

**Scoping of resources to support
alcohol and health behaviour change**

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Executive Summary

Introduction

This study is concerned with individual health behaviour change (HBC) in the form of brief interventions which are usually based on motivational interviewing. Brief interventions fall into two categories: a shorter, basic one of 3-15 minutes and a more in depth approach lasting 15-40 minutes, utilising motivational interviewing.

The study aims to review the current use and appropriateness of existing HBC resources on alcohol by a variety of professional audiences within a range of settings. This includes the following specific objectives:

1. Identify, map and review the range of existing alcohol HBC resources currently being used nationally and locally across a variety of settings.
2. Review the relevance of current resources available and whether they meet NICE guidelines and/or SIGN guidelines.
3. Review the evidence base for the link between topic areas to inform the development of future resources that take a more holistic approach to lifestyle change.
4. Identify and establish the views of a range of stakeholders regarding the potential use and format of existing resources and to make recommendations regarding the development of future alcohol HBC resources.
5. Identify the perceived needs and appropriateness of resources for the public with regard to HBC resources especially for those experiencing health inequalities.

In carrying out the research, the following working definition of an alcohol HBC resource was used:

“A resource (paper or otherwise) which does more than simply provide facts or information on alcohol but is designed to support people to reflect on their drinking and make changes, or to help professionals to support people to do this.”

There were 3 elements to the method:

1. collection and review of HBC resources, using a framework developed specifically for this purpose
2. a review of the literature for the evidence base to compare holistic and topic based approaches to HBC
3. three focus groups with the general public, six focus groups with relevant professionals and interviews with key informants from the equality and diversity agenda.

Literature review

Current guidance for HBC is either generic or specifically for the topic of alcohol. The latter includes SIGN 74, which draws on an evidence base for effectiveness in reducing total alcohol consumption and binge drinking in hazardous drinkers for up to a year. It is not intended for use with dependent drinkers. It emphasises the use

of motivational interviewing, the importance of training for professionals and the use of screening tools, but it relates only to the health care setting. There is some evidence for effectiveness of brief interventions in other community based settings. More generic guidance is found in texts relating to motivational interviewing and draft guidelines from NICE.

The evidence-base for HBC interventions on alcohol issues is strong and clear recommendations can be made in this field. In contrast, research is less well developed regarding the effectiveness of motivational interviewing, which indicates some potential for a wide range of lifestyle topics. We found very little evidence for a holistic approach involving multiple risk behaviours. There is recognition that the research in this field is under-developed. Examination of the key areas of guidance from NICE and SIGN for HBC indicates that each risk behaviour has its own specialist body of knowledge about risk assessment, strategies for behaviour change and evidence based approaches to intervention.

Scoping and review of alcohol HBC resources

In order to objectively review the quality of existing alcohol HBC resources, an assessment framework was developed based on existing guidance and evidence. Three frameworks were developed for the following types of resources, which reflected principles of HBC:

1. client based resources – self help leaflets, booklets, workbooks, websites
2. practitioner guidelines
3. training packs for practitioners

Resources were sought within these categories from health promotion libraries, national alcohol organisations and alcohol specialists within Health Boards and Alcohol Action Teams. Many of the resources were quite old, and some did not meet the criteria for HBC resources. The number which were identified and reviewed was:

- 8 Written self-help resources
- 4 Web-based self-help resources
- 10 Practitioner guidelines/"prompt sheets"
- 7 Practitioner training packs

All of the self help client based resources were designed for use with the general public in any setting. The practitioner guidelines tended to be setting specific with most being set in primary care. Training packs were more likely to be setting specific but were aimed at a wider range of settings, but many were not written with an HBC focus.

The review showed that the client based written resources which scored best tended to be longer and therefore less accessible by the public. They tended to be poorer at supporting assessing and engaging with motivation to change and better at identifying the problem and supporting change through providing a menu of options and goals. The web sites scored poorly overall, particularly on assessing and motivation to change, which was surprising as they have the potential to include a greater range of self assessment tools.

The practitioner guidelines were the most likely to be written specifically with brief interventions in mind and as a result scored highest. Length was not a

factor in this. The shorter resources were more likely to be intended for trained professionals.

Most of the training packs scored poorly overall in relation to brief interventions, and also on theoretical background. Most tended to be stronger on motivational interviewing practice, but did not set it in terms of brief interventions. The top scoring pack was designed specifically for carrying out brief interventions in a range of settings.

Findings from the public and professional focus groups and interviews

Drinking patterns, units, sensible guidelines and problem drinking

Focus groups participants with the general public found the concept of units abstract and irrelevant to their social drinking patterns and were unlikely to count them. They were surprised by their levels of consumption compared to the sensible drinking guidelines, which they perceived as very low and unrealistic, and discounted them. They lacked understanding of the health consequences of their alcohol consumption.

The use of resources to support process of a brief intervention for health behaviour change

Professionals were delivering brief interventions in a range of health and community settings. Sometimes there was a blurring between the terms brief, medium and longer term interventions and motivational interviewing. Resources were rarely used to raise the issue of alcohol but more for screening, assessing and supporting motivation to change and the process of change.

Alcohol was commonly raised as part of a routine health check in health settings and more usually through related problems in other settings. It was regarded as requiring sensitivity and enhanced by a good relationship with the client/ patient. Most practitioner informants were confident at raising the topic and saw training as an important contribution to this. Legitimacy was generally high for all informants, but might be lower for mental health workers. All felt it was important for clients / patients to prioritise alcohol for themselves as a lifestyle topic they wanted to change .

Screening tools were viewed by some health workers as easier to use as prompts for questions. They were less commonly used in other settings except by alcohol specialists. Worksheets to aid decisional balance and increase motivation were seen by professionals as more useful than counting units. They saw the biggest challenge being patients/clients who did not perceive their heavy drinking as a problem. Drink diaries were used by some practitioners to support the process of change, but the general public informants did not think they would use them. Links between Cognitive Behavioural Therapy and motivational interviewing were recognised as a possible referral pathway.

Working with young adults as a target group

Young people were perceived as having different needs and drinking patterns from older adults and reacting differently to health messages. Raising drink as an issue was not a problem for youth workers, but young people felt they would be offended if a health worker asked them about their drinking. Long term health was not a trigger to cut down but life changes and legal and social problems with alcohol might be.

The format of resources was important and there was a gap in suitable resources to support brief interventions. There was a view that a brief intervention might be combined with a harm reduction approach. There was also a lack of national guidelines for interventions with young people and alcohol, compared to other topics. Web based resources were being used by some professionals with young people.

Health behaviour change in the prison setting:

Prison staff felt brief interventions were not usually appropriate in prisons because:

- prisoners were more likely to prioritise dealing with their drugs misuse rather than drinking
- the men commonly had very heavy drinking patterns when not in prison influenced by strong social pressures
- many prisoners were leading chaotic lifestyles outside
- there appeared to be little access to follow on support when they were discharged

Literacy was often an issue for resource development and comic strips were favoured.

Holistic versus topic specific approaches:

Most practitioners in the study preferred to introduce alcohol as part of a wider lifestyle intervention with other topics but would work on these separately. Although there were common underlying principles of motivational interviewing, they felt that topic specific work was necessary because:

- screening tools for alcohol did not transfer to other topics
- the strong cultural influence on alcohol was important
- alcohol specific resources were required
- the process of change was not the same for all lifestyle issues

Equality and diversity issues:

Many of these issues are interlinked, especially for people living in regeneration areas. There are issues which are relevant to delivering brief interventions and communication issues that are relevant for accessing resources:

- literacy, requiring simple text with appropriate visuals
- language barriers requiring resources translated into other languages or the use of interpreters, which was viewed as difficult with the sensitive nature of alcohol interventions
- access to service. This requires to be considered for many equality groups as brief interventions cannot be delivered if barriers to accessing services are not addressed
- blind and partially sighted people need large print and resources available as word or PDF documents which can be accessed through computer audio software
- people with learning difficulties require interventions from people who understand how they communicate, and resources need to be clear and concise but not childish or patronising
- different approaches are required for people with mental health problems depending on their condition as well as their level of drinking problems. There can be memory and concentration issues

General issues on using resources and recommendations for future resource development:

All professionals in the study favoured the use of resources to support brief interventions. They considered training to be essential for delivering effective brief interventions. Guidelines and screening tools were seen as useful but they should be brief and easily accessed.

Resource gaps were identified for older people and younger people and the community care setting. Guidelines for settings other than health were highlighted. More positive resources were suggested, since all the current ones seemed only to be effective if a person acknowledged they had a problem.

The booklet 'So you want to cut down on your drinking' was not given to clients or patients because it was viewed as inaccessible, but the interactive sections were used by practitioners with their clients / patients.

Discussion, conclusions and recommendations

- A range of HBC interventions were being delivered which relate to the target group and the opportunities and constraints of particular settings. There is blurring between series of brief interventions and medium to longer term interventions using motivational interviewing.
- Professionals made links between using brief interventions initially and the use of CBT as possible referral pathway for alcohol interventions that could be explored in developing guidelines.
- The findings indicated that professionals in the study were delivering brief interventions in a range of settings and felt that this was a legitimate area of their role.
- Professionals favoured the use of practitioner guidelines for health behaviour change which are short and succinct and easily accessible. Most current guidelines apply to health setting and there is a need for guidelines for other settings. Guidelines for professionals were the type of resource which scored highest in the resources review in relation to supporting a HBC approach.
- Confidence in the area of delivering health behaviour change was seen to be increased by provision of training, however, few of the training packs reviewed demonstrated a comprehensive HBC approach. HBC resources designed to support interventions need to be adequately supported by linked training, which might need to be designed for specific settings.
- In the categories of client based resources, written and web sites, there were few resources which demonstrated an HBC approach.
- Client based resources were viewed by professionals as important in supporting role legitimacy and adequacy. The social drinkers thought leaflets would have more impact if delivered in a health care setting, but required sensitivity.

- There was agreement that current resources are aimed at people who have already acknowledged they have a problem with drink. There is potential for more resource development which supports increasing motivation through decisional balance exercises, for example.
- Most of the social drinkers in our study were embedded in a heavy drinking culture, showed poor understanding of units and strength of drinks, found the sensible guidelines unrealistically low and would not be interested in cutting down their drinking. It may be useful to explore resource development which involves cutting down drinking as a positive choice, rather than focussing on creating awareness of a problem which requires a solution.
- There are important issues around resource development in relation to accessibility for particular equality groups. These involves addressing issues of literacy, languages other than English and resource production in special formats, e.g. large print or voice text accessible.
- Older people in a range of settings, especially in community care, have specific resource requirements and there is a gap in these resources being available.
- Motivational interviewing, brief interventions and harm reduction could be combined in developing resources for young people. There is a big gap for health behaviour change resources for this target group, as many are educational.
- There is limited support in this study for the development of a holistic HBC resource. While the principles and methods of motivational interviewing are core, there was agreement in the qualitative findings that each lifestyle topic was informed by a separate evidence base and required specific strategies to be effective in supporting change.

Recommendations for development of new resources which incorporate principles of health behaviour change

1. In developing the new resources suggested below we recommend further needs assessment specific to the setting, target group and use.
2. It would be useful to develop new resources to support the process of health behaviour change in a linked set comprising a training pack, practitioner guidelines and resources for clients.
3. New practitioner guidelines should be developed for settings other than health which incorporate screening tools, simple algorithms and interactive worksheets for clients. These guidelines could take the form of a generic, holistic core element supported by topic specific supplements.

4. There is merit in drawing on the model and format of resources available for cognitive behaviour change as these seem to be well used and liked by practitioners.
5. The guidelines should be supported by training, or be linked with existing training programmes in health behaviour change. Development of training for practitioners which is based on principles of health behaviour change would be useful to enable more practitioners to access training and increase confidence and skills to deliver brief interventions.
6. Written client based resources should be developed to support the practitioner guidelines, which could be used more widely on a self help basis. It is important that these are interactive and accessible and we commend the recommendations of the general public participants on page in particular avoiding the terms alcohol and problem on the front page.
7. These resources could be developed from the interactive parts of 'So you want to cut down on your drinking' and supported by an accessible booklet for practitioners.
8. Establish a new website which would provide a self help resource for the public using health behaviour change principles, or adapt an existing one.

Recommendations for further research

9. Investigate the potential role of brief interventions in specific settings such as prisons, youth work and social care settings.
10. Investigate the opportunities for and use of brief interventions in relation to people with mental health problems.

1. Introduction

1.1 Health Behaviour Change

“Health-related behaviour results from individual choices and these choices are influenced by the social structures and the social context of people’s lives. Together these factors affect people’s ability to make positive changes to their behaviour. Behaviour change is, therefore, very complex and difficult to achieve, both for the individuals who want to change and for the public health professionals who want to help them.

Many models and theories have been used to explain and support knowledge, attitude and behaviour change. Interventions based on these models and theories have generally been used at three levels.

- Individual-level interventions target people directly, for example, in clinics or classes, in families or in one to one advice or information-giving sessions.
- Community-level interventions and programmes e.g. setting up healthy living centres.
- Population-level interventions and programmes use legislation, national policies or whole-population campaigns (for example, mass media campaigns) to try to change people’s behaviour.”

Adapted from NICE (2007).

This study is concerned with the scope and quality of resources to support health behaviour change interventions in relation to alcohol consumption at the individual level identified by NICE above. Interventions designed to support individuals in changing their alcohol consumption can be self-help resources or resources to support professionals in discussing behaviour change with individuals.

Health behaviour change interventions on alcohol are more commonly known as “brief” or “minimal” interventions including brief motivational interviewing and typically follow a structure that can be described using the FRAMES acronym (ref. 45 from SIGN, 2003).

- *Feedback: about personal risk or impairment*
- *Responsibility: emphasis on personal responsibility for change*
- *Advice: to cut down or abstain if indicated because of severe dependence or harm*
- *Menu: of alternative options for changing drinking pattern and, jointly with the individual, setting a target; intermediate goals of reduction can be a start*
- *Empathic interviewing: listening reflectively without cajoling or confronting; exploring with people the reasons for change as they see their situation*
- *Self efficacy: an interviewing style which enhances peoples’ belief in their ability to change.*

This study is concerned with interventions for health behaviour change (HBC) which fall into one of two categories:

1. Interventions lasting between 3-15 minutes where there is a basic professional level of HBC expertise and communications skills required (can be referred to as opportunistic 'brief advice', 'brief intervention' or 'brief negotiation').
2. Interventions lasting 15-40 minutes where there is an advanced level of expertise and skill required (i.e. help seeking situations, 'HBC Counselling'¹, 'brief motivational interviewing' or 'adaptations of motivational interviewing').

The term brief intervention is used throughout this report to refer to a health behaviour change intervention with individuals on alcohol consumption which falls into one of the categories above.

1.2 Aims and objectives

This research project aimed to review the current use and appropriateness of existing (HBC) resources on alcohol by a variety of professional audiences within a range of settings. This included the following specific objectives:

1. Identify, map and review the range of existing alcohol HBC resources currently being used nationally and locally across a variety of settings.
2. Review the relevance of current resources available and whether they meet NICE guidelines and/or SIGN guidelines.
3. Review the evidence base for the link between topic areas to inform the development of future resources that take a more holistic approach to lifestyle change.
4. Identify and establish the views of a range of stakeholders regarding the potential use and format of existing resources and to make recommendations regarding the development of future alcohol HBC resources.
5. Identify the perceived needs and appropriateness of resources for the public with regard to HBC resources especially for those experiencing health inequalities.

In carrying out the research, the following working definition of an alcohol HBC resource was developed and used:

What we mean by a “health behaviour change (HBC) resource on alcohol” is:

A resource (paper or otherwise) which does more than simply provide facts or information on alcohol but is designed to support people to reflect on their drinking and make changes, or to help professionals to support people to do this.

The resources should be structured in a way that supports Behaviour Change. This will most likely be resources that follow, or at least loosely follow a brief interventions structure such as “FRAMES” (Bien et al., 1993) or something similar and that use a motivational interviewing style (Miller and Rollnick, 2002).

¹ As noted in the tender brief, the use of the term 'counselling' is problematic in this context but has been used in the publication (Miller, W.R and Rollnick, S, ed. (2002) *Motivational Interviewing: Preparing People for Change*, London, The Guilford Press. The term counselling gives rise to the perception that only trained counsellors can provide interventions at level 2, whereas this is not the case.

This piece of work forms part of a larger programme of work on Health Behaviour Change at NHS Health Scotland which will involve the development of practitioner and client resources to support behaviour change on a variety of topic areas, the provision of practical guidance on techniques and strategies for HBC and the development of a training for trainers programme.

1.3 Research methods

The method for the study involved three distinct elements:

1. Review of Resources:
 - a. Desk based scoping exercise to gather resources
 - b. Development of framework to review and assess resources
2. Review of literature for evidence base for comparison between a holistic and a topic based approach to health behaviour change.
3. Focus groups and interviews with key informants drawn from the general public and relevant professionals.

The three elements of the method are reported in more detail in the following chapters in the report:

Chapter 2:

- Examination of key guidelines for alcohol health behaviour change practice and review of the current evidence base to inform the development of a framework for reviewing alcohol HBC resources.
- Consideration of key published and grey literature comparing holistic versus topic-specific approaches to Health Behaviour Change practice and training.

Chapter 3:

- Development of framework for the resource review.
- Identification, mapping and review of resources currently in use in Scotland or particularly relevant resources UK-wide.

Chapter 4:

- Qualitative research with professionals and the general public to gather more detailed data on appropriateness of resources, and needs for future resource development.
- In-depth interviews with key informants with specific knowledge of the needs of equality groups.

2. Literature Review

2.1 Current guidance and evidence Base

Current guidance and research on health behaviour change (HBC) around alcohol issues can be found in two areas. General HBC guidance and research that has a holistic focus (i.e. is not topic-specific) and HBC guidance and research that is specifically related to alcohol. HBC guidance or research relating to other topics may also have relevance to the implementation of HBC for alcohol. The following discussion refers to key documents in each category and is not intended to be a comprehensive review of the literature.

2.1.1 Alcohol-Specific HBC Guidance & Research

Recent guidance relating to HBC interventions for alcohol can be found in the Scottish Intercollegiate Guidelines Network Guideline 74 on the management of harmful drinking and alcohol dependence in primary care (SIGN, 2003). This key document provides a clear review of the research evidence in this field within the primary care setting. It also makes unambiguous recommendations for practice based on the available evidence. Key findings from this document relevant to the current review include:

- there is consistent evidence from a large number of studies that brief intervention in primary care can reduce total alcohol consumption and episodes of binge drinking in hazardous drinkers for period lasting up to a year.
- the optimum type of intervention is still to be defined – sometimes advice is given, while other times a motivational interviewing style is used.

It is noted in the SIGN guideline that very brief interventions (5-10 minutes) may have a similar effect to extended interventions (20-45 minutes or several visits) although the evidence was inconsistent. A key recommendation of SIGN is that:

“Primary care health professionals should opportunistically identify hazardous and harmful drinkers and deliver a brief (10 min) intervention.”
(Moyer et al., Kahan et al, 2005, see SIGN (2003) for a complete list of references.)

SIGN emphasises the importance of training for healthcare providers and provides guidance on how practitioners should initiate health behaviour change discussions with clients in an opportunistic fashion:

“Training healthcare providers in the use of structured interventions enhances the efficacy of brief interventions.”

“The intervention should, whenever possible, relate to the patient’s presenting problem and should help the patient weigh up any benefits as perceived by the patient, versus the disadvantages of the current drinking pattern.”

The SIGN guideline provides advice for the delivery of brief interventions in primary care, accident and emergency settings and in the antenatal setting. There is no equivalent guidance available for other settings and the evidence base is much

weaker for the use of brief interventions outside of healthcare situations. This is primarily due to the lack of research rather than a body of negative findings. Apart from the lack of evidence, it is not easy to “translate” the findings of SIGN to other settings. The practicalities of delivery of brief interventions in non-health settings and the legitimacy of non-healthcare workers questioning clients about alcohol issues may be very different.

When exploring the use of brief interventions in other settings Cambridge and Strang's (2004) multi-site cluster randomised trial in Further Education colleges found that a single session of motivational interviewing is effective in reducing multiple drug use (cigarettes, alcohol and cannabis) amongst young people, when compared to a non-intervention control. Monti et al. (2001) and Baer and Peterson (2002) have also shown brief interventions and motivational interviewing to be effective at reducing alcohol related risk in 18 to 19 year olds but less successful in those aged 13 to 17. The Brief Interventions (BI) and Motivational Interviewing (MI) techniques may be a useful approach for outreach or initial engagement as the brief format is appropriate for use in informal settings (Baer and Peterson, 2002). This is thought to make brief interventions ideal for community work, detached work and drop-in youth centres (Winterbottom, 2005).

A recent study of brief interventions in community pharmacies emphasised the importance of adequate training especially when implementing this kind of work in a novel environment (McCaig et al., 2007). In a study of brief intervention provision by nurses in 2001, Kaner et al. found that skills-based training was both the most effective and cost-effective implementation strategy (Kaner et al, 2003).

Moyer et al (2002 – in SIGN) found that the evidence does not support the use of brief interventions for more severely affected individuals who are or who may be dependent on alcohol. If such individuals were to suddenly stop drinking without specialist support, the sudden withdrawal can be dangerous and has been known to result in alcohol-related brain damage. This may have parallels with interventions on physical activity where sudden involvement in vigorous exercise without supervision may be dangerous. Brief interventions are effective for individuals who are either “hazardous drinkers” - those who regularly drink more than the recommended daily drinking limits or “harmful drinkers” – those whose drinking is in some way causing them harm at the current time. This does not suggest that motivational interviewing techniques do not have a place in treating dependence but that in such cases they should be delivered by specialists in alcohol treatment services.

The importance of objective screening tools to determine an individual's current risk and level of drinking when deciding whether or not they need or are appropriate candidates for a brief intervention is emphasised in the alcohol HBC literature. There is a large volume of good quality evidence indicating that appropriate screening helps the detection and treatment of alcohol problems and there is a range of related guidance on this topic (Alcohol Concern, 2002; WHO, 2001). Again, it is worth noting that this evidence relates to healthcare settings and “screening” therefore relates to whether or not the alcohol consumption is adversely affecting or hazardous to the drinker's health. For professionals in non-healthcare settings, other adverse effects of alcohol are likely to be more immediately relevant such as impact on family or relationships, career or education, links to crime or violence and so on.

Some significant trials of brief interventions for alcohol in a range of settings have recently been funded or are in the planning stage. It was recently reported at the conference of the International Network on Brief Interventions for Alcohol, that a team has been commissioned by the Department of Health to implement the “Alcohol Screening and Brief Intervention Trailblazers” programme or SIPS. The programme consists of three cluster randomised controlled trials investigating the best method of helping people who attend primary care, accident & emergency and criminal justice agencies in England (www.sips.sgul.ac.uk). In addition, the team responsible for the drinking interventions in pharmacies study (McCaig et al., 2007) is collaborating with Kaner et al., in the development of a randomised controlled trial in the pharmacy setting.

Finally, it is worth noting that there is little evidence from the literature on how to design effective HBC *resources* for alcohol rather than how to deliver interventions. The SIGN guideline does outline however that there is some evidence that the use of written media such as booklets or leaflets enhances the efficacy of brief interventions (Mullen et al., 1997 - ref 60 from SIGN).

2.1.2 General HBC Guidance & Research

Guidance relating to HBC generally, rather than specifically relating to alcohol interventions, can be found in the following key international and national publications:

1. Health Behaviour Change: A guide for practitioners, Rollnick et al., 1999.

This book aims to provide health professionals with “a method they can use to help patients make health behaviour (sic) change in both hospital and community settings”. Focusing solely on interventions with individuals, this is a seminal text on how to discuss HBC with patients.

2. Motivational Interviewing: Preparing people for change, Miller & Rollnick, 2nd Edition, 2002.

This is the updated and expanded second edition of this definitive text on the theory and practice of motivational interviewing (MI). The book explores the conceptual and research background supporting MI, elucidates guiding principles and then provides a practical description and examples of the approach and learning about the approach.

3. Health behaviour change training guidance, Jenkins for NHS Health Scotland, 2005.

This brief report is aimed at those wishing to organise or commission health behaviour change training and it gives some pointers on what should be included in such a training course. For the skills development aspect of training, the report refers readers to the first document above.

4. Generic and specific interventions to support attitude and behaviour change at population and community levels NICE public health programme guidance 1 (DRAFT), National Institute for Clinical Excellence, April, 2007.

Although this guidance will not be finalised until October 2007, these draft findings are based on 9 evidence reviews which were commissioned by NICE. Some of the recommendations are relevant to HBC interventions with individuals or related training.

These documents are relevant to this study in that they play an important role in guiding current practice in delivering HBC interventions in general. However they make little reference to what resources to support HBC should look like. In the absence of any specific resource related guidance or evidence, they have been used (along with the alcohol specific research evidence above) for the development of a set of criteria by which the alcohol HBC resources found in the research were assessed. This assessment framework is described in the next chapter.

In addition to current guidance, there is a modest body of research emerging in relation to HBC generally (rather than relating to specific health behaviours). One key point emerging in the research literature is a concern that the quality of practitioner skills and the actual interventions delivered in the reported trials in this field may not be adequate. In some trials of effectiveness, training provided to practitioners is minimal, and there is poor assessment of the quality of interventions provided. This has led to speculation that some weak or negative results may be the result of poor quality interventions (Jenkins, 2005). A further key finding (Riemsma, 2002) in relation to the combination of HBC interventions with a Stages of Change model of intervention is that there is little evidence to suggest that stage-based interventions are more effective than non-stage based interventions.

2.2 Current Practice

In addition to the research and guidelines on HBC, there is a growing body of data that provides information on practitioners' current levels of knowledge and practice. In 2003, Greater Glasgow NHS Board commissioned a project investigating the relevance of a range of training competencies on substance misuse for non-addiction specialists especially health and social care practitioners. Very few of the practitioners in this study had heard of SIGN Guideline 74 and most reported a lack of confidence in relation to this competency.

In a training needs assessment of health visitors seeking training on alcohol and drug issues in 2003 (Fitzgerald), more than half the sample had no previous training on the topic. Perceived knowledge of brief interventions was low, with only 14% of respondents feeling they understood this issue well or very well. A more recent national survey of community pharmacists (McCaig et al., 2007) found that very few respondents (5%) currently advise clients on alcohol consumption once a week or more and 29% had never done so. In addition, 40% lacked confidence in screening and providing a brief intervention on alcohol. In a small needs assessment of youth workers and community workers in 2006 (Dowds) commissioned by the Glasgow South East Community Health & Care Partnership, all respondents indicated low levels of knowledge of motivational interviewing.

There is also some available research on what factors influence practice in this field including the work of Kaner et al. (2003) who found that written guidelines alone were less successful than a combination of guidelines, training with/without outreach support in increasing the level of provision of brief interventions on alcohol by nurses in primary care.

2.3 Holistic Versus Specific Approaches

The evidence-base for HBC interventions on alcohol issues is strong and clear recommendations can be made in this field. In contrast, while research regarding the effectiveness of motivational interviewing and its adaptations indicates some potential for a wide range of topics e.g. diet, sexual health, physical activity and smoking cessation (Riemsma, 2002; Burke, 2002; Dunn, 2001), the evidence is less well developed. However, as pointed out by Jenkins (2005), the weakness of the evidence is largely to do with the lack of adequate research rather than a body of negative findings.

The remit of this aspect of the literature scoping was to review the evidence base for linking separate topic areas to inform the development of future resources which take a more holistic approach. This encompasses the following questions of interest:

1. What balance should there be between providing professionals with training on the generic skills required to provide an HBC intervention versus the specific information and skills required to deliver an intervention on an individual topic? What is more effective, feasible and acceptable for professionals and training providers?
2. Should HBC interventions focus on addressing specific topics with individuals, or should they begin holistically, allowing the individual to then decide what issue they wish to discuss further? Which option is more effective, feasible and acceptable to clients and professionals?

The answers to both of these questions will impact on the nature and content of HBC resources. In seeking answers to these questions we attempted to find key research reviews for HBC for other health issues or in general from recognised sources including the following:

- the National Institute for Clinical Excellence
- the Cochrane Database
- the NHS Health Technology Assessment Programme
- key national topic specific websites e.g. Alcohol Concern, Ash Scotland and government websites e.g. NHS Health Scotland; UK Department of Health etc
- key peer reviewed journal articles that discuss these questions

The key findings are presented here and a full list of the documents found is outlined in the reference section.

The rationale for a holistic approach to health behaviour change is that many health conditions such as diabetes, cardiovascular disease and obesity are affected by a range of risk behaviours such as smoking, lack of physical activity, overeating, alcohol consumption and so on. It is also suggested that addressing multiple risk behaviours at once may provide an efficient use of professionals' time than addressing each behaviour separately (Pronk et al., 2004).

One very recent study of interventions to stop smoking, increase physical activity and reduce dietary sodium intake concluded that addressing multiple behaviours sequentially was not superior to, and may be inferior to, a simultaneous approach (Hyman et al., 2007). We were unable however to find any robust reviews of

research on the relative effectiveness of addressing single or multiple behaviours. One review concludes that “large gaps remain in our knowledge about the efficacy of interventions to address multiple behavioural risk factors in primary care” (Goldstein et al., 2004).

The primitive nature of research in this field was discussed by Nigg et al. in 2002 and many of the points they raise are still valid. They note that “the critical questions of interest are:

- Is it valuable to work on multiple behaviours simultaneously or should one behaviour be addressed at a time?
- What are the key behavioural constructs and processes common to these problem behaviours?
- How do multiple behaviours interact to increase or decrease health risks?”

They also note that it is currently unknown whether addressing single risk behaviours at a time is more or less effective than addressing multiple risk behaviours and, if so, why.

“Treating multiple behaviours may have a positive effect due to the multiple exposures to the principles of behaviour change. Conversely, treating multiple behaviours may be less effective due to the increased response burden produced by trying to change several behaviours at once. Moreover, there may be a maximum number or hierarchy of order of behaviours that individuals can better cope with trying to change at any given time and with different incentives. Understanding the best ways to change multiple risk behaviours and what motivates those changes is essential for designing effective intervention programs” (Nigg et al., 2002).

Thus, there is still much that is unknown about the relative effectiveness of holistic versus specific approaches to health behaviour change. In the absence of empirical data, we have sought to compare existing guidance for health behaviour change interventions for single topics/behaviours with a view to drawing out any similarities. Key documents are compared in Table I. As the only guidance, albeit draft, that refers to HBC generally, it is worth highlighting the findings of the most recent NICE report (2007) in relation to the contents of HBC interventions with individuals on any health topic:

Recommendation 5 (NICE, 2007)

Commissioners and practitioners working with people who are motivated to change their health-related behaviour should provide interventions that:

- Aim to make it feasible for people to change their behaviour
- Enhance and develop people’s skills to help them make positive changes
- Help and support individuals to plan in advance for situations where they might feel tempted to revert to behaviours which could damage their health.
- Focus on the feasibility of change and its benefits.

Guidance On:	Alcohol (SIGN, 2003)	Cardiovascular Disease (SIGN, 2007)	Physical Activity (NICE, 2006)	Smoking (NICE, 2006)	Generic Behaviour Change (NICE, 2007)
HBC Intervention Components	<ul style="list-style-type: none"> Validated screening tool recommended. Advocates 10 minute interventions relating to presenting issue and helping patient weigh up benefits and disadvantages of current behaviour. Based on FRAMES (and MI including Portraying empathy; developing discrepancy; avoiding argument; supporting self-efficacy and facilitating and reinforcing self-motivating statements. The evidence on follow-up is inconclusive. 	<ul style="list-style-type: none"> Addresses a range of risk factors separately and refers to national guidance. Various validated risk assessment tools recommended. Interventions to improve diet should be based on educational competencies (improved knowledge, relevance, individualisation, feedback, reinforcement and facilitation. No guidance on the practicalities of addressing multiple risk factors with clients. The guideline is positive about cognitive behavioural therapy and motivational interviewing but notes the lack of evidence for a stages of change approach. 	<ul style="list-style-type: none"> Validated screening tool recommended. When providing advice practitioners should take into account the individual's needs, preferences and circumstances. They should agree goals with them and provide written information about benefits of activity and local opportunities to be active. Several follow-up sessions over a period of 3-6 months recommended. 	<p>Advocates 5-10 minute interventions including one or more of:</p> <ul style="list-style-type: none"> Simple advice to stop. Assessment of commitment to quit. Offer of pharmacotherapy or support. Provision of self-help material and referral to stop smoking services. No evidence to support stages of change approach. 	<p>Interventions should:</p> <ul style="list-style-type: none"> Aim to make it feasible for people to change their behaviour Enhance and develop people's skills to help them make positive changes Help and support individuals to plan in advance for situations where they might feel tempted to revert to behaviours which could damage their health. Focus on the feasibility of change and its benefits.
Training for HBC	Training in the identification of hazardous drinkers and delivery of an intervention and in MI should be available.	Notes importance of "therapist training, skill and competence". Cites evidence that proficiency is best gained by adding specific feedback and/or coaching to workshop participation.	No discussion.	Training only mentioned in relation to provision of pharmacotherapy or stop smoking counselling rather than brief opportunistic interventions.	National training standards are needed. All involved in providing HBC interventions should "receive appropriate training".
Resources for HBC	Notes that the use of written media such as booklets or leaflets enhances the efficacy of brief interventions. No further detail.	No discussion.	Recommends written information (as above). Insufficient evidence to distinguish interventions that tailored materials to individuals or used standard materials.	No discussion.	No discussion.

Table 1: Comparison of Guidance on Single Topics & Generic HBC Guidance

None of the documents provides specific guidance on the format or content of self-help or training resources. The comparison of guidance illustrates that there are some similarities between what is recommended in terms of the style of a brief intervention for each topic. Provision of feedback, individualisation, and goal setting appear in more than one guidance and motivational interviewing recommended in most. Despite these similarities, the table illustrates key differences in terms of duration of intervention, the need for and nature of screening tools, the need for and level of follow-up recommended and the use of written/self-help resources. These differences may make separate topic-based training for professionals a more realistic and less confusing approach than training addressing skills and application to topics separately. There is also suggestion from previous work that role-play, along with coaching & feedback (Miller, 2004) are essential aspects of effective training on HBC. If role-play was included for a range of topics, it would be necessary for professionals to have topic-related factual information and screening knowledge prior to being able to practise the skills required. It is not clear how well this would work in practice.

Thus the key learning points which have emerged from the review of the literature and the guidance on HBC are:

- the guidance, including screening tools, is directed solely at the health care setting and is based on evidence for effectiveness from that setting
- there is some limited evidence for effectiveness in other settings such as community and education settings with young people, but there is also evidence from current practice that practitioners' knowledge of motivational interviewing and brief interventions is low in these settings and also in some primary health care practitioners
- there is a lack of robust evidence for a holistic approach to HBC which addresses multiple risk behaviours in the same intervention
- it is apparent from comparison of the guidance as a whole that each risk behaviour has its own specialist body of knowledge about risk assessment, strategies for behaviour change and evidence-based approaches to intervention.

3. Scoping and Review Of Alcohol HBC Resources

3.1 The Resource assessment framework

In order to objectively review the quality of existing alcohol HBC resources, an assessment framework was developed based on existing guidance and evidence. As noted above, the existing evidence base relates to how to approach and deliver a one to one intervention to change health behaviour but does not specifically discuss the format or content of an effective health behaviour change resource. The resulting frameworks were therefore based on the extent to which a resource included the components which were referred to in the guidance and evidence for a health behaviour change intervention to be effective.

Three assessment frameworks were developed to be used with different types of alcohol HBC resource and are shown in the following tables

Table 2

- Type 1: Self-help leaflets, booklets, workbooks, electronic resources
- Type 2: Self-help websites.

Table 3

- Type 3: Guidelines, recording tools or prompt sheets for practitioners in delivering HBC interventions on or including alcohol.

Table 4

- Type 4: Training packs for practitioners on the delivery of HBC interventions on or including alcohol.

Each of the six overall criteria were rated from 0-5 based on the following scale:

0= Not at all

1= Very brief information provided;

2= In between

3= Some information provided

4= In between

5= Detailed information provided, opportunity to enter own answers

Prior to assessment using the appropriate framework, a cover sheet was completed for each resource to provide a basic description of each one. A copy of this is provided in Appendix A. A system of cross-checking between members of the research team was used to maximise objectivity in the application of the review framework.

Table 2: Framework & Criteria for Resource Types 1 & 2	References (see below)	
1. Introduction: Does the resource...		
Have clear structure with sections?	8, 9	
Adopt an overall empathic tone?	1, 8, 9,	
Include opportunities for client to actively assess own drinking?		
Establish rapport by addressing client's thoughts and feelings?	4, 6, 8	
2. Identify the problem:		
Raise the issue and explain different types of alcohol problems?	2, 8	
Accurately explain units/quantities of alcohol?	4, 5	
Explain up to date recommended sensible drinking guidelines?	5,	
Use any kind of screening or assessment? If so, which/how does it do this? (Daily limits/AUDIT/FAST/CAGE...)	4,	
Give personalised feedback based on results of screening/assessment?	1, 9	
Offer a normative comparison?	4	
3. Assess readiness to change:		
Assess importance of change to individual?	8,	
Assess confidence in ability to change (self-efficacy)?	7, 8, 9	
Assess readiness to change?	8	
... in relation to Stages of Change model?	1, 3	
4. Engage with motivation to change:		
Assess existing knowledge and understanding of risks of behaviour?	3, 8	
Examine the pros & cons from client perspective (develop discrepancy)?	1, 2, 3, 8	
Provide accurate information on:		
...additional benefits of cutting down or abstaining?	1, 2, 3, 6, 9	
...potential negative consequences (physical, psychological, financial, and social)	1, 2, 3, 4, 9	
Encourage emotional attachment to changed behaviour?	3, 8	
Facilitate self motivating statements?	1, 2, 3, 8	
Show empathy with resistance to making changes?	2, 3, 8	
Facilitate exit if not ready to change?	3, 5, 8, 9	
Emphasise personal choice and control?	3, 8, 9	
Re-assess readiness, importance or confidence?	1, 8, 9	
5. Provide a menu of options and negotiate goals:		
Elicit patients concerns in achieving goal (perceived barriers)?	8, 9	
Explore potential solutions and coping strategies?	1, 7, 9	
Acknowledge past efforts: successes and failures?	7, 8	
Acknowledge the importance of family and peer reinforcement?	9	
Encourage the client to set realistic goals?	2	
6. Indicate options for further support and/or follow up:		
Signpost to ongoing support or review?	6, 9	
Recommend onward referral to specialist support for dependent drinker?	9	
Offer guidance for relapse management?	9	
References:		
1. Barry, (1999).	4. Monti et al., (2001).	7. NICE, (2007).
2. Jenkins, (2005).	5. NICE, (2006a).	8. Rollnick et al., (1999).
3. Miller & Rollnick, (2002).	6. NICE, (2006b).	9. SIGN, (2003).

Table 3 illustrates the additional criteria and main adaptations to the first assessment framework which were used when assessing resource Type 3 above. Each of the seven overall criteria were rated from 0-5 based on the following scale:

- 0= Not at all;
- 1= Evident but not expanded upon;
- 2= In between;
- 3= Some information provided;
- 4= In between;
- 5= Detailed information/tool/resource provided.

Table 3: Additional Criteria for Type 3 Framework	References (as above)
1. Introduction: Does the resource support the practitioner to... Structure the intervention? Adopt an overall empathic listening approach with open ended questions? Include the background to & evidence for HBC & MI?	8, 9 1, 8, 9, 2
2. Establish rapport: Address physical setting? Establish rapport by addressing client's thoughts and feelings?	8 4, 6, 8

Table 4 illustrates the additional criteria and main adaptations to the first assessment framework which were used when assessing resource Type 4 above. Each of the seven overall criteria was rated from 0-5 based on the following scale:

- 0= Does not mention at all;
- 1= Mentions but doesn't expand upon;
- 2= Discusses and provides references to theory;
- 3= Applies knowledge to practice appropriate for practitioner role E.g. role-play/case studies;
- 4= Provides opportunities for in depth practice with self assessment and individualised feedback;
- 5= Provides a system for reflective practice in the future.

The following alternative scale made more sense for some items: 1= Mentions, 5=Covers in-depth.

Table 4: Additional Criteria for Type 4 Framework	References (as table 2)
<i>Does the resource train the practitioner to...</i> 1. Introduction: Structure the intervention? Adopt an overall empathic listening approach with open ended questions? Theory & evidence for HBC approaches? Theory & evidence for MI approaches? Relevant national and/or local policy context? Discussion of systems structures (e.g. needs assessment, systematic recording) as mentioned in HBC Training Guidance?	8, 9 1, 8, 9, 2 2 2 2
2. Establish rapport: Address physical setting? Establish rapport by addressing client's thoughts and feelings?	8 4, 6, 8

3.2 Identification of Resources

Using our definition of a Health Behaviour Change resource as outlined in section 1.2, we sought resources in the four categories described below, with the addition of electronic resources – DVDs and CD Rom. Since none were found in the last category, this section was dropped from the assessment framework.

Categories of Resources Sought

1. Client Oriented Resources – Written

- Leaflets/booklets/drink diaries but only those intended to support HBC.

2. Client Oriented Resources – Web-Based

- Online screening & self-help guides.

3. Client Oriented Resources – Other electronic – DVD/CD Rom etc.

- Not teaching packs for group work, one to one HBC resources only.

4. Professional Oriented Resources – Guidelines/Supporting Documentation for Discussions – Written

- Local pointers/instructions for carrying out a brief intervention.
- Step by step instructions.
- Protocols for research-based interventions
- Leaflets designed to support HBC
- Prompt sheets

5. Professional Oriented Resources – Training Packs

- Actual training designed to support professionals to deliver brief/HBC interventions on alcohol.
- Packs for delivery by a trainer or for self-directed study.

The resources for professionals were those which focused on providing HBC interventions at two levels as described on page 5, shorter 3-15 minutes interventions and those lasting 15-40 minutes. Resources designed to support an ongoing counselling role with clients were not sought as part of this research. Some useful resources of this nature were identified which contain short assessment tools which would be valuable in the development of some aspects of future alcohol HBC resources.

Resources were sought by reviewing the library catalogues of health promotion libraries Scotland-wide as well as Alcohol Focus Scotland and Alcohol Concern, telephone contact with individual practitioners at local councils on alcohol, and email contact with individuals identified as having an alcohol remit at local health boards or alcohol & drug action teams. This was supplemented with extensive web searches for online resources and other relevant materials in the rest of the UK.

The following resources were identified and assessed using the frameworks. A further four practitioner training packs were identified which could possibly be HBC resources but could not be obtained in time for the review. All the resources identified are described in detail in Appendix B, including those not reviewed.

- 8 Written self-help resources (Type 1)
- 4 Web-based self-help resources (Type 2)
- 10 Practitioner guidelines/"prompt sheets" (Type 3)
- 7 Practitioner training packs (Type 4)

3.2.1 Electronic Resources

No electronic resources such as DVDs or videos that fit with our definition were identified, leaving the four types of resource outlined here.

3.2.2 Written and Web-based Self Help Resources

All of the self-help resources both web-based and written were aimed at the general public and none were designed for use in any specific setting. There may be scope for more setting-specific resources which have less of a health focus. No library or contact referred to any resources for specific equality groups. There is a need to consider how specific resources would be developed and used in practice. For example, it may be that existing resources could be adapted to be more suitable (particularly web-based resources) or that different versions would be produced. This issue is discussed further in the findings from the qualitative data in Chapter 3 and the discussion.

Most of the local councils on alcohol to whom we spoke indicated that they used resources from Alcohol Focus Scotland (AFS). While there are many short leaflets available to the public on alcohol (including a whole series through AFS and a new series published jointly by Scottish Executive in partnership with AFS and NHS Health Scotland), and there are also many counselling techniques and guidelines to which some professionals referred, this left a gap for individuals who needed more than a leaflet but less than counselling. The resources we found that attempted to fill this gap were the *So You Want to Cut Down Your Drinking*, the AFS drinks diary and the *Think About Drink* resource. These are reviewed below however it is worth noting the limited number of resources of this nature.

We did not seek out resources for the under 16s. However there are many alcohol leaflets available for young adults but these tended to be educational and have a harm reduction focus rather than trying to get people to cut down for health reasons.

3.2.3 Professional Guidelines and Training Packs

Many of the professional guidelines and training packs were quite old. We also identified a number of other training packs which could not be considered health behaviour change resources and had clearly not been designed with health behaviour change theory in mind. There are also a whole host of alcohol teaching packs for professionals to use with groups especially for young people, but again these did not fit with the HBC approach which is focused on one to one interventions.

Not surprisingly the professional guidelines (Resource Type 3) were generally setting specific, but the vast majority were for primary care staff including some specifically for GPs and community pharmacists. We found one resource that was for professionals in general, though had a health focus: *Get the Full Bodied Facts – practitioner folder* (Resource 3.5). We also found one which was designed for use in youth work settings: *Recording Sheet for Alcohol Interventions* (Resource 3.2). This also reflects the balance of research into current practice on brief interventions on alcohol discussed in the literature review.

The practitioner training packs which were identified were much more likely to be aimed at a particular group or setting and covered a wide range including youth workers, GPs, care workers, health trainers and other packs and a couple of packs which were aimed at working with older people. Once again, many were old and a

significant number of training packs on alcohol were not written with a health behaviour change focus.

The on-line survey designer 'Survey Monkey' was used as an additional way to scope what alcohol resources practitioners were accessing and using. The aim of this was to ensure that core resources had not been missed in the review process. The link to Survey Monkey was sent via e-mail to each ADAT team across Scotland in addition to key contacts in youth organisations, health boards and in the voluntary sector. A minimum of forty people received the e-mail as the first point of contact, with requests to forward it on to known contacts.

A total of 32 responses were received. The majority of respondents worked as health promotion/public health workers (n=12), youth worker (n=5) and addiction workers (n=5). The remaining respondents identified themselves as community workers (n=3), ADAT staff (n=4) a social worker, psychologist and new deal advisor. Respondents were asked to outline which HBC resources they had used and with what client groups. The results showed that all the resources highlighted were either included in the review or had been discounted as they did not match the working definition of an HBC resource.

3.3 Results of Resource Assessment

This section provides information on the review of each of the identified resources against the above frameworks. As noted above, the framework relates specifically to the Health Behaviour Change approach and the reviews are based on the information available in each resource as to its purpose and scope.

The review is not intended to provide an objective rating of the resource in general, but only of how it reflects health behaviour change theory and practice. The final score assigned to each resource should not therefore be viewed as providing an indicator of the overall quality or value of a particular resource for other purposes. The resource may not have been developed using a Health Behaviour Change approach and the criteria for scoring may not have been acknowledged at that time.

The following tables show the review of each of the four categories of resource according to the criteria listed in Tables 2-4

3.3.1 Framework Criteria Headings for Types 1 & 2: scored 1-5

Table 5: Written self-help resources

Sections of the Framework:

1. Introduction
2. Identify the problem
3. Assess readiness to change
4. Engage with motivation to change
5. Provide a menu of options and negotiate goals
6. Indicated options for further support and/or follow up.

Code	Title	Author, Date, Publisher	Description	Score for Section of Framework:						Score /30
				1	2	3	4	5	6	
1.1	So you want to cut down your drinking?	Heather, N & Robertson, 2003, NHS Health Scotland	A self-help manual for people who wish to cut down their drinking including a pocket drink diary.	5	3	2	3	4	3	20
1.7	Think About Drink	Jeannette Chantler, Date unknown, Alcohol & Drugs Support South West Scotland	Self help guide and drinks diary booklet designed for people who have drinking problems and also people at risk of health problems. Provides advice on low-risk drinking limits, good reasons for drinking at these levels and advice on changing habits	5	3	0	2	4	4	18
1.9	DRAMS Scheme: Helping Problem Drinkers – Skills for the General Practitioner (Patient Booklets).	Ian Robertson, 1990?, Scottish Health Education Group	4 patient booklets "How much do you drink?, Cutting down, Coming off and Keeping going" designed to be given to patients by GPs	5	2	2	3	4	2	18
1.6	Drink diary and self help guide	Author unknown, 2005, Alcohol Focus Scotland	Originally adapted from "So you want to cut down your drinking" designed to provide information for those wishing to adopt a relatively harm-free style of drinking	4	3	0	1	4	3	15
1.3	Alcohol and Sensible Drinking	Sandra Johnston, 2004, NHS Greater Glasgow STEPS	Booklet for people who would like to cut down on their drinking (part of a training course on Stress Control)	4	3	0	1	3	3	14
1.5	Get the full bodied facts (booklet) See also 3.5	Author unknown, Date unknown, Scottish Executive/ Gender Issues Network on Alcohol	Booklet for women containing factual information, tips for staying safe, hints on cutting down, advice for coping with another's drinking and sources of further help	3	3	0	1	1	2	10
1.2	Recognising Problem Drinking	Author unknown, 2007, NHS Health Scotland & AFS	Leaflet designed to help people spot a problem with alcohol and find out what they can do about it.	3	2	0	1	0	3	9
1.8	Alcohol & Healthy Living	Author unknown, 2007, NHS Health Scotland & AFS	A leaflet "guide to how you can enjoy alcohol & stay healthy".	1	2	0	0	1	1	5
		Average Scores:		3.8	2.6	0.5	1.5	2.6	2.6	13.6/30

The resources that scored best using the HBC review framework tended to be longer, however, this raises other difficulties including:

- less accessible, particularly those with literacy or language difficulties
- less likely to be picked up and used by someone with no prior awareness of the risks of their current drinking pattern.

This makes this type of resource more likely to be used by a professional in discussion with a client, and where the client wants some help in making changes to their drinking. On the other hand shorter leaflets, Recognising Problem Drinking (Resource 1.2) and Alcohol and Healthy Living (Resource 1.8) scored poorly in terms of the HBC approach but may be considered more "user friendly" and accessible. It is

possible that some balance between these two could be achieved. This is discussed more fully in the 'Discussion' section in light of suggestions made in focus groups on the development of resources.

Of the best resources, it is possible that the resource Think About Drink (1.7) provides some balance in that it is not as long as So You Want to Cut Down Your Drinking, but still included most of the key elements. Think About Drink and the Alcohol Focus Scotland Drinks Diary (1.6), could perhaps be made more attractive/colourful to encourage their use without a professional's input.

Overall, self-help resources (especially the shorter ones) tended to be poor at helping people to assess their readiness to change and engage with their motivation to change. The assessment of readiness to change ties in with the stages of change model which is less evidence based, but the engaging with motivation to change criterion is a core part of the motivational interviewing style and therefore is more of a concern. This may be a reflection on the purpose of the resources, most of which did not seem to have been specifically designed with HBC theory in mind.

The shorter leaflet-style resources could be improved to incorporate more of an HBC approach, even without increasing length. It is worth noting that there is no evidence to suggest that the inclusion of an HBC approach within such resources is more effective than the information style currently used. The HBC evidence relates to consultations/discussions rather than resources per se, particularly resources for individuals to read by themselves without practitioner input.

3.3.2 Type 2: Web-based Self Help Resources

Overall, web-based self help resources scored poorly, particularly on two criteria of assessing and engaging with motivation to change. Although this is similar to written resources it is surprising considering the flexibility that can be offered in web based resources. Compared with written resources it should be easier for websites to include a greater range of self-assessment, scale questionnaires (e.g. on confidence to change etc.) and information without feeling unwieldy to the person using it.

This area may have a lot of potential, however it is worth considering the public and professional views on whether they would use these resources and how the public could be encouraged to use them.

Table 6: web-based self-help resources

Sections of the Framework:

1. Introduction
2. Identify the problem
3. Assess readiness to change
4. Engage with motivation to change
5. Provide a menu of options and negotiate goals
6. Indicated options for further support and/or follow up.

Code	Title	Author, Date, Publisher	Description	Score for Section of Framework:						Total Score/30
				1	2	3	4	5	6	
2.4	Info Scotland: Alcohol	Author & date unknown, Scottish Executive	Aimed at the general population of Scotland aged 25-45. It is not aimed at known problem drinkers. The purpose of the website is to alert the much larger section of the population whose drinking may be causing them harm but who are not aware of the health consequences of their drinking behaviour and habits.	4	3	0	1	1	4	13

2.2	Drinkaware	Author & date unknown, Drinkaware Trust	Designed to provide facts and practical tips to suit a variety of people and occasions	5	3	0	0	1	1	10
2.5	Netdoctor - Test yourself	Author & date unknown, netdoctor.co.uk	Online AUDIT style screening test	2	1	0	0	0	0	3
2.1	Down Your Drink	UCL Medical School, date unknown, Alcohol Concern	Screening tool with 3 questions.	1	1	0	0	0	0	2
Average Scores:				3.0	2.0	0	0.3	0.5	1.3	7/30

3.3.3 Type 3: Practitioner Guidelines

Of the four resource types, the practitioner guidelines scored the best. This is perhaps an indication of them being written specifically to help practitioners to deliver a brief intervention. Thus, they are closely aligned to HBC theory and good practice. It is interesting to note that the top five resources ranged from a single sheet (to be used following an in-depth training course) to a full manual. This indicates that length was not necessarily an indicator of how well practitioner guidelines scored. This may suggest that a resource can be designed to a high standard without the need for large amounts of background information.

It is significant that the shorter the resource, the more likely it was to be intended for use by trained professionals. In contrast some longer resources, such as the WHO manual, were intended for practitioners to use to self-train. However, despite its length, the NHS Health Trainer Handbook clearly states that it is not intended as a replacement for a training course. Interestingly, the two general guidelines – Health Trainer Handbook (3.11) and Better Living Better Life (3.6) – scored well and the latter was not too lengthy considering the range of topics which it covered.

Professional guidance resources scored most poorly on the criteria of assessing readiness to change, engaging with motivation to change and providing a menu of options for action and negotiation of goals. This is surprising as it might be expected that generic HBC resources would score higher on assessing and engaging motivation to change but less well on the menu of options. This was not the case and the generic resources were amongst the better examples. The specific resource 'How Much is Too Much (3.3) demonstrated this well and managed to incorporate information/tips on practical options without this becoming overly complicated or long, which may indicate that this can be done without too much difficulty.

The resources which fared less well, tended not to provide sufficient guidance to lead the practitioner through assessing readiness and engaging with motivation to change. This may reflect a lack of awareness of or emphasis on the FRAMES model on the part of those who have developed these resources.

Table 7: practitioner guideline resources

Sections of the Framework:

1. Introduction
2. Establish rapport
3. Identify the problem
4. Assess readiness to change
5. Engage with motivation to change
6. Provide a menu of options and negotiate goals
7. Indicated options for further support and/or follow up.

Code	Title	Author, Date, Publisher	Description	Score for Section of Framework:							Total Score/35
				1	2	3	4	5	6	7	
3.9	Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care	2001, World Health Organisation	A manual to help primary care workers to deal with persons whose alcohol consumption has become hazardous or harmful to their health. Designed for use alongside AUDIT Guidelines.	5	5	3	4	3	4	4	28
3.11	Improving Health: Changing Behaviour. NHS Health Trainer Handbook	Health Psychology Team, Dept of Health.	Handbook introducing approaches and techniques for "NHS Health Trainers" to use to help people change behaviours that are known to cause ill health. Includes client "reminder sheets" and worksheets	5	5	1	4	4	4	3	26
3.3	How much is too much?	Institute of Health and Society, Newcastle University, 2006, Trailblazer SBI	A set of resources including a Clinician Guide, Screening Tools Simple Structured Advice prompt sheet and Extended Brief Intervention prompt sheet. Designed to support primary care clinicians to deliver appropriate interventions.	4	4	4	4	4	4	2	26
3.6	Better Living Better Life: Moderating Alcohol Consumption for CHD and Stroke Prevention	Linda Gask, 1993	Resource to aid GPs to reduce the incidence of CHD & strokes. Includes discrete section on alcohol.	4	4	3	3	4	3	4	25
3.8	Brief Interventions Step by Step	Dr. Niamh Fitzgerald, Drinking Interventions in Pharmacies Study.	Single sheet designed to support pharmacists in providing a brief intervention on alcohol. To be used following 2 days of training along with research protocol & record sheet which includes FAST screening tool.	3	4	3	1	3	3	4	21
3.7	DRAMS Scheme: Helping Problem Drinkers – Skills for the General Practitioner (General Practitioner's Guide). See also 1.19&4.10	Linda Gask, 1990, Scottish Health Education Group	General Practitioners' Guide to accompany DRAMS training and patient booklets. Contextualises the latter in relation to the Stages of Change.	3	5	1	3	2	1	4	19
3.5	Get the full bodied facts (practitioner folder) See also 1.7	Author & date unknown, Scottish Exec & GINA.	Folder resource designed to assist professionals to provide information and support to women who approach them for help	2	4	1	3	2	1	2	15
3.10	Alcohol Flip-Guide for Community Pharmacists	2007, Dept of Health & Pharmacy HealthLink	A set of laminated cards in a flipper style format for community pharmacists in England to use to provide "brief advice" (5 minutes) to clients on alcohol.	3	4	4	1	1	1	0	14
3.1	Management of harmful drinking and alcohol dependence in primary care: Quick Reference Guide	2003, Scottish Intercollegiate Guidelines Network.	Quick summary of guidelines for the management of harmful drinking and alcohol dependence in primary care.	2	3	3	0	1	1	4	14
3.2	Recording Sheet for Youth Work Alcohol Interventions	Winterbottom, J, 2004, GEAAP Young Person's Alcohol Pilot	A discussion prompt and monitoring tool based on the stages of change model designed to support youth workers to address alcohol issues in informal settings.	2	1	3	0	0	0	0	6
Average Scores:				3.3	3.9	2.6	2.3	2.4	2.2	2.7	19.4/35

3.3.4 Type 4: Practitioner Training Packs

Training packs for professionals scored poorly in relation to first criterion on structure and theoretical background with many having no explanation of theory at all. Another gap was in relation to the systems structures, in particular a lack of systematic

recording. The training resources also scored poorly in relation to identifying the problem. This was partly due to inaccurate and outdated information in relation to unit calculation and sensible limits but more so due to the lack of opportunity for practitioners to practice raising and discussing these issues with a client.

The training resources were generally good at explaining and providing practice opportunities for motivational interviewing but fell short of a full FRAMES style brief intervention as they scored poorly in relation to the criterion on providing a menu of options and negotiating goals. For the resources where this was mentioned, there was no opportunity to practise this element.

The packs were also limited in the information provided for follow up support, onward referral and relapse management. Most of them were relying on the trainer to source local information and did not provide suggestions for the types of services they should provide information on. Scores were also low on the assessing motivation for change criterion. Not a single training resource considered importance and confidence as the key markers of readiness and only a few provided the opportunity to apply this element and then only to a case study.

Amongst the highest scoring training packs were a number that were clearly designed to prepare the practitioner to carry out brief interventions in particular settings. However, the top scoring pack, Managing Drink (4.9), is designed for participants from a variety of disciplines, thus demonstrating that one pack can work for a variety of settings. All of the packs reviewed were alcohol specific.

Table 8: practitioner training packs

Sections of the Framework:

1. Introduction
2. Establish rapport
3. Identify the problem
4. Assess readiness to change
5. Engage with motivation to change
6. Provide a menu of options and negotiate goals
7. Indicated options for further support and/or follow up.

Code	Title	Author, Date, Publisher	Description	Score for Section of Framework							Total Score /35
				1	2	3	4	5	6	7	
4.9	Managing Drink (video/pack)	Pip Mason	Health Professional Pack comprising materials needed to run a four-day course to educate workers in the community about drink-related problems.	3	4	2	3	4	2	3	21
4.1	Lager and Blastaways: An Alcohol Training Programme for Youth Workers: Unit 4: Youth work with young problem drinkers	Linda Wright, 1995, Tacade	Covers identifying drink related problems, clarifying youth worker's role in raising the issue, stages of change, enabling decision making, functions of drinking and the role of specialist agencies.	2	4	1	4	4	2	2	19
4.10	See also 1.9&3.7 DRAMS Scheme: Helping Problem Drinkers – Skills for the General Practitioner (Course Organiser's Guide / Video)	Linda Gask, 1990, Scottish Health Education Group	1 hour training video (20+40 min) with course organisers guide, designed for use with practitioner guide and patient booklets for patients who are drinking excessively/whose consumption may be causing them harm	1	4	2	3	4	2	3	19
4.4	Alcohol and Care of Older People. STRADA. (Training Course)	Caroline Cherry, 2004, STRADA	A 1 day course on alcohol issues for workers who care for older people. Aims to increase alcohol awareness and develop practice skills in working with older people with a range of alcohol related problems.	1	3	2	3	2	3	3	17

4.8	Alcohol On The Agenda: A training pack for health and social care workers	Thurstine Bassett, Judith Beer and Pam Naylor, 1995, Health Education Authority	Aimed at experienced trainers to enable them run courses on alcohol issues. Aims to assist primary and secondary level workers and managers in understanding, recognising and responding to alcohol problems in their work.	1	3	3	3	3	3	1	17
4.3	STRADA Introduction to Motivational Interviewing	Mary Girvan, 2004. STRADA	A two-day practice based course introducing the basic skills employed in Motivational Interviewing.	3	3	0	3	3	2	2	16
4.11	Not Born Yesterday (pack)	Sheila Raby, 1999, Aquarius Action Projects	A Training Manual about Alcohol and Older People for Care Workers. See appendix ?? for learning outcomes.	1	3	1	0	1	1	1	8
			Average Scores:	1.7	3.4	1.6	2.7	3.0	2.1	2.1	16.7/35

In summary, the review showed that the majority of the resources we reviewed appeared not to have been developed with HBC and brief interventions as an underlying theoretical background, with some notable exceptions.

The client based resources, both written and websites, were better at identifying the problem, giving information and goal setting and poorer at assessing and engaging with motivation to change. The written resources which scored best tended to be longer and therefore less accessible by the public. The web sites scored poorly overall, particularly on assessing and motivation to change, which was surprising as they have the potential to include a greater range of self assessment tools.

The practitioner guidelines were the most likely to be written specifically with brief interventions in mind and as a result scored highest. Length was not a factor in this. The shorter resources were more likely to be intended for trained professionals.

Most of the training packs scored poorly overall in relation to brief interventions, and also on theoretical background. Most tended to be stronger on motivational interviewing practice, but did not set it in terms of brief interventions. The top scoring pack was designed specifically for carrying out brief interventions in a range of settings.

4. Public & Professional Views on Resources: Method and Findings

4.1 Method

The stakeholders identified in relation to resources for HBC and alcohol include both professionals who make interventions and members of the general public, who would be their clients. Although the role that both groups play were recognised as significant, in this study the focus groups were weighted towards seeking views of professionals, in the belief that the data gained through the professionals would be richer in relation to the theoretical background to health behaviour change. The groups with the general public were conducted prior to those with professionals and the data informed the protocol for use with the professionals.

4.1.1 Focus groups with the general public

Three focus groups were conducted with members of the general public in different parts of the country, which took into account some aspects of the equalities agenda, namely socio-economic, gender and age.

1. Mixed socio-economic group in a town in a rural area
2. Group was located in a Regeneration and Keep Well pilot area
3. Group of young people aged 16-25

These groups generate data on the perceived needs and appropriateness of resources for people who might be interested in cutting down on their drinking. A market research company was used to recruit the focus group participants for groups 1 and 2, using the terms regular, social drinkers, according to our criteria for socio-economic group, age range and gender. The young people's group were recruited through youth work contacts. Table 9 outlines demographic information collated on participants.

Table 9: participants in general public focus groups

	Group 1	Group 2	Group 3	Totals
Gender: male	3	4	2	9
female	2	3	7	12
Age: 16- 19	0	0	6	6
20-29	1	1	3	5
30-39	2	3	0	5
40-49	1	1	0	2
50-59	1	1	0	2
60-69	0	1	0	1
Employment status:			Group were	
Working	5	2	all students	7
Not working	0	5	who worked	5
Student	0	0	part-time and	9
Other	0	0	in holidays	
Number in group	5	7	9	17

Previous work has suggested that asking for participants who are “regular, social drinkers” was likely to recruit people who are drinking above the recommended levels without having to use screening tools. The Drinking

Interventions in Pharmacies study (McCaig, Fitzgerald & Stewart, 2007), where clients were recruited when accessing their pharmacy, found that over 50% of those recruited were drinking hazardously.

The groups were held in accessible community venues and participants were paid a standard incentive of £25. The same client based self help resources as were used in the professional groups were used in the groups with the general public. Participants were given time to read them at the start of the group. The protocol is included as Appendix C. Vignettes were used in these groups to promote and depersonalise discussion (Appendix D).

4.1.2 Focus groups with key professionals

The purpose of the focus groups was to gather detailed data on the use and format of existing resources and the needs for the development of new resources to support the behaviour change process. Six focus groups were viewed as appropriate for this purpose.

Informants for the first three groups were recruited through local Alcohol / Alcohol and Drug Action Teams. The first four groups were sector based to ensure that the findings were sensitive to the different levels of interventions offered and support required by health, local authority and voluntary sectors. The location of the groups was chosen to cover a geographical / urban / rural spread.

- 1) A range of NHS staff – primary care, mental health teams, alcohol liaison nurse, homelessness, healthy living initiative
- 2) A range of Local Authority staff – social workers, addiction workers, social care staff, youth and community workers.
- 3) Staff from the voluntary sector, councils on alcohol, youth organisations.
- 4) Prison Staff based at a male prison.
- 5) A multi-disciplinary group of practitioners recruited through STRADA². This group had been trained recently in health behaviour change and motivational interviewing in relation to alcohol and drugs.
- 6) An expert group of key professionals in the field of alcohol and HBC in Scotland. These were recruited from organisations such as Alcohol Focus, Local Councils on Alcohol, an academic department, the Scottish Association of Alcohol Action Teams and the Scottish Executive. This group was asked to validate the findings from the study.

Focus group participants were asked to look at the booklet “So you want to cut down on your drinking” beforehand and this and the following resources were selected to inform the discussion in the professional focus groups:

Client based self help leaflets:

- Two leaflets: “Alcohol and Healthy Living” and “Recognising Problem Drinking”, produced by NHS Health Scotland / Alcohol Focus Scotland.
- Drink Diary: Alcohol Focus Scotland.

² Scottish Training on Drugs and Alcohol

Practitioner guidelines:

- Screening tools as part of “How Much is Too Much?” produced by Institute of Health and Society, University of Newcastle.

The selection of the resources was informed by suitability across settings and in the light of the resources review. The focus group protocol is included as Appendix C.

4.1.3 Interviews with key informants for the equality and diversity agenda

In order to determine the appropriateness of current resources for different inequalities groups, six semi-structured interviews were conducted with key informants in this field. These were professionals who are able to give an overview of needs of different groups through their experience. The informants were selected so that the following aspects of the inequalities and diversity agenda were represented:

- a strategic view from a health board inequalities team
- mental health
- minority ethnic groups
- blind and partially sighted
- deaf and hard of hearing
- learning disability

4.1.4 Analysis

Data from the focus groups and interviews were recorded electronically, transcribed and explored for key themes. A coding framework was then developed using these themes and those that emerged from the earlier parts of the study: the literature review and the review of resources. Both researchers involved in the data collection used the same coding framework to analyse the data and it was summarised under these themes. Further analysis was then undertaken to draw out sub-themes and chart comparisons between the groups of informants and between different settings in which professionals operated, such as NHS, community and social justice. A further step in the analysis was to explore the data in relation to the particular target group of young people and young adults. Finally the data from the expert validation group was analysed in comparison with the findings from the other groups.

4.2 Findings

The findings from all the focus groups and the interviews are presented together in the following sections:

1. Drinking patterns, units, sensible guidelines and problem drinking
2. The use of resources to support process of a brief intervention for health behaviour change
3. Working with young adults as a target group
4. Health behaviour change in the prison setting
5. Holistic versus topic specific approaches

6. Equality and diversity issues
7. General issues on using resources and recommendations for future resource development

4.2.1 Drinking patterns, units, sensible guidelines and problem drinking

The measuring of alcohol consumption through the calculation of units is standard practice in health service and other settings. However, the majority of the informants in the three focus groups with the general public found the concept of units abstract and irrelevant to their patterns of social drinking. Their knowledge about units was limited, as was their understanding of the comparative strengths of different drinks. Some participants were familiar with the now outdated equation of one unit as a standard drink and they were surprised at the unit content the drinks that were listed in a recently published leaflet. They felt they would be unlikely to count units when drinking and perceived this as an unrealistic expectation:

“At the end of the day, if you’ve had a stressful day, you go out and that’s it. If you know you’re having too many units, you don’t say at ten o’clock, that’s it. I’m going home, I’ve had enough. You just go back to the bar.” (Participant, general public focus group)

Sensible guidelines for alcohol consumption are used by practitioners as an important measure for assessment of whether an individual is drinking problematically and would benefit from a brief intervention. The participants in the general public focus groups regarded the guidelines as very low and unrealistic, and tended to discount them. A view was expressed that they were artificially low as a device, because people would interpret them as being overly cautious. However, some participants appeared quite shocked by the difference between their consumption levels and the sensible drinking guidelines and assessed themselves as being in the ‘danger zone’. The consumption rates for the individuals described in the vignettes were viewed as normal: 34-39 units for women and 47-58 units for men. The vignettes proved useful for participants to relate to in terms of their own drinking patterns and consumption levels:

“I think that last guy’s me. He’s nearly my age and I play football a lot and drink at the weekends. He’s the only one who doesn’t drink all week, but he’s drinking 47-58 units at weekends and its way above everyone else. I can understand why, its binge drinking, just drinking at weekends”

“I wouldn’t say that’s binge drinking, that’s just a night out”.

“He’s not drinking that much.” (General public focus group)

These findings were supported by the perceptions of the professionals in all settings, whose clients and patients appeared to be drinking well in excess of the sensible guidelines and similarly found them unrealistic. Drinking behaviour was seen as embedded in a culture of heavy drinking by the public and the professionals, and the social pressures of round drinking hard to avoid.

“If there’s 4-5 of us, your round, my round, it just keeps going on. You’re tied in; it just keeps going on and on.”

“It is quite a hard thing; when you get involved with friends you don’t want to say I’ll stay myself.”

“You think they’ll think you’re a miserable so and so.” (General public focus group)

Although the general public participants knew they were drinking quite heavily, they did not regard it as a problem. They lacked understanding of the health consequences of their alcohol consumption but the information on the leaflets clearly raised awareness:

“If your drinking 5-6 pints like myself, go home, having dinner, bed, bit of crack in the pub, couple of beers. I don’t think I’m damaging myself, but if you look at that, obviously I am.” (Male, general public focus group)

Validation Group:

- Supported the view that units were difficult for the general public and this method is not working for encouraging the population to be aware of harmful consumption levels and reduce them.
- Suggested the terminology of harmful and hazardous drinking is misleading for public and practitioners.
- Agreed creating awareness of problem drinking was difficult using sensible guidelines, which were viewed as unrealistic.

4.2.2 The use of resources to support a brief intervention for health behaviour change

The process of delivering a brief intervention concerning alcohol involves several different stages relating to the cycle of change:

- raising alcohol as an issue
- assessment of consumption levels and problems,
- appraising readiness to change
- supporting motivation to change
- supporting the change process including relapse.

A number of different types of interventions depended on the settings, professional groups and client groups were described. Practitioners gave accounts of brief interventions in primary care, hospitals, drug and alcohol drop in services, for assessment prior to referral to a specialist agency, in social care situations, youth work settings and health improvement activities, such as Healthy Living Initiative programmes. The possibilities for raising the issue within the privacy of a routine health check by primary care staff, or on a hospital ward, were considered very different to those in public health events, or other community settings.

The use of terminology in the data was sometimes unclear in that practitioners referred to 'brief interventions' and 'motivational interviewing' interchangeably and in relation to different types of intervention. The latter term was applied to brief, medium and longer term interventions which led to some blurring of boundaries. It appeared that brief interventions were being delivered singly and in series, for example a practice nurse and a youth worker described their circumstances as having the opportunity to see people for short periods of time but on several occasions.

The professional informants in this study rarely used resources to raise the issue of alcohol, except in the case of health events, but more often for supporting assessment, motivation to change and the change process. The use and type of resource to support a brief intervention was influenced by the setting in which it was made.

Raising the topic of alcohol: This was seen as legitimate by all the professionals in the study, but generally required sensitivity and delicacy. The general public participants and the professionals tended to share the same views: it was seen as legitimate for health professionals to raise alcohol in the context of a broader lifestyle input, at a health check, a health event or connected with a health problem, but otherwise it could be interpreted as interfering, rude, prying or scaremongering. Pharmacists were reported as raising alcohol with customers who asked for help with insomnia or the morning after pill. Primary care staff might approach the topic through other lifestyle issues such as diet or smoking.

"I ask routine questions about how much they drink, how often, and how many units. The patient expects it as part of routine health assessment. It's relatively easy to ask, it's more difficult when that has been done and to take it further. It's more a question of negotiation and it depends upon trust, it's a much more delicate negotiation with the patient." (Health visitor)

Other professionals such as social workers and social care workers frequently approached the topic indirectly through the client's main concerns, for example legal problems or mental health problems. Legitimacy for raising alcohol as an issue was strengthened by having a good relationship with the client, young person or patient. However, it could be affected by practitioners' attitudes to drinking. One informant in the local authority group commented that "workers were probably more tolerant of alcohol issues than drugs with young people, so they may not be raising it as often as they could". An NHS trainer also suggested staff attitudes to alcohol were important in determining their approach to alcohol interventions.

Most of the professional participants in this study expressed confidence in using brief interventions with alcohol. However, a practice nurse reported feeling more confident with smoking as a topic because she had received more training and there was a longer history to tackling smoking cessation within primary care. Some mental health workers reported that brief interventions with alcohol were not viewed as a legitimate part of their role and

required referral to a Community Addiction Team or a specialist agency. One participant described using brief interventions to tackle unhelpful behaviours which impacted on their client's mental health.

“The clinical psychologist I work with uses these tools (motivational interviewing) but nobody else in my department is trained in it. I thought it would be useful and pointed that out to people at work, but they said but ‘it’s mostly the CAT team that do that and its alcohol related so there’s no point in us doing that’.”
(Community mental health nurse)

Training was seen as very important in terms of gaining confidence to make interventions and some participants had found it difficult to access. One person had waited three years to go on a STRADA³ course. Resources for training were seen as limited in the voluntary sector, and in other sectors there were accounts of reductions in training budgets.

Assessment: Whilst resources were less likely to be used as an aid to raise the issue of alcohol, they were seen as supportive to assessing consumption levels, problem behaviours and motivation to change. Health professionals described using screening tools more than staff in other settings, but several informants felt they could be awkward to introduce and it was better to use them as a guide to which questions to ask. Some practitioners did like to use a scoring system as a motivator for change, and a guide to progress.

In other settings, screening tools were seen as less useful and one social worker stated “when the pen comes out, the barriers go up”. It appeared that local authority staff were less familiar with the standard screening tools unless they were alcohol specialists. They were not something that could be used at health events, where there was no privacy and they were too personal. Unit calculators were mentioned as useful in this context and could provide an opportunity to discuss the issue of alcohol. Some health professionals felt that practitioner guidelines were valuable as a prompt when making a brief intervention and particularly liked simple algorithms, or a simple A4 sheet that could go on the wall, or a few sheets available on the NHS intranet.

An important aspect was the use of a holistic approach to determine patient / client priorities. Primary care workers used a general lifestyle intervention and then worked with the patient on their priority issue. Other practitioners in the community setting, including practitioners in Keep Well areas, agreed with this approach and stressed that they would only work on alcohol issues where it has been prioritised by clients and there was a readiness to change.

Supporting motivation to change: professionals viewed resources as useful in this area, particularly in relation to working with ambivalence and the decisional balance. Worksheets with exercises such as looking at pros and cons or costs and benefits worked well in helping patients and clients to become more motivated to change. Decisional balance exercises helped

³ Scottish Training on Drugs and Alcohol

increase motivation through linking problems in people’s lives with heavy drinking.

The perception of problem drinking was a key issue which emerged in the data. Practitioners saw the biggest challenge as being a patient / client not perceiving heavy drinking as a problem. Resources that used counting units and making comparisons with the sensible guidelines did not appear to be a fruitful technique to stimulate behaviour change in the view of both professionals and the general public:

“What you need is, you’ve got all the units and that here, but what you need is what would happen if you keep drinking. What would be the effect on your body if you keep drinking.”

“You would need some better reason than just the knowledge of the amount of units, you’d have to have a reason, a professional to explain why, is it going to affect your health or your relationships. Just saying ‘don’t drink’ and the number of units isn’t going to have much effect.” (General public focus group)

At one level people did not translate heavy drinking above the sensible guidelines as problematic:

“People go ‘that’s not realistic’, so they dismiss it. ‘Are you trying to tell me I’m a binge drinker? It’s ridiculous!’” (Professional, community setting)

However, they might accept it was a problem, but not want to change it:

“Even if you’re over the units, if someone tells you you’re damaging your health you’re just going to keep doing it”. (Participant general public focus group)

Supporting the process of change: professionals viewed drink diaries as a useful resource for supporting the process of change and helping patients / clients to calculate their consumption levels. However, there were differing views about their use, which is shown in table 10.

Table 10: Opinions on the Use of Drink Diaries

General Public	Professionals
<ul style="list-style-type: none"> • would be unlikely to complete • aroused guilt compared to smoking diary • would lie if asked to complete for a professional • difficult to remember what you have drunk after a night out • One heavy drinker was given one by his doctor and threw it in the drawer. 	<ul style="list-style-type: none"> • People find them helpful if they have already recognised drinking as an issue • Gives something tangible to work with • Encourages people to be pro-active and take responsibility • Incorporates costs and consequences of drinking and supports motivation to change • Some young people's drink and drug use is too complex for a drink diary alone • Limited use in a prison environment.

The disparity of views is interesting and could be related to the recruitment to the focus groups of 'social drinkers'. The majority were heavy drinkers and appeared unwilling to cut down, which supports the view that drink diaries are a tool best used with a person who has already recognised the need for change. They were also used as tools to promote discussion. A practice nurse did not ask her patient to complete diaries as she felt that asking them to write introduced too much formality. She did discuss weekly drinking patterns with her patients and found they were able to recall it. Youth workers took a similar approach in reviewing a week's drinking with young people.

The professional groups discussed the use of the booklet 'So you want to cut down on your drinking'. There was a unanimous view that they would be extremely unlikely to give this resource to a patient or client because of the presentation and amount of information in it. However, the exercises were considered very useful and some practitioners did use them with patients/clients. They suggested that the exercises in the booklet would be more accessible as worksheets which could be photocopied and given to patients/clients. Some were already using tools for Cognitive Behavioural Therapy (CBT), which were very similar and they recognised the links between these two approaches.

"A lot of CBT stuff comes from motivational interviewing so it may be a bit of repetition, but we've got binders with motivational interviewing stuff in them, so you take what you need out of it. We probably need something more condensed. It could have couple of decisional balance sheets, a P and C model of change⁴, and a diary, just have 2-3 things in there, so its standard instead of leaving it up to the practitioner to decide whether its worthwhile or not." (Community Mental Health worker)

Validation Group

- Training combined with professional guidelines is essential for developing role adequacy in practitioners
"It's more the sensitivity that's the biggest part. A lot of people have done the brief intervention training. They have the confidence in themselves and the training in how to raise the issue in a sensitive way, that's the key"
- The alcohol liaison nurse post provides role support in the hospitals and could be considered as a model in other settings.
- Creating a problem where there was not one previously is too complicated and not effective in supporting motivation to change.
- Using positive choices and inquisitiveness was more likely to motivate than developing perception of problem use
- Drinking diaries were useful as a tool to support the process of change

⁴ Cycle of Change – Prochaska and Di Clemente (1982)

Young people were viewed as having different needs as a target group. Their drinking patterns and reasons for drinking tended to differ from older adults. Whilst participants in the young persons' group in the study were aged 16-24, youth workers in the professional groups worked with younger age groups. All the professionals felt that young people tended to respond differently in their response to messages and information. For example it was suggested that labelling drinks with their strength encouraged young people to buy the strongest drink as value for money in getting drunk. Sensible guidelines would be the complete opposite of how they wanted to drink. The unit descriptions in the leaflets were seen as inappropriate for younger people, who tend to drink vodka rather than whisky and see sherry as an uncommon drink. Another example was that strong cider is a usual drink for young people they tend to consume this in litre bottles, not in pints as was shown in one leaflet.

Raising the topic of drinking was not seen as problematic with this group because it is so much part of their lives. A good relationship between the worker and young person facilitated raising the topic and could lead to meaningful discussion. Participants in the young persons group said they would feel offended if it was raised by a health professional and they would lie about their drinking:

“I would be like, how much do *you* drink, you cheeky...”

“It's like when people ask you how much you smoke a say, you're not going to say 20 even if you do.” (Young persons' focus group)

Workers felt their interventions with young people were repeated brief interventions since they rarely had much time with individuals. Motivation to change was viewed in similar ways by young people and professionals. Triggers might be:

- Moving on in life – getting a job, having children
- Fitness, weight loss, improvement in sport
- Repeated incidents which compromise safety, lead to unprotected sex or violence, ending up in hospital or trouble with police

Health in the longer term was not seen as a trigger to cut down, as with smoking the young people had a perception that they would cut down later in life. Harm reduction was an important approach and there were obvious links between the two in the triggers to cut down. Youth workers suggested there was merit in combining harm reduction and brief intervention approaches.

The format of resources to support work with young people was important. Leaflets were regarded as not useful by both young people and professionals. They would not be read and were often targeted inappropriately. For example, one leaflet had visuals of young people drinking but they were in wine bars and pubs, not on the street corner or in bus stops where young people drank. There were several suggestions that it was better not to include visuals of people as these quickly become out of date and young people are very specific about identifying with their own group in terms of appearance.

The young people in this study thought that TV advertisements and posters on toilet doors had more impact.

Web based resources were being used by some of the youth workers with young people and they found them quite successful in engaging their clients. One youth worker was trying to develop professional guidelines for working on alcohol issues for young people. He felt that there was no standardised approach at a national or local level in the same way as with other topics, such as sexual health and relationships. This was an important gap and meant that it was left to individual staff to decide how to respond to problem drinking.

Validation Group

- The message of sensible drinking was irrelevant to many young people
- Labelling drinks with strength was likely to encourage them to choose a stronger drink to get drunk
- Normative work could be a way forward for working with young people, giving a positive message about majority drinking behaviours

4.2.4 The prison setting

Data from the prison setting revealed particular issues in delivering health behaviour change as brief interventions. The focus group with prison staff was conducted in a male prison, with a turnover of 200 prisoners a day. Some are placed whilst on remand, and others are waiting for a long-term placement in another jail. Generally the role of the staff is to provide information and to support the prisoners to start to identify problematic areas in their life. They felt they were expected to raise the issue since prisoners' alcohol consumption was frequently related to their crimes. However, often issue of alcohol in relation to the wider social context was difficult since reducing their alcohol consumption was not a priority for many prisoners. They felt that due to their experience and previous training on addiction issues, they had a good knowledge of the principles of health behaviour change and were comfortable in raising the issue.

The prison staff described how prisoners tended not to consider drinking a bottle of vodka a day as problematic so long as they did not do this everyday, However when this was explored it often emerged that the issues that lead them to jail often happen when they are under the influence of alcohol. Their drinking was generally dictated by whether or not they had money and there was considerable social pressure to drink. Some groups of men would meet on the day their benefit was paid and then spend all day in the pub, or take turns every other day buying a 'carry out'. Not taking your turn could have violent consequences, a beating, for example.

This and other factors indicated that the staff considered brief interventions to be inappropriate for their setting because:

- many of the prisoners were leading chaotic lifestyles and that they are consuming quantities that considerably exceed the sensible guidelines
- Dealing with their drinking is not a priority for many prisoners
- Dealing with drug misuse is often more of a priority for prisons
- The social pressure to drink is very strong when prisoners are released and are in their own community
- They felt that there is no follow up support for prisoners when they are released, although they do signpost services.

The staff were about to introduce an 8 week course with inmates on alcohol. In terms of resources to support any alcohol work, literacy is often an issue, so pictures and visuals are an important aspect of any resource. Comic strips are the preferred format.

4.2.5 Holistic or topic specific approaches and resources

There was a discourse on the comparison between a holistic and topic specific approach in the focus groups. A holistic approach was interpreted as one which engaged with a number of different lifestyle factors or risk behaviours at the same time. Both health workers and community based workers found it beneficial to introduce alcohol together with other lifestyle topics, but then might work on one of these according to client/patient priorities. The participants in the general public groups also found it more acceptable to accept discussion of drinking within a broader health intervention. At health fairs for example, general information would be available on how to improve your health which included alcohol messages.

However participants highlighted the difference between giving information and delivering a health behaviour change intervention. There was a clear view from professionals that the principles of health behaviour change could be applied commonly across topics, and that holistic tools were appropriate to a certain extent. For example, some identification tools and decisional balance tools utilised common questions, but then different interventions and a different knowledge base were required for different topics. Comparisons were drawn with resources for CBT which took this approach, which have a general book and then follow on ones relating to specific topics.

The reasons given for requiring a topic specific intervention were:

- screening tools for alcohol were very specific and did not transfer to other topics.
- the strong cultural influence on alcohol was important, for example the normative behaviours in some groups were a powerful disincentive to acknowledging problem use of alcohol
- alcohol specific resources were required
- the process was not the same for all lifestyle issues, for example topping smoking required complete cessation, whereas brief interventions on alcohol were about cutting down.

Primary care staff would often combine alcohol and diet, especially when working with patients with diabetes. There was a suggestion that the calorie

content of drinks might be more useful for motivation than unit measures in encouraging reduction in those wanting to lose weight.

Validation Group

- Some practitioners are bound by the nature of their core business
- Lifestyle topics tend to be compartmentalised and staff may not be confident in all areas
- Health professionals and social work staff might have different perspective on a holistic approach and come from different directions, e.g. cycle of change compared to social implications
- Core guidelines could be developed using a generic, holistic approach combined with specialist information and interventions for specific topics, applying the tiered approach to healthy living with level one applying to everyone and increasing specialism in higher tiers

4.2.6 Equality and diversity issues

The following equality and diversity issues were considered to be pertinent to the study and were explored with all groups and with representatives from key agencies:

- Socio-economic inequality
- literacy
- minority ethnic groups and cultures
- blind and partially sighted
- deaf and hard of hearing
- learning disability
- mental health.

Many of these issues are interlinked, with people experiencing several dimensions of inequality. For example, in areas of socio-economic disadvantage, there are also likely to be higher concentrations of people experiencing other dimensions of equality issues, such as disability, learning difficulties, illness and minority ethnic groups, with the result that the problems people face are interlinked and complex. It was reported that a third of people who have learning difficulties also have severe sight problems. An additional issues that effects many equality groups and in particular those living in areas of socio-economic disadvantage is access to services. Barriers to access should be considered as a brief intervention cannot take place unless the person turns up.

There are equality and diversity issues which are more relevant in terms of delivering health behaviour change and those which relate particularly to access to resources to support the intervention. The focus here is on the latter. There are issues around access to services such as cultural expectations, identification of the agency as being inaccessible and language barriers.

Role adequacy and support are areas which might be influenced by the equality and diversity agenda for many workers. For example:

- staff may lack confidence around the diversity agenda due to fear of using inappropriate language, being seen as discriminatory or lack of knowledge of the legislation
- making assumptions about linking alcohol issues with ethnicity, disability or deprivation in ways which might offend

Accessibility of Resources: Communication issues were central to accessibility of resources and within this literacy was important for a number of groups. The need for health information leaflets to present information through a combination of simple text and pictures was highlighted as being essential for many people in the general population and some specific population groups including:

- prison populations
- vulnerable groups such as homeless, older people and those with learning disabilities.
- people with multiple and complex needs
- people from ethnic minority groups whose first language is not English
- deaf people whose first language is British Sign Language (BSL)

When exploring HBC leaflets on alcohol within the focus groups it was pointed out that the increased significance of visuals in leaflets can be misleading for people with literacy problems. This is because in many instances the message the pictures conveyed sometimes differed significantly from the text. Several informants commented that the positive nature of the visuals of people drinking gave the wrong message when the leaflet text was intending to give a message that too much alcohol is harmful. In one leaflet in particular, a picture of a pregnant woman drinking a glass of wine gave an opposite message to the text. Whilst some leaflets were simply written with clear layout, the booklet 'So you want to cut down on your drinking?' demanded a high level of literacy to read it.

Language barriers faced by many groups in Scotland whose first language is not English was raised as an issue, particularly for older people who may not have attended school or formal education in this country. It was recognised that whilst resources are sometimes available in Asian languages, there are considerably fewer available in Eastern European languages. This issue was raised in conjunction with the importance of being able to deliver brief interventions because of the heavy drinking culture linked with some nationalities. Conversely, it was suggested that there may be cultural issues for Muslims whose faith requires they do not drink, so disclosure of a drinking problem is very difficult. In some instances this led to very late presentation with problem drinking and a brief intervention would no longer be appropriate.

One large Health Board has undertaken an audit of available addiction resources for the BME agenda and identified gaps. They then tried to match

the needs of specific groups with a required format and produced resources for that need in a suitable format. In terms of the large numbers of languages now required, resources are printed in 5 languages as standard (Punjabi, Urdu, Chinese, Turkish and Polish) and conform to easy read format. An interpreting service has been contracted to provide 14 languages at all the additions services. British Sign language is available for videos.

The use of interpreters for language barriers was seen as particularly difficult. It may not always be feasible for the use of these services in situations where a brief intervention takes place i.e. pharmacy or GP appointment. Since alcohol is a very personal and sensitive issue and a third party in the intervention has a significant effect. An interpreter needs a high level of translation skills due to the subtlety of the dialogue and sensitive, and a non-judgemental approach is required. Additional issues were raised about the use of family members, or known members of a small community as interpreters, and the inhibitions this could place on a persons' ability to be open and honest about their alcohol intake. These issues also applied to the use of interpreters for deaf people.

Written resources to support brief interventions with partially sighted people require large print and a clear layout. The use of colour could be difficult if there was not sufficient contrast. The RNIB gives guidance on these issues on its home web page⁵ in a booklet 'See it Right'. They find that resources are not made routinely available in other formats, and they have to be specifically requested on a one by one basis, with obvious difficulties.

The use of Braille is tending to diminish, as it is only taught at special schools to people who have been blind from birth. There is a difficulty in presenting information in an audio format at present because of the number of different formats available, and the gradual withdrawal of the cassette tape. If leaflets were routinely available as Word documents or in PDF format then computer software can be used for audio presentation. Web sites should have an automatic link so they can be spoken.

Since many blind and partially sighted people are over 70, it is particularly important to produce resources aimed at older people in accessible formats. In addition, 1 in 3 people with learning disabilities have a sight problem, so there are connected issues.

The needs of people who are deaf or hard of hearing would be met, to some extent, by implementing the good practice outlined for other equality groups. The Scottish Council on Deafness provides a position statement on information and access to health services for people who are deaf or hard of hearing. This outlines the requirement for clear, concise written information with illustrations reflecting the culture, identity and language of deaf people. Health promotion information should be available in formats such as signed videos, DVD's with subtitles and websites with non-text versions. Health services should also incorporate the use of communication services such as

⁵ <http://www.rnib.org.uk/xpedio/groups/public/documents/code/InternetHome.hcsp>

sign language communicators, lip-speakers and loop systems to improve communication with deaf and hard of hearing people. It was recognised that front line staff who engage with the public should be trained in accredited deaf and deafblind awareness. Finally the importance for information leaflets to provide helplines with a textphone number and/or fax not just a phone number was highlighted. People who have BSL as their first language may also have literacy problems.

For people with learning disability it is important for any professional who wishes to carry out a brief intervention on an issue like alcohol that they have a clear understanding of how the person communicates. A professional should not predict, or make assumptions about how a person with learning disabilities interprets the question and/or their ability to fully understand it. Some individuals may interpret a question very literally or as a 'telling off' with others may not fully understanding what is being asked. Therefore it is important for practitioners to put in additional effort and checks to ensure that the person does understand what they are saying i.e. the effects of drinking too much.

It was suggested that practitioners should avoid asking too many direct questions and that the best way to approach a brief intervention would be to incorporate it as naturally as possible into the discussion. It may be useful to ensure that resources are available for the person to take away and reflect upon. The most effective resources for people with learning disabilities are those that present a mixture of clear and concise text with associated pictures but are not childish or patronising.

Mental health and alcohol problems are often linked and there are particular concerns in interventions with these clients. The purpose of brief interventions was sometimes different with people with mental health problems. One Community Mental Health nurse described how she uses brief interventions to tackle unhelpful behaviours, which are going to make their symptoms worse, such as anxiety and depression, if they are mentally ill. Drinking comes into this category. Using brief interventions to help clients cut down their drinking reduces their anxiety, so they can manage their symptoms better. However, if the alcohol problems are too severe she would refer the person to the Community Alcohol Team. One worker with a mental health voluntary organisation related using brief interventions with people with who were taking Disulfiram (Antabuse), but as most of these clients have severe dependencies, brief interventions would not be appropriate.

People with enduring mental health problems can have communication difficulties in terms of understanding and retaining information, particularly if they are in crisis. As alcohol is often used as a coping mechanism, it is especially important that clear, accessible written resources are available to support a brief intervention. Access to the internet may be limited for people with long term problems who are not working, especially if they are living in a regeneration area and are over 25. In these cases, they are unlikely to have access to computers, or any experience of them since they would be unlikely to have used them at school.

Validation Group:

- Development of work in Community Care is an important area to consider. The range of groups now living in the community have an expectation of normal lifestyle, and that includes drinking alcohol and may have access issues in relation to resources
- Older people with number of issues on accessing resources are a priority.

4.2.7 General issues on use of resources, gaps and recommendations for future development

There was general agreement among the professional informants that written client based resources were useful in supporting the behaviour change process because they:

- could support the identification of drinking as a problem behaviour
- provided a focus for discussion
- supported the practitioner in reinforcing the message and giving it validity
- facilitated motivational processes such as the decisional balance, goal setting, taking responsibility and measuring progress (interactive resources such as worksheets and diaries)

Most professionals in the study viewed the illustration of the unit content of drinks in many resources as being out of date and inappropriate, in terms of the drinks given as examples and also the quantities.

Health service professionals felt that the practitioners were the important resource and use of written resources required sensitivity or they could damage the intervention. They stressed the importance of training to ensure the most effective interventions. Practitioners in all settings favoured the use of guidelines and screening tools, but preferred them to be short and simple so they could be easily accessed. Primary care staff in one Health Board area were able to access written resources via the NHS intranet and found this helpful.

Practitioners who were working with homeless people had not found any written resources that were appropriate for their client group which would support them in a behaviour change process, but for many of this group more specialist interventions were required since their alcohol problems were complex and associated with dependency.

Interactive internet based resources were considered potentially useful by some groups, but there were limitations of access for people who were not working and some older people. The data from general public groups showed a mixed response. The group in the regeneration area all agreed that they would not use the internet for accessing information about drinking and most

did not have internet access at all, whereas in the rural mixed group there were some people who said they would be interested in websites.

There was some discussion about the use of resources as self help tools without practitioner intervention, and whether or not these could form an effective brief intervention. There was no evidence in the study to support the view that written resources would be useful in this respect. Practitioners and the general public participants felt that they had more impact in supporting a practitioner intervention.

There were a number of issues raised about the booklet 'So you want to cut down your drinking?' It was not seen as appropriate to give to clients/patients because its size, amount of information, inaccessibility of the text and layout made it difficult for a patient/client to take ownership of it and to use it. There was general agreement it was a useful resource for professionals to use with a client/patient in a longer term intervention.

The participants in the professional focus groups identified some gaps in resources aimed at particular target groups, both client based and for professionals to use with health behaviour change led interventions:

- Older people: larger text, age appropriate visuals, reference to mixing alcohol and medication. It was suggested older people had little knowledge of units and it was difficult to raise the issue of drinking, as there was more stigma attached to heavy drinking. There was reference to a pack for older people, produced in Ayrshire.
- Young people – although there were already some leaflets they tended to be information and education, but not health behaviour change resources which would support practitioner led interventions.

Participants would welcome more professional guidelines. We found eleven examples, which are listed in section 3 of Appendix B, but most are for the health setting and some are out of print. It may be that awareness and dissemination is an issue for health and other settings.

The data from the general public focus groups suggested the following recommendations for alcohol based resources, although they were not commenting from the perspective of brief interventions:

- Display information on units in more public places where people drink, at point of sale and on bottles and cans
- Formats such as credit cards for your pocket, or displayed on pub bars, with units and a title "have you exceeded your credit limit?"
- Ensure information is up to date and accurate
- Use whole numbers and not decimal fractions
- Give more specific information about health risks as with tobacco
- use more hard hitting information to highlight problems as with tobacco
- Keep information short, succinct and easy to read
- Avoid messages which conflict with other health messages, such as healthy eating (e.g. drink a spacer, a lot of soft drinks are unhealthy)

- Avoid unrealistic messages on cutting down – e.g. ‘take a limited amount of cash’. People have cards and just go and get more
- Health professionals delivering resources has more impact
- Don’t use words ‘alcohol’ or ‘problem’ on the front of leaflets
- Make sure pictures support message
- Use triggers to help people decide to cut down e.g. having children, health problems, relationship problems.

Validation Group

- Training is being delivered in the Community Care setting (see section 4.2.6), but there do not appear to be resources to support practitioners in this setting. This is a gap to be filled.
- Positive, normative resources for young people and a resource on alcohol and falls prevention for elderly should be developed.

5. Discussion

The key issues which have emerged from the findings from the literature review, the resource review and the focus groups are as follows:

- Differences in understanding in relation to HBC terminology
- The extent to which resources support delivery of HBC interventions
- The importance of training
- Interventions in different settings and with different target groups
- Arguments for and against holistic versus alcohol specific interventions

5.1 Health Behaviour Change Definitions and Terminology

The terms brief interventions, health behaviour change and motivational interviewing were used freely in the focus group data with professionals, but their meanings were often blurred. SIGN guidelines are quite specific in defining brief interventions and recommending motivational interviewing as an appropriate method. The principles outlined below can be found in Miller and Rollnick (2002):

General Principles of Motivational Interviewing

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self- efficacy

Whilst the parameters of this study are health behaviour change involving brief interventions of 3-15 minutes and 15-40 minutes, professional informants often referred to delivering these interventions on a number of occasions with the same client / patient. They suggested that a book of worksheets would be useful to support this process. They also referred to motivational interviewing and cognitive behavioural therapy (CBT) and the links between these. In reality, the interventions that were being delivered were dictated by the need of the client /patient and the opportunities and constraints of the setting. Mental health workers were more likely to mention CBT, which although draws on motivational interviewing principles is focussed on changing thoughts and behaviours in the present and requires more than a one-off input. It may be helpful to locate CBT in resources as a “referral” option as part of a FRAMES style brief intervention as outlined in the SIGN 74 guideline (2003).

5.2 Resource Content and Design

The literature review did not uncover an evidence base for resource design for HBC. Therefore, resource content was assessed against criteria developed

from the good practice guidance. Practitioners expressed a preference for clear and concise materials and, as length did not necessarily prove to be an indicator of quality, this should be possible in any future designs. In addition, resources were viewed as important in supporting role legitimacy and adequacy. A key finding in this area relates to accessibility as many of the client resources were lengthy and poorly illustrated, rendering them less than helpful for some equality groups. Any future resource development should take account of specific needs and mainstream resources should be made as accessible as possible. Where this still excludes certain groups, alternative formats should be made available. There are a number of suggestions in the findings which could be easily achieved, increasing accessibility to specific groups.

The client based resources tended to focus on providing information, probably working on the traditional but often invalid assumption that if people had the right facts that they would change their behaviour. Furthermore, several of the resources contained outdated and inaccurate information, particularly in relation to unit calculation and sensible drinking guidelines. Inclusion of key facts is an important element of brief interventions. However, social drinkers in our study were reluctant to use units to measure their alcohol consumption. Most appeared to be drinking at hazardous levels and they considered the sensible guidelines to be very low and therefore discounted them as unrealistic. When they compared their own levels of drinking with the guidelines some were shocked with the majority being pre-contemplative and determined not to cut down. Counting units did not appear to be a motivating factor.

The review of resources found very few which were based on the principles of health behaviour change, with the guidelines for professionals being the ones which scored the highest overall. Since these were written to support delivery of brief interventions this is not surprising.

Screening tools were seen by some of the focus groups as a barrier but others considered them as a potentially valuable prompt. Health focussed screening tools have limited transferability to other settings. Screening is also potentially at odds with the key principles of motivational interviewing as they could be seen as determining problem drinking from the professional's perspective rather than the client's. However, they contribute to the exchange of factual information and may be useful in affecting decisional balance and motivation to change. The emphasis given by so many resources to the stages of change model is not supported by the evidence base. In addition, the absence of support in many resources to assess readiness to change and engage with motivation may be crucial omissions as evidence suggests these are key elements required to personalise the impact of behaviour and prepare to make a change.

An interesting discourse emerged in the findings in relation to motivation. The traditional view is that an individual has to accept their drinking behaviour is causing them problems before they will consider changing. This is reinforced in all the resources and the view from the public and professional informants

was that the resources are all aimed at people who accept they have a problem. The practitioners viewed pre-contemplative individuals as presenting the greatest challenge, and found the idea of alerting people to see their drinking as a problem being complex and difficult. The participants in the validation group raised the evidence supporting motivation to cut down on drinking for positive reasons. However, this was included in very few resources.

Some practitioner resources fared poorly on the criterion of “menu of options and negotiate goals”. This could easily be improved by adding a reminder to the practitioner to negotiate individual strategies with the client. There is a tendency in some of the resources to slip into “advice giving” using an almost paternalistic approach, rather than supporting practitioners to discuss options for what might suit different individuals.

Overall, the review found a limited number of client based health behaviour change resources and clearly this is an area for development. The resource which might fill this gap is ‘So you want to cut down on drinking’. Unfortunately the format of this was universally acknowledged in this study to be totally unsuitable for individual members of the public and professionals agreed would not give this booklet to clients or patients. The content of the book, apart from having too much information to digest, was found to be helpful and was the highest scoring resource in this section of the review. We would recommend not reprinting it in its present form but using some of the information and interactive sections in a more user friendly format which a practitioner could give to a client/patient to support a brief intervention. It would be useful if there was a professional version for the practitioner, but we would still recommend a more accessible format. The suggestion in the findings of motivational interviewing worksheets for brief interventions, for use with clients and for self help is worth pursuing.

Although there were some reservations in the study about access to web-sites on cutting down on drinking, this is clearly an area which would appeal to an increasingly large section of the population, especially students and young adults, who are more likely to have internet access. Given our review found the current websites to be limited in their application of principles of health behaviour change, there is a gap here. This could be filled through developing a website which could function effectively as a brief intervention, or adapting an existing one such as Info Scotland: alcohol, produced by the Scottish Executive⁶.

5.3 Training

A lack of knowledge and confidence amongst practitioners was identified in the review of the literature and the evidence based guidelines and the findings from the focus groups supported the notion that training is important if not essential to address this.

⁶http://www.infoscotland.com/alcohol/interactivedisplay.jsp?pContentID=79&p_applic=CCC&p_service=Content.show&

The training packs in general were strong on providing practice opportunities for general motivational interviewing but weaker at providing the context for this within the wider framework of a brief intervention and in particular, gave limited support in making onward referral. Furthermore, very few resources outlined the relevant theory and all lacked adequate systems structures (e.g. systems for ongoing recording and reflection). This provides a solid argument for development of a set of linked resources (training pack, practitioner guideline and client resource) which reference one another and would make any learning more sustainable.

Many of the shorter Type 3 (practitioner) resources could be incorporated into the handouts or post-training material of a well-designed training resource, as is the intention with the DRAMS pack. The longer ones might be adaptable to e-learning or distance learning packs such as those used by some professions for continuing professional development. It is questionable how many generalists would be willing to give the time required to work through the information provided in the longer packs. Generic resources may be considered by busy professionals to be a more efficient use of their time, and could also be converted to an e- or distance learning package.

Some participants from the focus groups had found accessing training to be difficult, possibly due to it not being seen to be relevant for their role

5.4 Settings and Target Groups

The evidence base for the SIGN and NICE guidelines lie in the health care setting and only apply to specific health settings e.g. primary care, accident and emergency and ante-natal settings. SIGN also recommends a motivational interviewing approach for brief interventions. However, brief interventions are also the model for health behaviour change used by the larger public health workforce. This includes local authority, voluntary sector and other settings such as prisons and youth work.

The issues of role legitimacy and adequacy⁷ were important elements in the literature and the findings from the professional focus groups in relation to different settings. Practitioners in most settings felt that brief interventions were a legitimate part of their role, but this was modified to some degree by the target group. Brief interventions are not appropriate for people who are alcohol dependent and therefore workers in specialist services and services for people with complex needs such as homelessness did not use this approach with these groups. However, brief interventions were being used in specialist alcohol services and in other settings as part of an assessment

⁷ Role legitimacy is an aspect of therapeutic commitment which influences professionals' intellectual and emotional preparedness to work with problem drinkers: "Role adequacy" is the belief that the professional has sufficient knowledge. "Role legitimacy" involves the belief that alcohol issues are a legitimate area for the professional to examine. The final factor is termed "role support", where the professional has confidence that advice and assistance is available when needed. It follows that those professionals with a high therapeutic commitment work more effectively in all areas in dealing with patients who may have alcohol problems. (Shaw et al, 1978; Deehan, Taylor and Strang, 1997).

basis so that clients might be referred on to appropriate services. Role adequacy seemed high in the focus group informants, although some felt less confident with alcohol than other topics, but this would not be transferable to a wider group of professionals

All of the client based resources reviewed were designed with a generic audience in mind. However, most practitioner guidelines were for specific settings and the one generic resource reviewed was not among the best. Conversely, most of training packs were also were setting specific but a generic resource scored highest.

Screening tools commonly used for alcohol were less likely to be used in non-health, generalist settings. This was despite some being designed with a general function focusing on the role alcohol plays in lifestyle generally and not specifically health issues. There would seem to be potential for making these more accessible to other disciplines, however the usefulness of them may require further exploration. Similarly professional guidelines were more likely to be aimed at health settings. Once again there is potential for these to be adapted and disseminated in other settings to support the training programmes currently being delivered. Client based resources were less specific to settings and target groups but with notable gaps.

The focus of existing practitioner guidelines on the health setting leaves a large gap for other staff in the public health workforce. In view of the numbers of people being trained in Keep Well areas, the social care setting and for older people it is certainly important to have robust guidelines for these settings. Perhaps more investigation is required to determine if these need to be setting specific or can be more generic, and could be linked with the revising of the 'So you want to cut down on your drinking' resource.

The study revealed a large gap in terms of resources which are suitable for practitioners to use with young people, in a youth work setting or indeed in other settings such as health drop ins and education settings where one to one interventions can be made. The findings suggest it would be useful to explore resource development for young people which combine harm reduction and motivational interviewing in a brief intervention style and develop professional guidelines for this setting. Evidence from the validation group also suggests exploring the value of a normative approach based on the consumption and drinking behaviour of the majority. We would add to this that good practice for working with young people suggests there should be a high level of young people's involvement in the development of new resources. This is supported in the findings by the recognition that young people respond to standard health messages in a very different way from older adults.

Although the SIGN guidance does not relate to adolescents, the issue of combining a harm reduction approach with brief interventions was raised by youth workers. These two approaches do not seem incompatible and it may be worth exploring the possibility of developing resources to support this work with alcohol and young people, since youth workers tend to be familiar with

this approach. Safety issues or social problems which arise as a result of alcohol use with young people could be used in decisional balance techniques to increase motivation to develop discrepancy. It was absolutely clear from the findings that young people are not interested in cutting down for longer term health reasons. There is potential to develop guidelines for professionals which combine these two approaches and client based resources to support them. In addition, there are currently no national guidelines on intervening with alcohol and young people as there are for other topics such as sexual health.

Another major gap identified in the findings was in the area of resources for older people. While they have been developed in at least one Health Board area, we did not identify others. A recent report on alcohol and ageing (Health Scotland, 2006 identifies that this is an issue of increasing importance as more older people are consuming high levels of alcohol and to increased death rates from alcohol are likely in this population group. There are also special resource requirements by older people and those in community care.

The findings in this focus groups support the potential use of brief interventions in other settings, with the exceptions of prisons, where staff felt that it was not an effective intervention. All practitioners expressed the ability to explore the link between alcohol and the “presenting problem” and where appropriate initiate HBC discussions on alcohol. The central premise that interventions should be relevant to the clients’ current concerns was expressed very strongly in all settings. However, it is important to recognise the current lack of research into the impact and cost effectiveness of brief intervention in non-health care settings.

The prison setting is unique and although it might seem to provide appropriate opportunities for brief interventions, the study revealed that there are some serious drawbacks to this. The findings indicate that staff feel that medium or longer term interventions are more appropriate, and in a group setting. This area would benefit from further exploration, to determine if perceptions of role legitimacy, adequacy and support could be influenced, and to review the evidence for brief interventions in the prison setting.

5.5 Holistic Versus Topic Specific Approaches

A holistic approach can be interpreted in several different ways:

- Interventions which tackle common factors underlying health behaviours such as self esteem, communication skills, environment. These are usually long term interventions and are not relevant here.
- Interventions which include a number of different lifestyle topics together in a common approach, e.g. stopping smoking, cutting down drink, increasing exercise and improving diet. We were unable to find any robust evidence that this is a more effective way to work than working on single issues. In addition, practitioners did not support this approach as being realistic since clients/ patients prefer to work on one or two behaviours at one time. The exception to this is alcohol and diet since they are very clearly linked.

- A third approach is to consider holistic guidelines and training which is based on core skills and the motivational interviewing approach, but which then diverges into specialist topics. This approach seems the most favoured by the professionals in this study, who support the premise that alcohol has a specific body of knowledge and requires topic specific strategies to cut down, linked with a strong cultural influence on behaviour.

The comparison of guidance on page 13 supports the view that each lifestyle topic has specific requirements in terms of the nature of the intervention, which is developed from topic based evidence, and the resources required to support them. In the review of the resources, the holistic practitioner guidelines scored well but holistic training lacked specific alcohol related information to facilitate effective HBC interventions. However this does not necessarily lead to the conclusion that it is not possible to devise holistic training which contains the necessary specific elements.

We cannot therefore recommend the development of a holistic resource for health behaviour change on the basis that we found no evidence to support this and it was not favoured by the professional informants. The findings suggest that a core generic guideline may be useful based on a brief intervention and motivational interviewing with specialist follow up inputs. Holistic screening might be best suited to a lifestyle intervention in a generic setting but, in reality practitioners will be limited to topics by job role.

6. Conclusions & Recommendations

6.1. Conclusions

- A range of HBC interventions were being delivered which relate to the target group and the opportunities and constraints of particular settings. There is blurring between series of brief interventions and medium to longer term interventions using motivational interviewing.
- Professionals made links between using brief interventions initially and the use of CBT for alcohol interventions. This is possibly a pathway that could be explored for developing guidelines
- The findings indicated that professionals in the study were delivering brief interventions in a range of settings and felt that this was a legitimate area of their role.
- Professionals favoured the use of practitioner guidelines for health behaviour change which are short and succinct and easily accessible. Most current guidelines apply to health setting and there is a need for guidelines for other settings.
- Guidelines for professionals were the type of resource which scored highest in the resources review in relation to supporting a HBC approach.
- Confidence in the area of delivering health behaviour change was seen to be increased by provision of training, however, few of the training packs reviewed demonstrated a comprehensive HBC approach.
- HBC resources designed to support interventions need to be adequately supported by linked training, which might need to be designed for specific settings.
- In the categories of client based resources, written and web sites, there were few resources which demonstrated an HBC approach.
- Client based resources were viewed by professionals as important in supporting role legitimacy and adequacy. The social drinkers thought leaflets would have more impact if delivered in a health care setting, but required sensitivity.
- There was agreement that current resources are aimed at people who have already acknowledged they have a problem with drink. There is potential for more resource development which supports increasing motivation through decisional balance exercises, for example.
- Most of the social drinkers in our study were embedded in a heavy drinking culture, showed poor understanding of units and strength of

drinks, found the sensible guidelines unrealistically low and would not be interested in cutting down their drinking.

- It may be useful to explore resource development which involves cutting down drinking as a positive choice, rather than focussing on creating awareness of a problem which requires a solution.
- There are important issues around resource development in relation to accessibility for particular equality groups. These involves addressing issues of literacy, languages other than English and resource production in special formats, e.g. large print or voice text accessible.
- Older people in a range of settings have specific resource requirements and there is a gap in these resources being available.
- Motivational interviewing, brief interventions and harm reduction could be combined in developing resources for young people. There is a big gap for health behaviour change resources for this target group, as many are educational.
- There is limited support in this study for the development of a holistic HBC resource. The principles and methods of motivational interviewing are core. However, there was agreement in the qualitative findings that each lifestyle topic was informed by a separate evidence base and required specific strategies to be effective in supporting change.

6.2 Recommendations

6.2.1 Recommendations for development of new resources which incorporate principles of health behaviour change

1. In developing the new resources suggested below we recommend further needs assessment specific to the setting, target group and use.
2. It would be useful to develop new resources to support the process of health behaviour change in a linked set comprising a training pack, practitioner guidelines and resources for clients.
3. New practitioner guidelines should be developed for settings other than health which incorporate screening tools, simple algorithms and interactive worksheets for clients. These guidelines could take the form of a generic, holistic core element supported by topic specific supplements.
4. There is merit in drawing on the model and format of resources available for cognitive behaviour change as these seem to be well used and liked by practitioners.

5. The guidelines should be supported by training, or be linked with existing training programmes in health behaviour change. Development of training for practitioners which is based on principles of health behaviour change would be useful to enable more practitioners to access training and increase confidence and skills to deliver brief interventions.
6. Written client based resources should be developed to support the practitioner guidelines, which could be used more widely on a self help basis. It is important that these are interactive and accessible and we commend the recommendations of the general public participants in section 4.2.7, especially avoiding the terms alcohol and problem on the front page.
7. These resources could be developed from the interactive parts of 'So you want to cut down on your drinking' and supported by an accessible booklet for practitioners.
8. Establish a new website which would provide a self help resource for the public using health behaviour change principles, or adapt an existing one.

6.2.2 Recommendations for further research

9. Investigate the potential role of brief interventions in specific settings such as prisons, youth work and social care settings.
10. Investigate the opportunities for and use of brief interventions in relation to people with mental health problems.

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Appendices

Appendix A: Resource Assessment Cover Sheet

Title	
Author	
Published/ Produced By	
Date	
Obtained from	
Type	
Description	<i>Aims & objectives if included in training packs</i>
Holistic/Specific?	<i>e.g. is it an alcohol resource or a holistic health resource that includes alcohol? Equally it could be a general training resource on HBC/ MI or an alcohol specific training resource.</i>
Resource intended for intervention by	
Target beneficiary	
Intended setting	
To what extent could this resource be used in another setting or with another target group (in its existing format)?	
How accessible and useful does the resource appear to be for its target audience?	
Is the resource up to date and does it contain accurate factual information? Provide comment.	
Is there anything in the resource that indicates whether it has been evaluated? If so, provide reference.	
Any other comments?	

Appendix B: Complete descriptions of resources sourced & identified, including those which were not received and/or not reviewed.

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
1.1	So you want to cut down your drinking?	Heather, N & Robertson, I 2003 NHS Health Scotland	A self-help manual for people who wish to cut down their drinking. Includes a pocket drink diary.	Alcohol specific	x - self help y - general z - home	Lengthy and difficult to follow.	Suitable for a range of settings but not appropriate for young people or for those with low literacy levels	None	Much of the information is now out of date. Plenty of opportunities for reader to engage with text and use as a workbook with quizzes and self assessments. Overall the length and volume of continuous text seems to be potential barrier for many readers.

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
1.2	Recognising Problem Drinking	Author unknown Date unknown NHS Health Scotland & AFS	Leaflet designed to help people spot a problem with alcohol and find out what they can do about it. http://www.infoscotland.com/alcohol/files/recognising-problem-drinking.pdf	Alcohol specific	x - self help y - general z – home	Simple and clear but very brief.	Generic resource, not suitable for young people	None	Simple and accurate but not detailed enough to support HBC in self help setting.
1.3	Alcohol and Sensible Drinking	Sandra Johnston 2004 NHS Greater Glasgow STEPS	Booklet for people who would like to cut down on their drinking (part of a training course on Stress Control) http://glasgowsteps.quietscience.com/_media/documents/alcohol.pdf	Alcohol specific	x - self help y - general z – home	Clearly labelled sections and accessible language	Some references to other parts of Stress Control course	None	Useful booklet with plenty of practical advice on cutting down with some opportunities to assess own drinking. Weaker on enhancing motivation.

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
1.4	Concerned About Someone's Drinking?	Author unknown September 2003 Alcohol Focus Scotland	A booklet for people who are worried about someone else's drinking covering common problems, what you can do, looking after yourself and where to get more help	Alcohol specific	x – self help y – people affected by someone else's drinking z - home	Clearly written for someone in a support role	Minimal use to the drinker her/himself	None	Not included in review as did not match criteria for an HBC resource. Useful as an information leaflet.
1.5	Get the full bodied facts (booklet) See also 3.5	Author unknown Date unknown Scottish Executive/ Gender Issues Network on Alcohol	Booklet for women containing factual information, tips for staying safe, hints on cutting down, advice for coping with another's drinking and sources of further help	Alcohol specific	x - self help y - women z - home	Volume of text and division of sections does not support use for HBC	Women only.	None	Difficult to extract key elements for HBC. Doesn't take reader through a logical process. Functions as an information booklet.

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
1.6	Drink diary and self help guide	Author unknown 2005 Alcohol Focus Scotland	Originally adapted from “So you want to cut down your drinking” designed to provide information for those wishing to adopt a relatively harm-free style of drinking	Alcohol specific	x- self help y – general z – home	Pocket sized and easy to read	Not suitable for young people	None	Useful pocket sized resource, rather brief in places, needs updating and better assessment tool with feedback. Does not attempt to support brief intervention in MI style
1.7	Think About Drink	Jeannette Chantler Date unknown Alcohol & Drugs Support South West Scotland	Self help guide and drinks diary booklet designed for people who have drinking problems and also people at risk of health problems. Provides advice on low-risk drinking limits, good reasons for drinking at these levels and advice on changing habits	Alcohol specific.	X – self help Y – general Z – home	Easy to read and engage with	Not suitable for use with young people	None	Well laid out and easy to use booklet. Needs updating with better assessment tool and more MI style intervention but excellent resource for goal setting and scenario planning for those wishing to cut down. Text largely taken from BI for harmful and hazardous drinking 3.9

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
1.8	Alcohol & Healthy Living	NHS Health Scotland/A FS	A leaflet "guide to how you can enjoy alcohol & stay healthy". http://www.infoscotland.com/alcohol/files/alcohol-and-healthy-living.pdf	Alcohol specific.	X – self help Y – general Z – home	Easy to read, clear document	Not suitable for young people	None	Although contains useful steps to cutting down, not an HBC resource
1.9	See also 3.7&4.10 DRAMS Scheme: Helping Problem Drinkers – Skills for the General Practitioner (Patient Booklets)	Ian Robertson 1990? Scottish Health Education Group	4 patient booklets "How much do you drink?, Cutting down, Coming off and Keeping going" designed to be given to patients by GPs	Alcohol specific	X – self help Y – GP patients Z – home	Useful separate booklets facilitate staged approach	Not suitable for young people	None	This document is designed to be used with the practitioner guide and training pack. Now largely out of date it appears to be a precursor to "So you want to cut down your drinking". Strong section on developing discrepancy

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
2.1	Down Your Drink	UCL Medical School Last updated ? Alcohol Concern	Screening tool with 3 questions. http://www.downyourdrink.org.uk/	Alcohol specific	x - self help y - general z - home	Requirement to take part in research could be very off putting	Not suitable for young people	z.khadjesari@pcps.ucl.ac.uk	Need to register to take part in the research to use the site which involves providing name and completing questionnaires on registration, in 1 month and in 3 months. Those who don't wish to register are automatically directed to Drinkaware see 2.2
2.2	Drinkaware	Author unknown Drinkaware Trust	Useful information about alcohol and drinking designed to provide facts and practical tips to suit a variety of people and occasions http://www.drinkaware.co.uk/check-your-drinking/	Alcohol specific	x - self help y - general z - home	Clearly written and easy to use	Not suitable for people unaccustome d to navigating web pages	None	Provides factual information, largely accurate and up to date with some harm reduction suggestions but no support for cutting down. Interactive diary and assessment tools are well designed but fall short at providing feedback once they have been completed.

Ref.	Title	Author Date Published/produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)professional with (y) target group in (z) setting	No of Pages (approx) & Accessibility for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
2.3	Info Scotland: Alcohol	Scottish Executive	Aimed at the general population of Scotland between the ages of twenty-five and forty-five. It is not aimed at known problem drinkers. Rather, the purpose of the website is to alert the much larger section of the population whose drinking may be causing them harm but who are not aware of the health consequences of their drinking behaviour and habits. http://www.infoscotland.com/alcohol/interactivedisplay.jsp?pContentID=79&p_applic=CCC&p_service=Content.show&	Alcohol specific	x - self help y - general z - home	Simple to use, attractive design, rather lengthy	Not suitable for young people or older people	None	Information based site containing extensive details of health and other effects and top tips for healthier drinking with addition of many interesting interactive elements which the persistent and thorough user could find very helpful. No attempt to facilitate brief intervention using motivational interviewing style.
2.4	Netdoctor - Test yourself	Author and date unknown Published by netdoctor.co.uk	online AUDIT style screening test http://testyourself.netdoctor.co.uk/interactivetests/alcoholdrinking.php	Alcohol specific	x - self help y - general z - home	Very general appeal	Not suitable for young people and no distinction for males or females	None	Simply an online screening tool with limited feedback provided which make this resource of no help to the reader/user

Ref.	Title	Author Date Published/produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)professional with (y) target group in (z) setting	No of Pages (approx) & Accessibility for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
3.1	Management of harmful drinking and alcohol dependence in primary care: Quick Reference Guide	Unknown 2003 SIGN 74	Guidelines for the management of harmful drinking and alcohol dependence in primary care. Aims to assist the general psychiatrist, the psychiatric nurse, GP and the primary care team to meet the challenge of assessing and treating patients presenting with alcohol-related problems, whether they be disclosed or undisclosed. www.sign.ac.uk	Alcohol specific	x - primary care workers y - general z – primary care	Very brief and readable clearly outlining evidence base for GP setting	Not suitable for other settings	None	Brief and easy to use document but lacking detail which makes of little value other than as a memory aid for a knowledgeable practitioner
3.2	Recording Sheet for Youth Work Alcohol Interventions	Winterbottom, J 2004 GEAAP Young Person's Alcohol Pilot	A discussion prompt and monitoring tool based on the stages of change model designed to support youth workers to address alcohol issues in informal settings.	Alcohol specific	x - youth workers y – young people z – youth work settings	Very brief recording sheet suitable for use in youth work setting or at debrief	Potential for use in community work setting	Winterbottom, 2005	Focuses on stages of change and relies on practitioner having been through “Lager and Blastaways” training programme

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
3.3	How much is too much?	Institute of Health and Society, Newcastle University 2006 Trailblazer SBI	A set of resources including a Clinician Guide, Screening Tools Simple Structured Advice prompt sheet and Extended Brief Intervention prompt sheet. Designed to support primary care clinicians to deliver appropriate interventions. http://www.ncl.ac.uk/ihs/news/item/?brief-interventions-alcohol-and-health-improvement	Alcohol specific	x – primary care workers y – general z – primary care settings	Useful guide seems very well suited to setting	Potential for use with adults in other settings. Further guidance on screening required	No reference relating to this resource specifically	A well designed and easy to read resource which would lend itself well to a variety of settings. Relies on practitioners having been through associated training course

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
3.4	Ending Offending: Alcohol Education Course of the Young Offender (Group work resource pack)				x – criminal justice workers y – z –				Not Received in time to be reviewed.
3.5	Get the full bodied facts (practitioner folder) See also1.7	Author unknown Date unknown Scottish Executive/ Gender Issues Network on Alcohol	Folder resource designed to assist professionals to provide information and support to women who approach them for help	Alcohol specific	x – generic professionals (women) y – women z – varied	Readable and attractive to a range of professionals	Suitable for women only	None	Designed for use with client booklet. Sections do not link together in coherent way and structure for intervention lacking. Folder lacks key information about alcohol

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
3.6	Better Living Better Life: Moderating Alcohol Consumption for CHD and Stroke Prevention	Linda Gask 1993	Resource to aid GPs to reduce the incidence of CHD & strokes. Includes discrete section on alcohol.	CHD & stroke preventi on – smoking , physical activity, diet & alcohol	x - GPs & Health professionals y – general z – primary care	Easy to read and follow but relies heavily on references which a busy practitioner is unlikely to follow up.	Heavy CHD and stroke focus and many references to GP setting	None	Helpful resource but now out of date.

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
3.7	See also 1.19&4.10 DRAMS Scheme: Helping Problem Drinkers – Skills for the General Practitioner (General Practitioner’s Guide)	Linda Gask 1990? Scottish Health Education Group	General Practitioner’s Guide to accompany DRAMS training and patient booklets. Contextualises the latter in relation to the Stages of Change	Alcohol Specific	X – GPs Y – general Z – GP surgery	Designed to be brief which would probably suit setting	Only suitable for GP setting	None	This guide makes little sense if separated from the related patient booklets. It also does not necessarily support the practitioner to address issues in the most logical order. However, key elements of motivational interviewing are present

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
3.8	Brief Interventions Step by Step	Dr. Niamh Fitzgerald, Drinking Interventions in Pharmacies Study	Single sheet designed to support pharmacists in providing a brief intervention on alcohol. To be used following 2 days of training along with research protocol & record sheet which includes FAST screening tool.	Alcohol specific.	X = pharmacists Y = general public Z = community pharmacies.	Ideal for pharmacy setting	Could be adapted to other settings but very health focussed	DIPS	This useful step by step guide leads the practitioner through the intervention in a logical order and highlights the key elements required for motivational interview. Document relies on additional leaflets for specific information to provide to client
3.9	Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care	2001 World Health Organisation	A manual to help primary care workers to deal with persons whose alcohol consumption has become hazardous or harmful to their health. Designed for use alongside AUDIT Guidelines	Alcohol specific	X – primary care workers Y – general Z – primary care settings	Reasonably easy to navigate document but quite lengthy	Could be adapted for a range of settings	None	A comprehensive resource focussing on brief intervention designed for use with AUDIT. Limited support for motivational interviewing contained in document but reader is referred to training and references.

Ref.	Title	Author Date Published/produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)professional with (y) target group in (z) setting	No of Pages (approx) & Accessibility for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
3.10	Alcohol Flip-Guide for Community Pharmacists	2007, Dept of Health & Pharmacy HealthLink	A set of laminated cards in a flipper style format for community pharmacists in England to use to provide "brief advice" (5 minutes) to clients on alcohol.	Alcohol specific.	X, - community pharmacists, Y – pharmacy clients, Z – community pharmacies.	10 pages. Flipper style.	Suitable only for pharmacy setting but parts could be adapted	none	A brief and easy to read guide. Very strong on helping the practitioner to raise the issue appropriately for setting. Lacks information required to accurately calculate units and doesn't progress to MI style intervention.
3.11	Improving Health: Changing Behaviour. NHS Health Trainer Handbook.	Health Psychology Team, Department of Health.	Handbook introducing approaches and techniques for "NHS Health Trainers" to use to help people change behaviours that are known to cause ill health. Includes client "reminder sheets" and worksheets	holistic	X - NHS Health Trainers Y – general public Z – variety of settings	76 pages total but this includes other topics.	Suitable for work with adults in any setting	None	A lengthy generic guide for practitioners containing clear summaries of the relevant theory and several useful interactive tools for structured brief interventions. Limited by lack of accurate alcohol related information

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
3.11	Screening and brief intervention handbook for at risk and harmful alcohol use.	NHS Tayside (date unknown)	12 page booklet for health service professional usewith screening tool AUDIT and guidance on how to interpret it . Also includes information on health effects and targeted recommendations.	Alcohol specific	X- health professionals Y – general public Z – health settings – predominately primary care	12 page booklet.	Suitable only for use by health professionals primarily in primary care	Unknown	Not Received in time to be reviewed.

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
4.1	Lager and Blastaways: An Alcohol Training Programme for Youth Workers	Linda Wright 1995 Tacade	Unit 4: Youth work with young problem drinkers. Covers identifying drink related problems, clarifying youth worker's role in raising the issue, stages of change, enabling decision making, functions of drinking and the role of specialist agencies.	Alcohol specific	x - youth workers y – young people z – youth work settings	Designed for youth work audience and would engage this group well	Could be easily adapted for generic community work settings but of most use for young people	Winterbotto m, 2005 GEAAP report – process evaluation not impact	This resource would be more helpful to the practitioner if the handouts were more use as tools to carry out interventions and the relevant information from Units 1, 3 and 4 were pulled together to make 1 course. These are the key recommendations from evaluation based on experience of delivery. Lacking detail on theory and opportunity for in depth practice with feedback. Lacking follow up recording tool but could be used combined with resource 3.2

Ref.	Title	Author Date Published/produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)professional with (y) target group in (z) setting	No of Pages (approx) & Accessibility for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
4.2	STRADA Motivational Interviewing Practice Based Workshop		Not included in review as did not meet working definition of an HBC resource.						
4.3	STRADA Introduction to Motivational Interviewing	Mary Girvan, 2004. STRADA	A two-day practice based course introducing the basic skills employed in Motivational Interviewing.	Generic	X – drug and alcohol workers, y – general public, z – varied settings	82 pages for handout portfolio only	Only suitable for in depth training on motivational interviewing	None	A generic training course, which contains a good theoretical grounding and some practice opportunities on motivational interviewing but no alcohol specific information. Relies of SOC but limited support to raise the i

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
4.4	Alcohol and Care of Older People. STRADA. (Training Course)	Caroline Cherry 2004 STRADA	A 1 day course on alcohol issues for workers who care for older people. Aims to increase alcohol awareness and develop practice skills in working with older people with a range of alcohol related problems.	Alcohol specific	x - care workers y - older people z – home and residential care settings	Designed specifically for older people. Nature of course (theoretical with many handouts) may not suit some care workers	Not suitable for any other group of workers	<i>No evaluation mentioned although STRADA have evaluated this course (process not impact I think), not sure if it is a public document – they wouldn't let GCA see it</i>	This training pack is largely made up of handouts. The content is reasonably comprehensive but focuses very much on information rather than practice. There are some opportunities in the form of case studies. No mention of MI techniques.

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
4.5	Drinking Choices Training Manual for Alcohol Educators This was the precursor to “More Drinking Choices” which is reviewed below.	Ina Simnett, Linda Wright and Martin Evans 1983 TACADE/ Health Education Authority	This manual exists to transfer knowledge and skills about alcohol to allow others to act as alcohol educators. It is designed for work within well motivated groups and, as such, is particularly suitable for inclusion within nurse training or for an in-service programme	Alcohol specific	NOT HBC			Yes – HEA/Tacad e evaluation led to developmen t of More Drinking Chices	Not an HBC resource. Now superseded by More Drinking Choices (see 4.6)

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
4.6	More Drinking Choices (pack) NOT AN HBC RESOURCE – REFERS READER TO “Managing Drink”	Linda Wright 1993 Health Education Authority	Training pack for 2-8 days worth of training aiming to: <ul style="list-style-type: none"> ▪ Increase knowledge of alcohol issues ▪ Increase understanding of own and society’s use of alcohol ▪ Practise sensible drinking skills for self and review own behaviour ▪ Increase understanding of approaches to health promotion and alcohol prevention ▪ Action plan prevention strategies 	Alcohol specific	x – alcohol educators and health promoters y - general z - varied	Good comprehensi ve background suitable for health promoters and those interested in developing prevention work	Not suitable for HBC work in any setting in current form. Section 5 could be adapted	None mentioned for this resource. However it was written following an evaluation and review of “Drinking Choices”, a consultation , a pilot of new materials, which were then re- written	Not an HBC resource. However this pack contains comprehensive sections enabling participants to examine the role of alcohol in society and individual attitudes and beliefs. Section 5 could be adapted to form a self help guide or practitioner guide but is not designed for this. Covers many of the key elements of HBC brief intervention and includes Stages of Change, goal setting, avoiding risky situations,

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4.7	Ayrshire Council on Alcohol: Alcohol and Older People	Author unknown Date unknown Ayrshire Council on Alcohol	Training pack for care workers covering alcohol knowledge and attitudes and a brief introduction to the stages of change with details of support agencies for onward referral	Alcohol Specific	X - Care workers Y - older people Z – care settings	Sensible quantity of information to train those new to topic working with older people	Only suitable for those working with older people	None	Not an HBC resource. Provides a good introduction for care workers but does not train or provide practice for carrying out Brief Interventions in a Motivational Interviewing style
4.8	Alcohol On The Agenda: A training pack for health and social care workers	Thurstine Bassett, Judith Beer and Pam Naylor 1995 Health Education Authority	Aimed at experienced trainers to enable them to organise and run their own courses on those specific alcohol issues, and aims to assist primary and secondary level workers and their managers in understanding, recognising and responding to alcohol problems in their work	Alcohol specific	x - health and social care workers y – women and older people z – varied	Well designed and clearly usable for target groups	Potential for more generic setting. Not suitable for young people	None	Clear and easy to follow training pack with possibility to pick a selection of sessions to meet the needs of a particular group. Needs updating in places. Good opportunities for role play but structure for feedback not in place. Weak on theoretical background

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
4.9	Managing Drink (video/pack)	Pip Mason	Health Professional Pack comprising materials needed to run a four-day course to educate workers in the community about drink-related problems. Includes * session plans * background notes * handouts* visual aids *	Alcohol specific	X – health professionals y- other workers Z- community	4 day course, well designed and clearly set out with visual aids and handouts	Suitable for use with varied range of professionals	West Midlands Regional Alcohol Training Scheme, Aquarius 1990	Although this resource is very old and lacks accurate info on units and limits, the key elements of Brief Intervention using a Motivational Interviewing Style are clearly explained with many opportunities for practice and some facilitation of ongoing reflective practice

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4.10	See also 1.9&3.7 DRAMS Scheme: Helping Problem Drinkers – Skills for the General Practitioner (Course Organiser’s Guide / Video)	Linda Gask 1990 Scottish Health Education Group	1 hour training video (20+40 min) with Course organisers guide, designed for use with practitioner guide and patient booklets for patients who are drinking excessively and whose consumption may be causing them harm	Alcohol specific	x - GPs y – general z – GP surgery	Clearly designed and suitable for GP audience	Video could be used for MI training in other settings but very dated	None	As a set of resources, DRAMS supports the GP to deliver BIs in the GP surgery setting. Training covers key elements of motivational interview but is weak on goal setting. Largely the shortcomings from these resources is the fact that they are not up to date and do not support interventions to take place in most logical order.

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
4.11	Not Born Yesterday (pack)	Sheila Raby 1999 Aquarius Action Projects	A Training Manual about Alcohol and Older People for Care Workers. By the end of the course participants should be able to: <ul style="list-style-type: none"> ▪ Count drinks in units and state daily benchmarks ▪ Describe effects of alcohol relevant to older people ▪ Describe role alcohol can play in older people's lives ▪ List typical problems related to older people's drinking ▪ List 3 points to consider when raising the issue ▪ Describe how and when to refer 	Alcohol specific	x - care workers y - older people z – home and residential care settings	Well designed basic level course, which seems well suited to target audience.	Focuses on older people and not transferable to other settings	None	Provides a good introduction for care workers but does not train or provide practice for carrying out Brief Interventions in a Motivational Interviewing style. Good section on raising the issue and relevance to care worker role.

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
4.12	Alcohol Education: Providing Training Courses on Women and Alcohol		A pack for trainers who wish to provide some training or education for those who are in the business of helping women with alcohol problems. Pack includes suggested courses, sources of further information & a set of reference leaflets		professionals working with women				Received too late for review.
4.13	Effective Approaches to Alcohol and Other Drug Problems: Motivational Interviewing (Book and Video Tape)	University of Newcastle							Received too late for review

Ref.	Title	Author Date Published/ produced by	Description. Including for training packs, (where stated) aims and objectives	Holistic or specific	Resource intended for intervention by (x)profession al with (y) target group in (z) setting	No of Pages (approx) & Accessibilit y for target audience	Potential for use with other groups or in other settings	Evaluation reference if available	Comments
4.14	Alcohol Awareness: Towards a Trans-cultural Approach (Training Pack)								Received too late for review

Appendix C

Resources to support health behaviour change - alcohol FOCUS GROUP PROTOCOL – GENERAL PUBLIC

Scatter leaflets on the table and encourage people to read them while waiting to start

Introduction

Introduce self and a wee bit about the research project – Health Scotland

Consent forms for recording

A lot of people who are regular social drinkers are exceeding the safe limits without realising it. These limits are:

- **For women:** no more than 2-3 units a day and no more than 14 units a week
- **For men:** no more than 3-4 units a day and no more than 21 units in one week

When they find out they are at risk of damaging their health in the long term, they often want to cut down on their drinking, but may not find it very easy. People like doctors and nurses can help, also community workers, social workers etc. This focus group is about the materials which might help people who want to cut down on their drinking.

Ice breakers

- Name and favourite drink
- Guess the units in these drinks: large glass of red wine (3), pint of ordinary beer (2.3 units), a double vodka and tonic (2.8), Smirnoff ice (1.5)

Vignettes of people who are putting their health at risk from drinking above the limits:

Give out cards and read vignettes:

What is your reaction to the amounts these people are drinking? *typical, surprising, sensible limits, too much?*

What would trigger people like these to see the need to cut down on their drinking?
Prompt: How do you think they would feel about a doctor/nurse/professional giving them information about sensible drinking and letting them know the risks?

What information do you think people like these would need if they wanted to cut down on your drinking?

Do you think these people would go to a doctor / nurse / alcohol project for advice/support or do you think self-help material would be useful?

If a doctor or nurse (or others youth workers/pharmacists/prison staff etc.) was discussing this with you would you find it helpful to have some information to take away?

What kind of information – leaflets, CD, DVD, website address?

Discuss merits and disadvantages of each.

If you wanted information to do this yourself what would you want? Leaflet, book, website, CD, DVD? Where you expect to find this?

Refer to the leaflets here – introduce the 2 leaflets and explain their purpose/format

If not had a chance to read them, do so now.

Yellow leaflet first – **Alcohol and Healthy Living**

What are your initial impressions of this leaflet?

Is this something that people would use by themselves or do you think they would need someone (e.g. a professional) to help them to work through it?

What do you think about the information in it? *Usefulness, most people know already, new – what?*

Amount of information?

How clear is the advice on units? How easy do they think someone would find it to work out whether they need to cut down or not?

What do you think about the guidelines for cutting down?

Do you think the people in our examples would find this useful if they wanted to cut down? What might be better?

Any particular sections you would remove or that are particularly valuable?

Not so good? Off-putting?

How could it be improved? Is any information missing?

What would you do with this if given it? Would you use it? Why/ why not? Would you want support from a professional to use it or would you use it alone?

What do you think of the tone? Does it feel understanding or patronising? Do you feel it recognises what people enjoy about drinking as well as the risks?

Do you feel it encourages the reader to make their own decision about cutting down?

Do you feel it encourages the reader to feel confident about making changes?

Any other general comments?

-

Drinks Diary

This is intended for people to use as a wee workbook to help them make plans for cutting down and to record their progress. It also provides lots of information on alcohol. *Talk thru the headings that are covered in the booklet*

Same questions as previously but include:

What do you think about this kind of resource? (i.e. a workbook type resource). - Initial impressions

Is it useful to have something that people can write their drinking down on? Or is it off putting or a waste because no-one would do it? Is this missing from the yellow one?

What are your views on the amount of information in each one – which quantity is better? *(But ignoring the formatting initially.)*

Other comparisons *(discreet versus colourful, size, presentation, graphics)*

Best bits from both? What would an ideal leaflet look like?

Appendix D – vignettes

Sensible drinking levels are:

Men: no more than 3-4 units a day and no more than 21 units in one week

Women: no more than 2-3 units a day and no more than 21 units a week

Jeannie

Jeannie is 51. She lives alone after being divorced about 5 years ago. She has a good job, plenty of interests and an active social life. She is happy with her life. She drinks wine most evenings, either with friends, at restaurants or at home with her feet up in front of the television. She drinks between 2 glasses most week days (4.2 units per day) and at weekends this could be 4-5 glasses each day (8.4 -10.5 units). **(About 34 – 38 units a week)**

Joe

Joe is 68 and happily married. He likes a bottle of lager if he is at home (4 nights = 7 units), but he goes down the pub on Wednesdays and Saturdays, to watch football, play darts or chat with his mates, and drinks about 3-4 pints of medium strength beer (17-22 units). He and his wife go out one night a week and he tends to drink about 3 pints of medium strength beer and a couple of whiskies (10 units). **(About 34-39 units a week)**

Darren

Darren is 20, single and working. He is health conscious and goes to the gym and plays five-a-side football in the week, but at weekends he goes to the pub and clubbing with his mates on Fridays and Saturdays. On those nights he drinks about 6-8 pints of medium strength lager (34 – 45 units) and a few shots (3 shots each night = 6 units). On Sundays he has a few beers at the pub – 3 pints ordinary strength lager (7 units). **(47-58 units a week)**

Appendix E

FOCUS GROUP PROTOCOL – professionals

Introduce self and background to the project. Permission to tape, anonymity, etc
Define type of interventions discussing, ie not long term counselling

3. Interventions lasting between 3-15 minutes where there is a basic professional level of HBC expertise and communications skills required (can be referred to as opportunistic 'brief advice', 'brief intervention' or 'brief negotiation').
4. Interventions lasting 15-40 minutes where there is an advanced level of expertise and skill required (i.e. help seeking situations, 'HBC Counselling', 'brief motivational interviewing' or 'adaptations of motivational interviewing').

- 1) **Names and posts:** brief background in relation to involvement with alcohol and health behaviour change
 - a) Knowledge and experience of health behaviour change in relation to alcohol
 - b) How knowledgeable /confident do you feel in relation to alcohol and health behaviour change (brief interventions, motivational interviewing)
 - c) Training received in health behaviour change and alcohol *generic / alcohol specific*. How useful was it?

2) **Experience:**

- a) Client / patient groups working with
- b) How do you raise the topic if they don't, client/ patient perceptions of appropriateness
- c) Is there a difference in perceptions of what constitutes an alcohol problem between you and clients/patients
- d) What kind of interventions are you making for alcohol problems: *Brief / longer interventions / refer to specialist agency*
- e) Use any of these resources with clients / patients? Would they find them helpful?
- f) Do clients / patients use drink diaries?
- g) Are there any other resources for clients/ patients you are using?

3) **“So you want to cut down on your drinking”**

- a) Familiarity with resource and use
- b) Who do you think this is aimed at?
- c) Client / patient group – nature of intervention
- d) How well does it reflect current sensible drinking guidelines ?
- e) How well does it reflect principles and practice of HBC?
 - i) Identifying the problem
 - ii) Assess readiness to change
 - iii) Engage with motivation to change
 - iv) Provide a menu of options and negotiate goals
 - v) Deal with relapse
 - vi) Indicate options for further support?
- f) Suitability for equality / diversity groups work with

g) Strengths and weaknesses of resource

4) Repeat with other leaflets yellow one, crib sheet and drink diary

5) General – what is missing?

- a) What kind of situations do you find yourself in when you would like a resource to back you up and there isn't one? What other kind of resources are needed? Obvious gaps for particular client / patient groups?
- b) What support / resources aimed at professionals are needed? *Crib sheets, guidelines, etc*
- c) Could a holistic resource be useful – ie same guidelines for different topics – smoking, eating, physical activity? Or are specialist alcohol resources required?
- d) Are there any important principles we could draw for HBC resources?

Appendix F

Participant organisations in Validation Group

Alcohol Focus Scotland

Ayrshire Council on Alcohol

Glasgow University – Department of Nursing, Nursing Council of Alcohol

National Substance Use Liaison Officer – alcohol

Scottish Executive – Alcohol Misuse Delivery (Public Health and Well-being)