging given the government

interest and economic ‘benefits’ of substances and gambling such as taxes collected through cigarettes, alcohol, lottery tickets, etc.

I think the media, is another barrier. I think the media has done a great job in marketing alcohol in particular, and so alcohol is seen as something that’s associated with freedom and a carefree lifestyle.....

... the government’s own conflict of interest in terms of their involvement with gambling, with taxation of cigarettes and taxation of alcohol. I think it’s a force that’s extraordinarily difficult to counter. ...The media as well, they still have the eyes and ears of the public in terms of substance use and gambling involvement, and it’s still a very normalized activity, even problematic use is normalized.

I think even the connection between our government seeing profits from the casino, alcohol sales, tobacco sales... when people say, oh, well you’re two-faced, how can you be employed by the same province that’s making money off of the very problems you’re trying to help?

∞ Lack of Interest or Role

A few key informants indicated that a barrier to screening and brief intervention was the lack of interest around addiction and a perception that this field was outside of the role of a primary health care provider.

I think that outside of the addiction field, nobody wants to touch this. So I think that there’s a pretty strong divide, that if you’re an addiction specialist, this is your job. And so, ‘I’m not an addiction specialist, I don’t want anything to do with this’. ... [in] family medicine practice, I think [addictions] kind of seen as, nope, this is not our deal.

Conclusion

This report presented the results of an environmental scan including a literature review and key informant interviews. The report highlights numerous barriers to screening and brief intervention as well as recommendations to address these barriers. In the majority of cases, there are no simple solutions to address these barriers as they require a shift in the health care system. In some cases, the barriers are beyond the health care system and are issues at a cultural/societal level. However, the benefits and opportunities of screening and brief intervention in primary health care settings are well documented. Therefore, efforts to overcome these systemic barriers and promote screening and brief intervention will have a positive impact on addiction in Nova Scotia.

Appendices

Appendix A: Interview Guide

Exploring the Systemic Barriers for Screening and Brief Intervention Initiatives for Universal & Targeted Prevention by Primary Health Care Providers

Interview Guide, July 2008 – FINAL

Interviewee: _____

Interviewer: _____

Date: _____

PURPOSE OF THE INTERVIEW

The purpose of the interview is to gather the perspective of key informants (e.g., family physicians, ER physicians, family practice nurses, social workers, Addiction Services staff, etc.) and discuss the systemic barriers for screening and brief intervention for substance use and gambling in the NS primary health care environment and other areas (i.e., ER Dept). Specifically, the interview will gather data to assess:

- Perspectives on Addiction;
- Perspectives on Addiction Services as a Provincial Service
- Barriers Preventing Screening & Brief Intervention; and
- Existing Screening & Brief Intervention Tools & Resources.

PURPOSE OF THE GUIDE

This guide will be used by the interviewer to guide the discussion and ensure that the data is gathered to fulfill the interview objectives outlined above. Interview probes will ensure that “depth” of response is captured.

INTRODUCTION & CONSENT

The purpose of the interview is to gather the perspective of key informants (e.g., family physicians, ER physicians, family practice nurses, social workers, Addictions Services Staff, Doctors Nova Scotia, etc.) and discuss the systemic barriers for screening and brief intervention for substance use and gambling in the NS primary health care environment and other areas. Screening and brief interventions can be described as screening and an interview process by which practitioners can identify at-risk drinkers, smokers, prescription and illicit drug users and gamblers followed by a one time or repeat short counseling sessions designed to help the patient reduce their drinking, drug use, smoking and/or gambling and minimize related problems. Specifically the interview will gather data to assess:

- *Perspectives on Addiction;*
- *Perspectives on Addiction Services as a Provincial Service;*
- *Barriers Preventing Screening & Brief Intervention; and*
- *Existing Screening & Brief Intervention Tools & Resources.*

The information and learnings from all of the interviews will be analyzed and compiled into a report as part of an information gathering process being conducted prior to development of a plan to build increased capacity for screening and brief intervention initiatives in the primary health care environment and other areas (ER Dept etc.).

Participation in the interview is voluntary. To help with the analysis of the information, I would like to audio-record and then have the recording transcribed. The responses provided will be reported only in aggregate, and although individual responses may be used as quotations, no one will be personally identified. Do you have any questions?

Do you consent to participate in this interview?

Yes No

Do I have permission to audio-record this interview?

Yes No (If no, ask if notes can be taken)

INTERVIEW

The interviewer will begin using the scripts and questions outlined below. Items printed in *italics* are scripts for the interviewer.

1. What is the nature of your involvement with addressing addiction?

Probes

- Professional Position
- Scope of work related to addressing addiction
- Duration of involvement

Perspectives on Addiction

I'd like to start off by asking some questions around perspectives surrounding addiction.

2. Among primary health care providers, how do you think addiction (e.g., smoking, alcohol, prescription or illicit drug abuse, gambling, etc.) is viewed?

Probes:

- Do you think addiction is viewed as a health concern? A broader social/societal issue? Personal problem of the individual? Why?
- How is high risk behaviour associated with substance use viewed among primary health care providers? Why do you think that is? How is it addressed in practice?
- Do you think that primary health care providers view addiction differently than those working in the acute care setting or those working in the area of addictions?
- Do you think primary health care providers are more comfortable or apt to engage in screening and brief intervention with certain addictions more so than others? Please explain.

3. Among primary health care providers and other stakeholders, how do you think Addictions Services is viewed as a provincial service?

Probes

- Degree of Leadership?
- Source of support & resource?
- Level of communication & collaboration?
- Strengths and challenges of the Service?
- What's the referral process?
- Do you think primary health care providers view Addictions Services differently than other stakeholders (e.g., HCPs in the acute care setting, Addiction Services Staff)? Why or why not?
- What other roles, services or functions would you like to see Addictions Services play?

Barriers Preventing Screening & Brief Intervention

Now, I'd like to ask some questions around systemic barriers.

4. In your opinion, what are some of the systemic barriers that prevent primary health care providers from engaging in screening and brief intervention?

Probes:

- Do you think primary health care providers are comfortable addressing addiction & providing screening and brief intervention services to

patients (e.g., comfort with the topic, patient reception and reactions, etc.)? Why or why not?

- Do you think primary health care providers have adequate tools and resources to provide screening and brief intervention services? Why or why not?
- Do you think primary health care providers are adequately trained (e.g., have the skills, knowledge, confidence) to provide screening and brief intervention? Why or why not?
- Do you think primary health care providers have adequate time to provide screening and brief intervention services? Why or why not?

5. In your opinion, what could be done to overcome the systemic barriers you've described?

Probe:

- Will be based on barriers identified (e.g., training opportunities; availability of tools & resources; change in MSI billing code etc.

6. Do you think these barriers differ by provider (e.g., family physicians versus family practice nurses or nurse practitioners versus Emergency Room physicians versus other professionals such as social workers, etc.)? Please explain.

Probe:

- Which primary health care provider(s) do you feel is best suited (e.g., has the necessary skills, time, comfort, etc.) to provide screening and brief intervention for patients? Why?

7. What types of supports do you think are needed to facilitate addiction screening and brief intervention among primary health care providers (e.g. training, resources, supports, financial incentives, etc.)?

Probes:

- Who should be responsible in providing these supports (Addiction Services – Provincial/District, professional bodies/organizations etc)?
- What would be the best way to provide additional supports such as training around screening and brief intervention (e.g., during medical school, other health care professional curriculums, CMEs, etc.)?

Screening & Brief Intervention Tools & Resources

In this last section, I'd like to discuss screening and brief intervention tools and resources.

8. Do you know of any screening and brief intervention resources (e.g., tools, programs, etc.) that are currently available or being used by primary health care providers or other health care stakeholders to address addiction? Please describe. Would you be willing to share them as part of this information gathering process?

9. Of those tools/resources you've described, or if new resources were to be developed to support screening and brief intervention by primary health care providers, what do you think are some key aspects or considerations in facilitating their uptake and use by primary health care providers?

Probes:

- Do you think there is a need for the tool(s) to be gender specific? What about age specific? Please explain.

10. Are these considerations specific to primary health care providers or for anyone engaged in addiction screening and brief intervention? Please explain.

CLOSING

That is the end of the formal questions.

11. Do you have any other feedback or comments you would like to add around the systemic barriers associated with screening and brief intervention among primary health care providers and other stakeholders?

Ask key informant if they would forward any screening and/or brief intervention tools addressing addiction that could be included in the Report for information sharing purposes. **If yes**, ask if they would e-mail or fax the information? Fax # of RPI: 902-463-2772 and/or email: natasha@researchpowerinc.com

Thank you for your time and thoughtful input. A report of the findings will be developed and available through Nova Scotia Health Promotion & Protection.

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