

Process evaluation of Alcohol
Brief Interventions in wider
settings (Young People and
Social Work)
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Glossary

ABI	Alcohol Brief Intervention
ADP	Alcohol and Drug Partnership
AUDIT	Alcohol Use Disorder Identification Test
BMI	Brief Motivational Interviews
CRAFFT	Mnemonic acronym for a behavioural health screening tool for use with children under the age of 21
Diversionary projects	Projects designed to attract young people away from drinking towards an activity viewed as health promoting
DRAMS	Drinking Responsibly and Moderately with Self-control
DUST	Drug Use Screening Tool
FAST	Fast Alcohol Screening Test
GIRFEC	Getting It Right For Every Child
HEAT	Health improvement, Efficiency, Access to services and Treatment
INEBRIA	International Network on Brief Interventions for Alcohol and Other Drugs
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use
SBIRT	Screening, Brief Intervention and Referral to Treatment
SCPHRP	Scottish Collaboration for Public Health Research and Policy
SIGN	Scottish Intercollegiate Guidelines Network
SIPS JR HIGH	Feasibility trial of screening and brief alcohol intervention to prevent hazardous drinking in young people aged 14-15 in a high school setting
SMACAP	Scottish Ministerial Advisory Committee on Alcohol Problems

Executive summary

About the study

This study aimed to explore the feasibility and acceptability of ABIs delivered to young people and in social work settings. The study did *not* aim to examine whether individuals who received ABIs changed their drinking behaviour and improved their health but did explore how feasible a future outcome evaluation of ABIs in these settings would be, and the issues and challenges which would be involved in such a study.

The study comprised two main phases of research:

- Phase 1 documented and analysed the set-up and delivery of ABIs and staff's perceptions of their feasibility and acceptability.
- Phase 2 explored the experiences and views of young people who had either experienced ABIs through the projects or might potentially experience ABIs. Phase 2 also included a desk analysis of project data to provide advice on how an outcome evaluation could potentially be undertaken in the future.

Twelve projects currently delivering ABIs in young people and social work settings (or planning to do so in the future) gave consent to be contacted by the research team, and ten of these 12 projects were able and eligible to participate in the study.

For Phase 1, qualitative interviews were conducted with 27 project managers, staff and related stakeholders. For Phase 2, individual, paired and group interviews were conducted with 61 young people (males $n=37$, females $n=24$), ranging in age from 12-23. Fieldwork was conducted between December 2012 and July 2013.

Delivery of ABIs

The ten projects included in Phase 1 of the study were heterogeneous in terms of aims, operated in a range of different settings, and used a variety of approaches and methods for addressing alcohol. Only one project operated in a social work setting, while nine worked with young people, and most of the findings and analysis focused on these nine projects. The settings in which ABIs were delivered reflected this diversity: some ABIs were being delivered in centres which young people visited for one-to-one health and other advice, while other settings for ABI work with young people included mobile vans which visited communities, the side of sports pitches, and street outreach.

Various drivers of alcohol work were identified, including a desire to address alcohol's negative impact on young people's lives (for example, the consequences of unprotected sex), a desire to engage with vulnerable young people around crime and anti-social behaviour issues, and a desire to provide alternative activities, such as sport. Use of ABIs with young people was driven by an ethos of harm reduction and minimisation. Central to much of the work with young people was a commitment to focusing on the individual young person in a non-judgemental way and equipping them with knowledge and skills to help improve their lives.

ABI delivery tended to be flexible and opportunistic, and could vary quite widely in approach. Generally project workers felt that there was a lack of suitable screening

tools for use with young people in these settings, although some projects had adapted tools that they described as having a good fit for their projects.

Monitoring and data collection practices varied widely, ranging from projects that had attempted to understand baseline levels of consumption and follow up ABIs, to those where no data were routinely collected.

Feasibility and acceptability: staff perspectives

A range of factors influence the feasibility and acceptability of ABIs in these settings. ABIs appeared more likely to be embraced where they were perceived by project staff to be compatible with existing goals and ways of working. A strong emphasis was placed by project staff on the relationship between the worker and the young person, and judgements about how ABIs might affect the relationship were a primary concern shaping whether and how ABIs are used.

There was a perception in some cases that an inflexible model of ABI delivery designed for adult and health care settings was sometimes being inappropriately expected of youth services. Training which recognises the values and methods of youth work, and which demonstrates how ABIs can fit with and complement this work, is important.

Organisational factors also affected the feasibility of ABIs in young people's settings. These included staffing consistency and continuity, the skill mix in staff teams, and organisational funding arrangements and stability.

Acceptability: Young people's views

The acceptability of ABIs to young people was also explored. Where young people had not experienced an ABI, the study explored their feelings about the concept of alcohol conversations and ABIs being offered by the particular project they attended.

The young people interviewed were mostly very positive about the projects, perceiving them as welcoming and safe places. Their perceptions of the staff were generally similarly positive. Young people indicated that they felt valued by staff and staff were seen as credible sources of advice and support. In this context young people were largely amenable to conversations about alcohol, or to the concept of conversations about alcohol, and felt that these fitted with the perceived concern that youth workers had for their wellbeing.

Young people did not always respond positively to form-filling and appreciated efforts to make conversations about alcohol more engaging and less formal. Some who had experienced ABIs or similar interactions welcomed the one-to-one format and felt that it enabled them to be more honest about their alcohol use.

The feasibility and acceptability of ABIs should also be considered in relation to the perceived needs of local communities and individual clients. The location, timing and targeting of ABI delivery, along with other services relating to alcohol, needed to acknowledge and adapt to these changing patterns where necessary and to adopt a tailored approach to different sub-populations where appropriate.

Related to the need for tailoring, a clear need was identified in the study for screening tools and resources which would be suitable for ABIs with young people. The lack of appropriate tools and resources reflects the still developing nature of ABI work in these settings. This is an area where future research and development should be directed.

Feasibility of an outcome evaluation

In terms of future evaluation potential, the projects examined in the study showed diversity in their readiness for outcome evaluation. Seven key issues and barriers to evaluating impact of these types of projects in the future were identified:

- Client access: Barriers to accessing young people who have received an ABI. E.g. in outreach projects where young people may only attend the project once
- Sample size: Insufficient numbers/positive screens coming through the system
- Recording: Absence of a robust system or culture of recording; inconsistencies in recording practice
- Screening: Limited or no use of screening tools; lack of appropriate screening tool; doubts about efficacy screening tools
- Follow-up: Limited ability to follow up young people who have received an ABI
- Attribution: Difficulties isolating the impact of ABIs from a broader package of intervention measures
- Fidelity: Difficulties in establishing when or how ABIs have been delivered.

Conclusions

This research aimed to address an evidence gap on the effectiveness of ABIs in non-health or “wider” settings. This study has successfully highlighted that it seems feasible and acceptable to deliver ABIs in young people settings.

Young people felt that the projects were delivered in a way that was welcoming and safe and at a time and place that was appropriate. However, young people did not always respond positively to form filling and project staff can be reluctant to collect data. Consequently, it could be challenging to undertake research in these settings to identify whether ABIs are effective.

1. Background to study

1.1 Alcohol Brief Interventions in Scotland: The HEAT H4 Target and Standard

Alcohol Brief Interventions (ABIs) are time-limited interventions that focus on changing drinking behavior. While there is no formalised definition of an alcohol brief intervention, it can be described as: *“a short, evidence-based, structured conversation about alcohol consumption with a patient/client that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm”* (Scottish Government, 2011). With over 50 randomised controlled trials, ABIs are currently the treatment modality best supported by research evidence in the alcohol field (Heather, 2011), with evidence strongest in primary care settings. However, there are still gaps in what is known about their effectiveness, particularly in non-healthcare settings, with women, with the adolescent population, and when delivered by staff other than health professionals (Kaner *et al*, 2007).

To address harmful and hazardous drinking, the delivery of ABIs has become a significant component of the Scottish Government Alcohol Strategy as recommended by the SIGN74 Guideline (Scottish Intercollegiate Guidelines Network (SIGN) 74, 2003), as well as other UK guidance in the form of the NICE Guidelines (2010a). In 2008, as part of this strategy, a new health improvement target for NHS Health Boards was set, HEAT H4, which specified a target number of ABIs to be delivered across the three priority settings of primary care, accident and emergency and antenatal care, between April 2008 and March 2011. These priority settings were chosen because the evidence was strongest in these areas. The target built on work that had taken place in six Health Boards that were already delivering ABIs through the Scottish Enhanced Services programme. The HEAT H4 target was supported by a substantial increase in funding for alcohol treatment and support services. In addition, the Scottish Government asked NHS Health Scotland, in collaboration with other national partners, to work closely with Health Boards to ensure that an effective programme of support was put in place to enhance the delivery of ABIs throughout Scotland, including training for all staff delivering ABIs. A subsequent one year extension target was introduced in February 2011, for delivery over the period April 2011-March 2012, with the aim of supporting the long-term embedding of ABIs. A national evaluation of the implementation of NHS delivered ABIs in Scotland was undertaken between 2010-2011 on behalf of the Scottish Government through the Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) work programme (Parkes *et al*, 2011).

The delivery of ABIs remains a key priority for Scottish Government and HEAT H4 has now become a HEAT standard in order to support the continued aim of embedding ABIs into core NHS business in the three original priority settings (Scottish Government, 2011). The standard builds on the target and supports implementation of the Quality Alcohol and Treatment Support (QATS) report recommendation *“that NHS boards and their ADP partners should continue to embed and sustain delivery of ABIs as a key early intervention which should form part of any local ADP strategy to reduce alcohol misuse and related harm”* (Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP, 2011, p1). In addition, as part of this HEAT Standard, up to 10% of ABI delivery towards the standard can now be

derived from non-priority (deemed 'wider') settings (Scottish Government, 2011). A wider setting is defined as:

'Any ABIs delivered outwith the priority settings, by any professional, will constitute wider setting delivery. Any delivery in the priority settings by a trained professional other than doctors, nurses and midwives will also be considered as wider setting delivery. Likewise, an ABI delivered to an individual under 16 in any setting will also constitute wider setting delivery' (Scottish Government, 2011).

Prior to the new guidance, NHS Health Scotland undertook a scoping study to identify the range of non-HEAT settings in which ABIs were being delivered, or could potentially be delivered, and to investigate how best to support current and emerging ABI delivery by NHS boards and partners in such settings (Laird, 2011). While the report clearly states the limitations of the data able to be collected in this regard, it was able to indicate the following:

- The extent of ABI delivery by community and voluntary organisations and the high number related to delivery to young people within a youth work or youth services setting.
- The diversity of settings and staff groups involved.
- Interest and commitment from external partners had often facilitated the development of the intervention.
- Other outcomes were seen to be important to these agencies/partners as well as the reduction of alcohol misuse.
- The lack of attention being placed on planning for programme evaluation by many of the projects and the lack of electronic data being recorded at that time within projects (Laird, 2011).

At the time of the data gathering for the Laird (2011) scoping review there was one report example of a local government social work/care project delivering ABIs and 10 examples of community justice/criminal justice projects delivering ABIs. ABIs are currently being delivered to young people by non-health professionals (e.g. youth workers, police, social workers) in a range of non-health wider settings such as youth groups and school (Laird 2011 and 2013).

The Scottish Government (2011) HEAT standard guidance outlines what should be considered when planning, delivering and evaluating ABIs in order to develop and strengthen the evidence base, and contains a 'checklist of requirements' for consideration by those delivering ABIs in wider settings. This document places significant attention on the importance of evaluating such approaches in order to inform future learning and delivery and develop the evidence base.

In 2012, the Scottish Collaboration for Public Health Research and Policy (SCPHRP) and NHS Health Scotland met to develop a study to evaluate ABIs which had been developed locally by health boards and others in such wider (non-NHS) settings. The project aimed to facilitate the development of:

- an understanding of evaluation and why it is important
- early stage evaluation plans which are relevant, efficient and effective
- robust evaluation which is both locally, nationally and internationally recognised

- research capacity within the workforce.

To meet these aims the project comprised four components:

1. Initial evaluation workshop for people involved in setting up ABI projects to develop implementation and evaluation plans.
2. On-going support in the development of the evaluation plans.
3. Scottish Government funding to explore the feasibility of evaluating ABIs.
4. Training fellowships for people involved in service delivery who wish to increase their research skills in an academic environment.

As part of the project, the current study was commissioned (see Section 1.5 below).

1.2 Rationale for focusing on young people and social work settings

Alcohol consumption in young people and adolescents (particularly binge drinking) and related disorders are worldwide public health problems (Jernigan, 2001). A survey of 16 year old school students in 35 European countries (Hibell *et al*, 2009) reported that, in the UK, a large majority (88%) of the students had consumed alcohol during the past 12 months and more than half (57%) had been drunk during the same period. In Scotland, 29% of boys and 25% of girls aged 11-15 reported drinking on a weekly basis (Currie *et al*, 2010). Alcohol consumption among young people aged 13-15 has varied over time and while it declined between 2002 and 2008 in 2010 this trend ended and consumption slightly increased (SALSUS, 2010). According to the Scottish Health Survey (Bromley *et al*, 2012, p70), drinking behaviour varies by age for both genders with 8% of men and 5% of women aged 16-24 drinking harmfully, and 30% of men and 22% of women aged 16-24 drinking at hazardous levels (calculated using the AUDIT questionnaire).

This risk taking behaviour has adverse consequences to the individual and can lead to health problems such as chronic liver disease, heart disease, stroke, depression, unintentional injuries and death (Grant *et al*, 2009). The consequences of alcohol misuse are both physical and emotional (Tomlinson *et al*, 2004). Early initiation of risk-taking behaviour frequently has a greater impact on health than is experienced those who undertake the same behaviour but at a later age. This pattern is observed for alcohol where adolescent drinking increases the risk of heavy drinking and alcohol dependence in adulthood (Andersen *et al*, 2003).

Although social services cover a wide range of issues, addressing alcohol misuse is a crucial part of their remit with a recent estimation that between 36,000 and 51,000 children in Scotland live with a parent or guardian with an alcohol problem (Scottish Government, 2012). Galvani *et al*'s (2013) study of child and adult social care professionals found that assessment of parental substance misuse often took place too late and with no guidance on how to undertake it effectively. Another area to note is criminal justice social work where a number of studies have shown a higher prevalence of alcohol problems amongst offenders than in the general population (Coulton *et al*, 2012; MacAskill *et al*, 2011).

1.3 Evidence for screening tools and effectiveness of ABIs

Screening for alcohol consumption is often viewed as an integral part of the ABI (sometimes referred to as 'screening and brief interventions' (SBI), sometimes with a follow-on of 'referral to treatment' (SBIRT)). There are a range of well validated

screening tools for the adult population (e.g. AUDIT, FAST) (see Glossary for full definitions). However, although there are some screening tools available for assessing alcohol use in adolescents (AUDIT, CRAFFT), none of the available screening tools has been shown to have the full complement of characteristics that would warrant widespread use with adolescents (Clark and Moss, 2010). Difficulties with accurately assessing harmful drinking in this population may affect the effectiveness of any intervention.

ABIs have been widely used in a variety of settings with a range of population groups. The focus until recently has been the health care setting (e.g. primary care, accident and emergency) and in adult populations. To date, 13 high quality reviews have been published which have evaluated the effectiveness of ABIs in health settings (Doi, 2012). Two focused on antenatal settings, four on primary care and a further three on emergency departments. The remaining reviews were carried out in general hospital settings. The definitions of ABI varied considerably between reviews. Despite this, there was consistent evidence that ABIs were effective in primary care. There was also some evidence that they were effective in general hospital and in antenatal care settings.

The evidence for effectiveness of delivery of ABIs in wider (non-health) settings has yet to be established in the UK, and a number of gaps in the evidence have been identified. A National Treatment Agency for Substance Misuse (NTA) review identified the effectiveness of ABIs with young people as being one such gap (Raistrick *et al*, 2006). Additionally, the recent NICE Public Health Guidance on Alcohol-Use Disorders also highlighted the limited evidence to date on ABI effectiveness for young people (National Institute of Clinical Excellence, 2010b).

One of the most significant gaps in the literature on ABIs is in the field of social work. The work of Coulton *et al* (2012) in England and Skellington-Orr *et al* (2011) in Scotland are most notable in exploring the use of ABIs in social work criminal justice settings. In terms of supporting families affected by parental substance misuse, Forrester *et al* (2008) implemented a training intervention using Motivational Interviewing for alcohol misuse in child and family social work in England; in Scotland, Fitzgerald (2011) has reported on training multidisciplinary health and social care teams to use ABIs in East Renfrewshire.

Another significant gap in the literature concerns the use of ABIs with young people. Only two published reviews have focussed specifically on ABIs for this population group. One systematic review of screening, brief intervention, and referral to treatment (SBIRT) for alcohol use in adolescents identified seven RCTs, but all took place in hospital emergency departments. The authors concluded that it was not clear whether SBIRT was an effective approach in this setting (Yuma-Guerrero *et al*, 2012). Another recent review of reviews (Patton *et al*, 2013) included similar studies and again the settings for most interventions were health related. The authors conclusions were focussed on the delivery of ABIs in the (health) settings where young people are likely to present to health services, rather than the community settings where they congregate and interact (e.g. school, youth clubs). Patton *et al* (2013) also concluded that further research to develop age appropriate screening tools needs to be undertaken, and suggested that screening and brief intervention activity should be undertaken in settings where young people are likely to present.

Only one (ongoing) study of the general adolescent population has been identified - the SIPS JR HIGH trial (Newbury-Birch *et al*, 2012), which is exploring the feasibility of delivering brief alcohol interventions using motivational interviewing principles to 14-15 years olds in school settings in the North East of England. Other relevant studies include a trial examining the use of SBI to reduce teens risk of substance-related car crashes in the USA and Czech Republic (Harris *et al*, 2012), and studies exploring use of SBI for alcohol use with youth in the criminal justice system (see D'Amico *et al*, 2010; Roberts-Lewis *et al*, 2010; Stein *et al*, 2011a and b).

Although not defined as a 'brief intervention', McCambridge and Strang (2004) found evidence for the effectiveness of a single hour long session of motivational interviewing (MI) in reducing substance use among adolescents in a further education setting. A study of MI in youth work was also supportive of an impact on adolescent substance use, particularly alcohol, with those receiving MI drinking on average two days per month less than controls after 3 months (Gray *et al*, 2005). Reviews of the evidence for the effectiveness of MI interventions of varying duration are cautiously supportive of a positive impact in reducing substance use in adolescents (Jenson *et al*, 2011; Barnett *et al*, 2012).

When implementing and evaluating ABIs in a different setting, with a different population group and a different model of service delivery, several key issues including context, mechanisms and outcomes need to be considered. For example, young people may not respond in the same way to an ABI as adults, given that their motivations to drink and reduce their drinking may be very different, and the 'risky behaviour' (hazardous drinking) may be less entrenched than in adults. An important distinction needs to be made between occasional experimentation and enduring patterns of risk behaviour. Rates of occasional experimentation in young people far exceed rates of enduring problems (Steinburg and Sheffield Morris, 2001; Percy *et al*, 2011). The context in which the ABI is delivered is also crucial, since many will not be delivered by a health professional. Finally, the most relevant outcomes may not be alcohol reduction or abstinence, but harm minimisation (Coleman and Cater 2006).

1.4 Qualitative studies examining barriers and facilities to ABI use and implementation

Similar to the quantitative evidence, most qualitative studies of ABI use have focussed on the adult population in the health care setting. A systematic review of barriers and facilitators to implementation published in 2011 identified 47 papers in total (2 systematic reviews, 6 RCTs, 25 cross-sectional studies and 14 qualitative studies) (Johnson *et al*, 2011). Despite extensive searching, the authors identified no qualitative studies for young people. This review also concluded that, whilst brief screening and brief interventions have been shown to be effective in some settings (primary care, accident and emergency), research is needed to assess implementation in other settings. One conference abstract has been published which examined young adult perceptions of and motivations for drinking, through analysis of brief motivational interviews (BMI) (Dupree *et al*, 2012). Twenty-eight participants aged 18-24 years were interviewed, and the authors found that reasons for drinking (and expected consequences of drinking) were interpersonal in nature - such as drinking due to peer influence and the belief that drinking will facilitate social

interaction. The researchers concluded that interventions with young people could especially benefit from an emphasis on social skills and abstinence-supportive relationships in trying to reduce alcohol use.

Another qualitative study also explored pathways for practice and policy to reduce alcohol abuse among adolescents aged 14-17 years (Coleman and Cater, 2006). These included: supporting policies that tackle generic risk taking; adopting a harm-minimisation approach (rather than promoting abstinence); identification of key risk groups; the provision of alcohol education in schools; and the promotion of alternative, safer activities for adolescents.

1.5 Qualitative studies examining the role of alcohol in young people's lives

Three qualitative studies have more generally explored the issues of alcohol and young people (two UK based and one Portuguese). Both UK studies found similar issues associated with younger drinking including social norms and the setting for the drinking, which was usually outdoors and on the streets. The most recent was funded by the Joseph Rowntree Organisation and was undertaken in Belfast (Percy *et al*, 2011). Thirty-six interviews were completed across eight friendship groups. Their analysis found that young drinkers place considerable emphasis on being able to control their drinking behaviour; made complex judgements about the volume, type and pace of their consumption; and had some strategies for harm minimisation but many were ineffective. The other UK qualitative study examined young people's perceived motivations for 'binge' drinking, and the associated harmful outcomes (Coleman and Carter, 2005). Sixty-four interviews were carried out with 14 to 17 year olds in Southern England who had experience of binge drinking. Most of the binge drinking took place in outdoor locations and key motivations related to social facilitation, individual benefits and social norms and influences. Consequences were health related (e.g. unsafe sexual behaviour and accidents); and personal safety (including walking home alone). The authors suggested that '*...making the transition to drinking in pubs/bars, offers a protective factor for a number of risky outcomes*'. A recent Portuguese study (published only as a conference abstract) explored social representation of alcohol use among young people (Brito *et al*, 2013). The study identified several risk factors associated with experimentation (curiosity, ignorance of the risks, behaviours and perceptions of parents) and regular alcohol consumption (peer pressure, looking for fun, social pressure) with some differences between males and females.

Findings from all three studies suggest that the main outcomes should not be abstinence but harm minimisation. For interventions (e.g. ABIs) to be effective, they need to be adapted and refined to take into account the motivations for drinking, the type of drinking, and the setting in which it take place.

1.6 Aims and objectives

This study aimed to explore the feasibility and acceptability of ABIs delivered to young people and in social work settings. While the study did *not* aim to examine whether individuals who received ABIs changed their drinking behaviour and improved their health, future studies of ABI delivery in these settings may choose to. The study therefore also explored how feasible a future outcome evaluation of ABIs in these settings might be, and the issues and challenges which would be involved in such a study.

The objectives of this work were to:

1. Describe the **set-up** of projects in detail, including project duration and funding, how each project was set-up, how staff were identified and recruited to deliver ABIs, type of staff, number of staff, amount of training provided, referral protocols.
2. Describe the **delivery** of ABIs, including when ABIs are being carried out, what the ABI content consists of, duration of the ABI, where it is being carried out, who is carrying them out, which groups are being targeted, which screening tool is being used, whether there is any onward referral and follow-up of service users, and what data are planned to be collected / being collected.
3. Assess the **feasibility** and **acceptability** of the projects from the perspectives of staff: Is the project plausible? Do projects come into contact with enough potential beneficiaries (hazardous drinkers) to be worthwhile and maintain their skills? Is the project sustainable (what are the plans for the future funding)? Is it generalisable (could this model be rolled out across the country)?
4. Assess the **feasibility** and **acceptability** of the projects from the perspective of individuals who have had an ABI in young people or social work settings: Are staff credible to the target group? Is the location and time of the project convenient for individuals in a young people or social work setting? Are individuals who receive an ABI in young people or social work setting comfortable talking about alcohol with project staff? Would service users want to discuss other issues as well as alcohol? Is the project young people friendly?
5. Assess the feasibility of an **outcome evaluation**: Could further data be collected if an outcome evaluation was to be run? Would staff be prepared to be involved in a trial? Are staff able to follow up 6 and 12 months after the ABI? Do staff collect the data to assess impact on an individual? How likely is it that enough interventions will be delivered with a 6 months follow up within 12 months to undertake a sufficiently powered study?

1.7 Ethical approval

Ethical approval for the study was provided by the University of Stirling Management School Research Ethics Committee. Two NHS Research Ethics Services which covered areas where projects were being delivered with some involvement of the local NHS were asked to advise on whether NHS ethical review and approval were needed for the study. It was confirmed that the study did not need NHS approval.

2. Methods

2.1 Overview

The study comprised two main phases of research:

- Phase 1 documented and analysed the set-up and delivery of ABIs and staff's perceptions of their feasibility and acceptability.
- Phase 2 explored the experiences and views of young people who had either experienced ABIs through the projects or might potentially experience ABIs. Phase 2 also included a desk analysis of project data to provide advice on how an outcome evaluation could potentially be undertaken in the future.

A theory-based approach informed the evaluation. This is an approach that is useful when exploring the development of complex initiatives (Connell and Kubisch, 1998; Fulbright-Anderson *et al*, 1998) where the problem of attribution is particularly challenging. It is often difficult if not impossible to 'prove' that any positive outcomes observed (such as improved health or amongst a particular group) are due to the intervention that is being evaluated and have arisen as a result of the funding that has been provided. The traditional approach to 'proving' outcomes (the randomized controlled trial, in which outcomes from one group that has received an intervention are compared with outcomes from another that has not received the intervention) is often difficult or inappropriate to implement in 'real world' settings. Likewise evaluation approaches that focus on process issues (such as did the training take place, did clients attend) fail to explain any outcomes – positive or negative – that are observed. Theory-based evaluation aims to provide a framework for assessing the progress made by a project or initiative by creating a blueprint of the building blocks required to achieve the project's longer term goals, such as reducing drinking amongst a particular population group in a particular area. Future studies can then map the extent to which outcomes and outputs anticipated by professionals and service users were realised in practice.

In this study a full theory-based evaluation was not attempted as that was not appropriate given the objectives of the work. However, the theory-based approach was used to inform topic guides with professionals and service users and analysis of project data collection arrangements and documentation.

2.2 Phase 1

2.2.1 Identification and recruitment of projects

A number of projects had previously been identified by NHS Health Scotland as being involved in delivering ABIs in young people and social work settings, or interested in doing so in the future. Information on 14 such projects was passed on to the research team at the start of the study. NHS Health Scotland obtained consent to be approached by the research team from the managers of ten of these 14 projects. A further two projects were identified during this recruitment phase which had not been in the original sample frame of projects but which were currently delivering ABIs; these two projects also consented to be approached by the study team. In total, 12 projects were contacted by the study team. One of the 12 projects was found to be working only with adults and not in a social work setting, and therefore it did not meet the selection criteria and was excluded. In addition, the research team identified that two projects were closely linked, and for the purpose of

the evaluation were treated as one. This resulted in ten projects being included in Phase 1 of the study.

2.2.2 Data collection and sample

Qualitative interviews were conducted with 27 project managers, staff and related stakeholders, such as those providing training to the project or working in partnership with it, between December 2012 and April 2013 (see Table 1).

Table 1: Phase 1 staff interviews: Role by interview method

Role*	Interview method		No. of participants
	Individual	Paired	
Strategic support*	6	1	8
Frontline delivery**	6	0	6
Combined	7	3	13
TOTAL	19	4	27

*Strategic support work was largely managerial in nature or involved providing specialist support such as training and advice

** Frontline delivery involved working in the field and directly with the client group

These participants were selected because the research team and study commissioners (NHS Health Scotland and the Scottish Collaboration for Public Health Research and Policy) felt they would have the best understanding of the project. For each project, the project manager and at least one member of staff who was currently delivering ABIs or was expected to be delivering them in the future were sent the interview guide in advance of the interview in order to help them to prepare. A mixture of face-to-face and telephone interviewing was used, with 17 participants interviewed by telephone and the remaining 10 face to face. Interviews lasted between 24 and 100 minutes, with an average interview duration of 52 minutes. The full interview schedule is included in Appendix A.

In addition to the interviews, field visits were conducted to five of the projects to enable researchers to familiarise themselves with the premises and setting and obtain a better understanding of the context in which projects worked. Informed consent was sought from all prospective interviewees. All candidates were forwarded a copy of the project information sheet and consent form by email (Appendix B). For face to face interviews, participants were asked to sign a copy of the consent form typically at interview. In the case of telephone interviews, consent was indicated by email.

2.2.3 Research questions

Questions explored during the Phase 1 fieldwork included: the project history/setting and host organisation; project relationships with local health board and other organisations; overall project target population/client group and size and which groups are being targeted for ABIs; staff recruitment and training in relation to ABI delivery; goals of ABI delivery, and intended outcomes, from the perspective of staff; the context and manner in which ABIs are being delivered, or expected to be delivered; use and perceptions of screening tools; how delivering ABIs relates to other project work and the extent to which it is perceived as worthwhile; perceptions of how clients respond to ABIs; factors which facilitate or constrain carrying out ABIs; perceptions of the sustainability and generalisability of carrying out ABIs in relation to

these particular projects and settings and more widely; experiences and perceptions of data collection, both actual and planned; and perceptions of the possibility of collecting follow-up data to inform an outcome evaluation.

Time was also provided within each interview for participants to raise issues of importance to them in relation to the projects and context, and follow up questions were used as needed to explore issues not originally considered in the interview guide. During the interview, staff were also asked for relevant project documentation including copies of any monitoring tools/forms used to collect data relevant to ABI delivery.

2.2.4 Analysis

Interviews were digitally recorded and almost all were fully transcribed; in two cases detailed notes were taken in lieu of full transcripts because of recording equipment failure. All interview data were uploaded into NVivo data analysis computer software programme to facilitate data management and analysis. Observation notes from field visits were also uploaded for analysis. A Framework Analysis (Richie and Spencer, 1994) approach was used for coding, categorising, summarising and analysis of data. Data analysis was closely guided by the research questions and objectives, but also allowed for open coding in order for new themes to emerge throughout the process. Two researchers coded the interviews and field visit data: one researcher coded two-thirds of the data and the other coded the remaining third, with regular discussions taking place throughout regarding coding decisions and coding labels for particular themes where there was some uncertainty. After approximately 50% of the data had been open-coded the codes were organised into major code categories and subcategories to support the emerging analysis and consequent coding followed that built on and refined the initial thematic framework. Analytic memos were also written when coding the data. Framework Analysis suggests the use of cases to retain the specificity of information about similarities and differences across the sample studied. The documentary sources were used alongside interview and field visits/email correspondence with projects to construct three page project case summaries. Ten anonymised project summaries were created and shared with project staff to ensure accuracy of the detail reported. A number of the research team were involved in commenting on the emerging analysis and write up of findings. The interim findings were also presented and discussed at a dissemination event in August 2013 attended by the majority of the research team, a number of staff members from the projects involved in Phase 1 of the study and the study commissioners.

2.3 Phase 2

The aim of Phase 2 was to explore the feasibility and acceptability of the projects from the perspective of individuals who had had an ABI or may potentially experience ABIs, and to assess the feasibility of an outcome evaluation. Originally it had been proposed that two sets of interviews would be conducted in Phase 2, interviews with clients of the projects and a further wave of interviews with project staff to focus on issues around data collection and potential recruitment of clients. It was agreed in discussions between the study commissioners and the research team that, because the interviews at Phase 1 had been more wide-ranging and detailed than originally envisaged, a further wave of interviews with project staff would not yield significant new relevant data, and would be potentially burdensome to staff.

Instead, it was agreed that more resource would be put into recruiting and supporting the Phase 2 interviews with clients. Accordingly the research team made visits to all of the projects included in Phase 2 to explore how best to recruit project clients to participate in interviews, and to conduct observations of project activities and client interactions. In addition, most of the Phase 2 interviews with clients were conducted face-to-face rather than by telephone, as had been originally proposed.

2.3.1 Identification and recruitment of projects

Eight of the ten projects included in Phase 1 were selected to participate in Phase 2 of the study. Two projects were not included in Phase 2 because one had reached the end of its funding and was not continuing, and the other was working in a criminal justice social work setting and envisaged ethical and other difficulties with client recruitment.

The project staff were aware that that the research team would be contacting them about Phase 2, which would involve the participation of young people in order to ascertain their views about ABIs. An initial approach about this was made to staff at the eight projects which could potentially be included between April and June 2013. Arrangements were made to meet with project staff to discuss the best ways of doing this. It was easier in some projects than others to access staff working directly with young people who would be able to support this. Some projects were keen to involve the young people who attended their projects and arrangements were made quite quickly and easily to interview young people or hold discussion groups with them. In contrast, a small number took as long as six months to arrange, sometimes because project activities scaled back in the school summer holidays. One project, although contacted several times, was not able to participate because the fieldwork coincided with a difficult period of change for the project. Another was willing to participate, but at the time of fieldwork, the young people it was able to put forward as potential participants in the study were being accessed through a different project setting from that which had been examined in Phase 1. This would have meant that the findings were not linked to Phase 1, and it was therefore decided not to include it. In total therefore six projects participated in Phase 2.

2.3.2 Data collection and sample

Interviews (both individual and group/paired) were conducted with a total of 61 young people (males n= 37, females n=24). The age range of the sample was 12-23. Table 2 below shows the distribution of the sample across the six projects (pseudonyms have been used to protect the confidentiality of the projects). The original proposed sample size for this phase of the study was eight to ten individuals per project (up to a maximum of 80 if 8 projects participated). The sample of 61 achieved from 6 projects can be seen therefore as satisfactory. It had originally been proposed that the sample might be stratified to reflect a range of ages, ethnicity, types of location, levels of drinking and other variables. In reality, it proved impossible to attempt to impose any sampling strategy because of the unpredictable composition of the young people accessing the projects, although efforts were made to include a mix of genders and ages. Although young people were not specifically asked about the extent of their alcohol consumption, most of the young people interviewed or who took part in discussion groups chose to speak about the types and amounts of alcohol they used and the environments in which they and their friends used it. This

information is outlined in section 5 and gives an indication of the range of young people's alcohol use and habits.

Table 2: Phase 2 individual and group interview participants

Project name	No. of participants	Participant characteristics	Interview method(s)
Aspen	15	All males, aged 12-23	7 paired 1 individual
Bracken	9	7 males aged 14-17 2 females aged 15-16	2 paired 1 focus group
Elder	9	4 males aged 16-17 5 females aged 13-14	4 paired 1 individual
Fir	7	7 females aged 13-16	3 paired 1 telephone
Hawthorn*	15	5 males aged 16-23 10 females aged 15-21	3 focus groups 1 large discussion group with role play
Rowan	6	All males aged 15-22	1 focus group
Total	61	Males n=37 Females n=24	

* Hawthorn was primarily a training project and, at the time of Phase 1 fieldwork, was not directly delivering ABIs. At Phase 2, the project put the research team in touch with one of the youth work agencies for which it had provided ABI training. This agency arranged for the research team to interview some young people about their response to the concept of ABIs, i.e. how they would feel if they were offered an ABI. These interviews involved role play, as outlined above.

Young people were informed about the research in various ways. Many were given information leaflets about the evaluation by staff at the projects and the research process explained to them in advance of the interviews. Others, such as those attending sports-based projects, were informed about the research on the evening that the interviews took place. On all occasions of data collection, researchers explained the research carefully to young people, reiterated the voluntary nature of participation and provided a written information sheet and consent form which young people were asked to sign if they wanted to participate. This included questions about their willingness for interviews to be recorded and the limits of confidentiality if young people spoke about issues which indicated that they or others were at significant risk of harm. It was made clear that participants could decide to stop the interview or discussion at any time. All participants were offered a small voucher as a thank you for participating in the research.

Group interviews were held with 47 of the young people, usually in groups of five. These took place at five of the six projects although at three of them individual or paired interviews were also held. The remaining 14 young people were interviewed in pairs (n=12 young people), one was interviewed individually face to face and one by telephone. Each group had an initial discussion with one of the research team and then worked on role-plays of ABIs. These role plays were then presented to the rest of the group and were followed by a general discussion about the perceived effectiveness of ABIs and other ways in which adults might best approach the subject of alcohol misuse with young people.

The face-to-face paired and individual interviews lasted between 20 and 45 minutes and the telephone one was shorter at 15 minutes. The discussion groups ranged between 15 and 90 minutes. These differences reflected the diversity of project context in which the fieldwork was conducted, with much less time available for the sports-related interviews (which were typically 15 minutes long) than for those taking place in youth centres and involving role play, which lasted an average of 60 and 90 minutes respectively.

Interviews were digitally recorded with participants' consent and transcribed verbatim for analysis. Twenty participants did not wish their interviews to be recorded. In these cases, detailed interviewer notes were taken.

2.3.3 Research questions

Questions explored during the Phase 2 fieldwork included: young people's perceptions and experiences of the project in general, including understanding of the referral process and initial expectations, practical aspects of the project (such as location, opening hours, atmosphere and privacy), and perceptions of staff approachability, trustworthiness, credibility, empathy and communication style; any recall of having had a conversation about alcohol at the project and the nature of that conversation; participants' willingness to be asked questions about, and comfort with, talking about alcohol; perceptions of the relevance, usefulness and feasibility of the advice given and whether participants had acted on it or made any changes in response to the ABI, and what they thought encouraged or helped them to make these changes; whether they had subsequently been referred to or accessed other services and help; participants' suggestions as to how to improve the project space, staff training and intervention, especially for younger clients; and participants' willingness to be followed up by the project with further questions about their alcohol use 6-12 months after the intervention.

The focus of interview and focus group discussion topics was adapted to take into account young people's familiarity with the term 'an Alcohol Brief Intervention', once this had been described to them. If they were not familiar with or did not recognise this, conversations about alcohol in more general terms were held. These included a role play exercise in which participants assumed the role of youth workers delivering an ABI. This was used to explore young people's response to discussing alcohol and the role youth workers might usefully play in providing information and advice. The full Phase 2 interview guide is shown in Appendix C.

2.3.4 Analysis

The interviews were transcribed by two researchers who also drew on detailed field notes from each of the sites for the analysis. The interview transcripts and notes were analysed thematically with reference to the project research questions by two researchers independently then discussed together. Similarly, attention was paid to other themes emerging from the data relating to alcohol use and relationships with other service providers in the areas where the young people lived.

2.4 Desk analysis of project data and proposals for future outcome evaluation

In addition to the primary data collection, an analysis was conducted of existing data collection tools and arrangements for routine monitoring within each project, bringing together material collected in Phases 1 and 2. This included project screening

instruments, activity monitoring forms and data collection forms, where these were used.

The purpose of this exercise was to inform broad theories of change for each project and the programme as a whole (focusing on key activities, outputs and outcomes in the short, medium and longer term) to develop an outline of how future outcome evaluation of ABI delivery in wider settings could be conducted. The findings from this exercise are reported in section 6 of the report.

The desk analysis focused on the eight projects originally selected to participate in Phase 2, as these were assessed to be the most relevant candidates to participate in a structured outcome evaluation study. In practice, secondary data and documentation provided by the projects varied; five projects provided copies of their screening tools, although in at least one case these were not routinely used or completed. Of the remaining three, two did not appear to have adopted a formal tool or screening process, while the third recommended the CRAFFT tool but was at too early a stage to assess adoption and implementation.

Three specific tools had been adopted across the eight projects, CRAFFT, FAST and DUST, the former being the most widely adopted (see Glossary for explanation of acronyms). Some projects had adapted these tools to reflect the focus on young people's use of alcohol.

Three of the eight projects also provided documentation mapping out their delivery and referral process, one of which included separate follow-up screening forms. Only one project provided screening data, although the level of detail provided made deciphering its value and relevance difficult. One other project appeared to have fairly robust data collection procedures in place. However, no access to this data was provided because of concerns about confidentiality.

3. Findings: Overview of the projects

The ten projects included in Phase 1 of the study were heterogeneous in terms of aims, operated in a range of different settings, and used a variety of methods for addressing alcohol. Pseudonyms have been used to protect the confidentiality of the projects. Appendix D provides more detail on project history, setting, key partners and set-up; delivery of ABI, including target populations, client group and numbers of clients; and feasibility and acceptability.

Some of the projects worked primarily through one approach, such as provision of diversionary activities, while others used a variety of linked approaches. The table below summarises the main approaches/settings used by the projects.

Table 2: Overview of project main approaches and settings

Approach/setting	Projects which used this approach
Diversionary activities (typically sports and outdoor activities)	Aspen Elder Fir Hawthorn* Myrtle
Street outreach	Bracken Fir Myrtle
School outreach	Bracken Fir Myrtle
Police-referred/involved	Juniper Rowan
Advice/support delivered through a drop-in centre	Fir Pine
Social work	Gorse

* Hawthorn was primarily a training project and, at the time of Phase 1 fieldwork, was not directly delivering ABIs.

Each project is now briefly described.

3.1. Aspen

Aspen was the latest in a series of six month, targeted, multi-agency community alcohol campaigns within a large urban area which had been running for around five years. The campaigns had two main strands: off-sales work to reduce access to alcohol, and diversionary activities for young people. This was the first Aspen campaign to incorporate ABIs in a systematic way, and this aspect was in a developmental phase at the time of fieldwork. The ABI work largely consisted of screening all young people who registered for a diversionary activity (football training in a local park). Coaches from the provider organisation carried out the screening and gave the young person brief information. Screening was originally done on a health drop-in bus but at the time of fieldwork was done opportunistically by football coaches at the side of the pitch. The football coaches carried out the screen, using the CRAFFT tool, and calculated units. They could also give a leaflet and brief information in the context of agreeing a physical activity plan. They did not at the

time of fieldwork offer the motivational interviewing aspect of an ABI, as that would have required additional training and practice, but formal or informal specialist input from a voluntary sector alcohol organisation could be arranged in case of doubt or following a positive screen. The profile of those attending reflected the ethnic diversity and high Roma population in the area.

3.2 Bracken

Bracken was the banner name for a mobile, multi-agency approach to addressing youth street drinking and anti-social behaviour across a local authority area, and was conceived of four years ago in one of the authority's major towns. At the time of fieldwork Bracken was operational across five areas of the local authority. A customised vehicle was used in one to two of these areas every Friday evening. The vehicle had two private sections in the rear for ABI delivery. In the prototype model, Bracken was staffed by a development/project worker from a voluntary sector substance misuse support and information service for young people, a detached youth worker, a public health nurse and a community police officer. Detached youth ('street') work engages young people on their terms on their own territory with the aim of supporting their personal and social development. Other forms of youth work engage young people through centre based or outreach activities. While there were always four workers on the vehicle, the team composition differed slightly across areas due to partnership arrangements; for example, in one there was no NHS involvement.

Using intelligence and referrals from detached youth workers, community wardens and the police, the vehicle was driven to where young people were drinking. If there was no intelligence – as was reported to be happening more frequently due to changes in drinking behaviour – the vehicle was driven around areas where young people were known to congregate and then parked. The two youth workers would approach the young people and engage them in conversation. ABIs were offered to young people who were found in possession of alcohol or who were known to drink alcohol; if a young person was under the influence of alcohol at the time, they were followed up and offered an ABI at school. Other health advice and condoms could also be provided. The young people were always advised that a policeman was part of the team, but that they were not in trouble.

The ABI comprised screening (using the CRAFFT tool modified to include a question about consumption), feedback, and a card game to structure thinking about new strategies to reduce risk or consumption. Less structured conversations around alcohol also took place outside the vehicle. ABIs were usually offered to individuals but could be delivered to small groups of young people if they preferred. Follow-up to do a fuller assessment of need was arranged as part of the process, usually in school. Outcomes were recorded to assess progress in reducing potential for harm as well as impact on consumption. Bracken statistics suggested that the drinking behaviour of the large majority of those receiving an ABI did not need referral on to specialist support. However, networks were in place for this where necessary, and there were pre-existing strong links with schools and other agencies.

3.3 Elder

Elder was one of two linked projects piloting the delivery of ABIs by leisure service staff in a local authority which included a number of areas of multiple deprivation (the

other project was not targeted at young people). Elder sought to incorporate ABIs into established indoor sports facilities and outdoor street sports provision. The leisure service had a network of 23 outdoor, multi-use games areas which provided free organised diversionary sport activities for young people aged 10-18. This service was developed in 2009 by the police, a community safety partnership and a professional football club. Both outdoor and indoor events were coordinated by a sports development officer for young people, and provided sessional work and volunteering opportunities for sports coaches.

Elder was a recent initiative, driven by the HEAT target for ABI delivery in non-NHS settings. The coaching team had however been aware of ABIs since 2008, and had received training previously both from a voluntary sector organisation for vulnerable children and the NHS. Coaches were more comfortable with client-led, opportunistic conversations around alcohol than with more prescriptive or formal approaches. ABIs appeared to involve naturalistic conversations around alcohol when the topic was raised by a young person, were not well-specified, and tended not to include screening (tools such as DUST and CRAFFT were perceived as unsuitable and not to fit with the project staff's way of working, and it was not clear how often screening had been undertaken or if it was recorded). Any follow-up tended to be individual, informal, opportunistic and dependent on voluntary re-attendance. Rather than operating as a referral pathway, the coaches were often encountering young people who were already known to other agencies and services.

3.4 Fir

Fir was an alliance between four youth agencies in a densely-populated area of urban deprivation: a confidential health and wellbeing centre and service for young people, a streetwork team and its youth centre base, and two community youth organisations. Fir had been operational for three years and aimed to provide integrated and accessible support for young people around alcohol issues. The health and wellbeing service included an open access drop-in, group activities, appointment-based support and counselling, and also engaged in detached youth work and outreach through schools and youth clubs. The streetwork team of detached youth workers went out at times when young people were known to be consuming alcohol, and also built relationships with staff and young people by dropping in to local youth facilities. The community youth organisations' diversionary provision included sport and outdoor activities and wilderness residential experiences.

ABIs were introduced early in the life of the alliance, coinciding with NHS strategy to move ABIs into wider settings. Following training, the alliance decided to use ABIs because they fitted with issue-based youth work and could be made young-person-friendly. Fir intended to continue using and learning from ABIs, and hoped to secure funding to expand the approach to topics such as sexual health and drugs.

ABIs were offered opportunistically to young people who might have been drinking at hazardous or harmful levels, and in streetwork they could be offered to young people in small groups. Consumption was discussed in relevant language, not necessarily as units *per se*, and rather than discussing long-term health consequences, ABIs tended to focus on regretted behaviour and harm reduction. If screening took place, the CRAFFT tool was used, modified in a credit card sized version and asking only

about alcohol. Population screening of all consenting clients over a month had been carried out twice, six months apart, with ABIs offered following a positive screen. While young people were encouraged to think about follow-up, this was easier to provide in centre-based activities than in detached work where no contact details were taken. Although Fir offered a comprehensive range of services for young people affected by alcohol, it was also connected to a range of statutory and voluntary agencies to which it could signpost young people as necessary.

3.5 Gorse

Gorse had been set up in a council area to deliver ABIs, where appropriate, as part of a Criminal Justice Social Work Report interview. A Criminal Justice Social Work Report is requested by court in order to understand more about an offender and inform decision making on the most appropriate type of sentence, and is mandatory if the person is going to jail for the first time. The Report interview is led by a criminal justice social worker and usually takes up to 90 minutes.

The decision to implement ABIs was taken by senior social work managers in conjunction with the local Alcohol and Drug Partnership (ADP). Drivers included the ABI HEAT Standard 2012-13 with its emphasis on development in wider settings, and funding was provided for a social worker for two years to build capacity for drugs and alcohol work. Alcohol was an issue for the majority of offenders and the ABI aim was therefore a logical fit, providing an early intervention opportunity for a group that did not engage well with specialist services. There would also be a natural opportunity for follow up, in that 25% of clients were likely to be required to have a review at three months.

Considerable work was done to prepare the social work electronic database to incorporate recording of ABIs, and all staff received training. However, at the time of interview, about two months into the project, no ABI activity had been recorded, and key personnel changes and a vacant post had occurred amongst those initiating the project. Front-line personnel reported continuing to address alcohol use within client interviews but admitted struggling to incorporate the ABI format. In response, local managers were addressing the lack of ABI activity by providing prompt sheets in interview rooms.

3.6 Hawthorn

Hawthorn was a pilot project in an ADP area which aimed to encourage and support service providers in contact with young people to adopt ABIs as part of their work. At the time of interview the project was only at the staff training stage and decisions had yet to be made about ABI delivery. Key drivers were the ABI HEAT Standard 2012-13 with its emphasis on development in wider settings, combined with concern among ADP partners about alcohol consumption and associated risk-taking among young people, in particular those who did not access mainstream services.

The Hawthorn training module was devised by a short-life working group and a national workforce development organisation. In a major adaptation of the adult model, discussion of units with the young person was not included. Instead, the focus was on the process of engagement, to allow the opportunity for alcohol consumption to be addressed in a meaningful way. Two waves of training had been delivered at the time of interview, one involving sports coaches from a local youth

diversionary initiative and youth development workers and one with NHS health improvement services, psychological services and youth development workers.

Although training was free, participating organisations received no additional funding to take part in the training or to offer ABIs, and there were no resources within the Hawthorn project to support data collection and collation for evaluation purposes.

3.7 Juniper

Juniper was a 15 month pilot project across a large geographical council area which ended between Phase 1 and Phase 2 of the study. There were three main drivers for its inception: the ADP was looking to diversify delivery of ABIs to help meet HEAT targets, the police were keen to have follow-up services for young people found on the streets with alcohol, and a voluntary sector children's organisation was already active in the field of alcohol and substance misuse, and saw this as an opportunity to bridge a gap in provision.

Juniper required a two-step referral process. Firstly, police identified young people who may be at risk from alcohol, and if the young person agreed they were referred to the children's organisation for an ABI. The project worker then contacted them to arrange the appointment, which was followed by a telephone review three months later. A customised screening tool was used, including information about units. The ABI was used as an opportunity to open a conversation about alcohol, covering the young person's perceptions of the impact of alcohol on their behaviour, physical and emotional health, participation and relationships; the advantages / disadvantages of drinking; safety aspects; and any changes they may want to make. The cycle of change model was integral to the intervention.

Feedback from the young people who received an ABI was positive, particularly around raised awareness of how much they were actually drinking and the health and safety implications. Furthermore, the majority had made positive changes by their three month review. However, referrals were lower than anticipated, partly because fewer young people were drinking on the street than envisaged, and at both stages of referral there was attrition due to non-consent. Funding did not therefore continue, and there was a range of opinion about what shape a future ABI service for young people in the area should take.

3.8 Myrtle

Myrtle was the youth service element of a voluntary sector social services organisation, serving a large rural council area with a higher level of drinking among 15 year olds than the national average. The three main elements of the service were mentoring, intensive support, and drug and alcohol outreach. The majority of young people receiving these services were referred by schools, social work and the police. Myrtle staff also visited schools and youth clubs, and had a vehicle which enabled them to go out to where young people were. Staff carried out streetwork, and had a mobile street football unit which could be set up as a diversionary activity.

Staff had been trained to deliver ABIs and offer them in all settings where Myrtle operated, to young people who may have been drinking or affected by parental alcohol misuse. The streetwork activity was the most challenging for staff, as it was perceived that some young people would not welcome incursion into their lives.

ABIs had become a routine way of practising, and as such were no longer seen as a discrete intervention. ABIs provided a means of engaging young people in conversations around alcohol, building up trust, and working through stages of change, and could be delivered to individual young people as part of a targeted group intervention package. ABIs were seen as adaptable according to the worker's professional judgement, appropriate for use within group as well as individual work, and deliverable over a period of time. Although screening was usually incorporated, the project worker would only use it when they judged the time to be right for that young person, and the service would prefer a more young-person-friendly tool that would also give an indication of parental alcohol misuse.

Follow-up was managed in a number of ways. Young people coming to the service through the GIRFEC (Getting It Right For Every Child) Child's Plan route were part of professional meetings to discuss progress. In some circumstances Supervision Orders made as part of the Children's Hearings system would include input from the Myrtle Project.

3.9 Pine

Pine developed over 17 years ago - in response to high teenage pregnancy rates - as a confidential health and information service for young people who were not accessing existing GP and sexual health services. From the beginning, emphasis was placed on seeking opinions from and listening to young people, and developing a service that would evolve to accommodate their changing needs and patterns of behaviour. At the time of fieldwork, Pine had three main service strands: a six day a week drop-in at its city centre premises, which catered exclusively for young people aged 11-25; peer-led programmes; and outreach services. The team had a holistic approach, with staff coming from a range of backgrounds, particularly community learning and development, and sexual health nursing.

ABIs were delivered opportunistically through the drop-in, where the majority of those attending were young females. As alcohol was woven through many of the issues facing young people, Pine's drop-in service already included opportunistic conversations around alcohol and onward referral to specialist services. It was therefore a natural progression for staff to implement ABIs. Staff had been proactive in seeking training and using ABIs in an informal, young-person-friendly way to help structure and record the discussions. ABIs consisted of screening (using the CRAFFT tool), calculation of units, raising awareness of consumption and ways to reduce it, and also included a focus on regretted behaviour, risk and safety measures and taking personal responsibility. The emphasis was on informality, and using the ABI judiciously as a tool to explore the risk taking behaviour rather than as a 'tick box' exercise. Pine informed and connected itself with specialist services - including a regional voluntary alcohol advice, information and support agency - and would signpost services and enable contact where appropriate.

3.10 Rowan

Rowan was the banner name for a multi-agency intervention to address youth disorder and alcohol misuse in a central belt local authority area. Previous police initiatives to tackle youth disorder in the area had been ineffective, because young people who had been drinking were not taken to a place of safety, and because they

gave false addresses to prevent their parents being informed by letter. Rowan addressed both these issues, and consisted of a series of intelligence-led operations on Friday evenings, which were each targeted on specific areas. According to interviewees, traditional patterns of drinking for young people more frequently involved Friday rather than Saturday nights in this geographic area because of early school closing that day. The operations involved police officers, a voluntary youth worker, and a member of a voluntary drug and alcohol service. Police officers would find young people under the age of 16 with alcohol and take them to the police station as a place of safety (those aged 16-17 were invited to go, but there was no power to force them). At the police station, the young person had a conversation with the two voluntary sector representatives to raise awareness of risk and identify major background issues. If they were under 16, their parents were called in to join the conversation, and plans for a follow-up were agreed. A conversation was also held with the Inspector or Duty Sergeant who would emphasise legal and safety aspects, and probe how the alcohol was sourced. Young people found under the influence or in possession of alcohol were not cautioned or arrested unless specific criminal offences had occurred, but were given a 'restorative' based warning, with details being passed to the social work department.

No ABIs were delivered during a Rowan operation. Instead, Rowan was a means of introducing young people found with alcohol to a voluntary sector organisation which then followed up with an ABI, usually carried out within a week. The ABI was usually carried out in the young person's home or at the project offices if the young person preferred, and was used as a means of identifying the level and type of support the young person needed from the service rather than as an end in itself. Screening used the FAST tool, and young people who received a longer-term service from the youth project were asked if they would mind a re-assessment using the same tool in three months. Rowan was one of several routes for young people to access ABIs from the youth project, and all ABI screening was recorded.

Rowan was judged a success because the number of calls to the police about youth disorder dropped considerably after it was introduced. However, at the time of fieldwork, fewer young people were found drinking on the streets due to changing patterns of drinking behaviour, and the strategy was under review.

4. Findings: Staff perspectives

The previous section, and Appendix D which accompanies it, have summarised the set-up of the ten projects (research objective 1). In this section, data are pulled together from across the projects to provide more detailed insight into aspects of ABI delivery (research objective 2). Key contextual and organisational factors as perceived by staff which relate to project feasibility and acceptability are described and analysed (research objective 3).

The findings are based on a cross-cutting analysis of the nine projects which worked with young people; the tenth project, which worked with adults in a criminal justice social work setting, was analysed separately, with material from this analysis being summarised in section 4.6. Key learning across the sample of nine projects working with young people is presented under the following headings:

- motivations for implementation and goals of ABI delivery with young people
- target populations and access / reach
- context and manner in which ABIs are being delivered
- facilitators and barriers to ABI delivery in young people's settings
- data collection and measuring outcomes.

Verbatim quotes from project staff interviews are used in this section to illustrate key findings. To avoid the risk of individuals being identifiable, job roles are described in general terms, using the same breakdowns as in Table 1 (section 2.2 above): Strategic support or frontline, or a combination. The method of interview (Individual or Paired) is also indicated for each quote.

4.1 Motivations for implementation and goals of ABI delivery with young people

This section discusses the projects' motivations for implementing ABIs and the goals which underlay their adoption.

4.1.1 Motivations for implementation

A number of motivations for implementation of ABI delivery were identified: existing health or social programmes where addressing alcohol was seen to be a natural extension; a realisation that existing services were not addressing alcohol problems effectively and the need to create more 'joined up' approaches; wider ABI activity in health settings that Health Boards wished to extend; and the reported 'fit' between ABIs and existing ways of working with young people on their alcohol use. These are now discussed in turn. The extent to which ABIs were perceived to fit with existing ways of working was an important aspect of feasibility and acceptability. This is discussed further in section 7 Discussion.

Some projects integrated ABIs into existing work addressing broader health or social issues. In areas of urban deprivation, this included youth or sports clubs engaging young people who would otherwise be 'wandering the streets'. Non-profit community-based youth drop-in centres offering mainstream services like sexual health wanted to address alcohol in a more structured way because of its negative impact – such as the consequences of unprotected sex – on young people's lives. A 'one stop shop' was considered less stigmatising and more responsive to what young people wanted.

In some cases crime and anti-social behaviour such as young people drinking on the street, vandalism and alcohol-fuelled violence led to a recognition that existing services and traditional responses were not working. ABI delivery was then included in new or existing proactive 'multi-component approaches' where local areas wished to address a lack of engagement with vulnerable young people, '*try to do something different*', and use scarce resources more effectively.

Another key driver was reported to be health boards that had identified existing projects as an opportunity to assist HEAT 4 targets for ABIs in wider settings. The impetus therefore came from outside the project. Staff and managers reported carefully considering the merits, risks and adaptations needed for effective delivery in their setting, and highlighted the importance of team decision-making rather than this being imposed on them.

Coherence or 'fit' between ABIs and existing practice seemed to be a major factor driving their adoption. Achieving this 'fit' did not always occur. However, the ethos of youth work was considered particularly well placed to facilitate integration of ABIs into young people's settings, as youth workers already incorporated conversations about alcohol in day-to-day work and used health promotion tools such as the stages of change model (Prochaska and DiClemente, 1992):

'ABIs are useful, you know, the term and the concept is useful for us because it is something that youth workers just by definition often do with somebody just in the way that we work. It's really non-judgemental, it's focused on the individual and, especially with young people, a lot of the time you are either educating them or informing them or advising them about changes that they could make that would improve their life on a lot of different topics' (Strategic support/frontline staff, Individual interview).

A characteristic of a number of the projects was the desire to work with multi-agency partners on ABI delivery. This was partly because traditional, single agency efforts to respond to alcohol use amongst young people were seen to be inadequate. In this way multi-agency working was seen to be necessary to provide a more 'joined-up' response. The motivation for implementation here was therefore a strong desire to work more effectively in dealing with this issue. For example, community safety groups involved police, schools, social work, non-profit organisations and NHS health promotion. Aspen used an explicit systems approach:

‘The model comes from the Harold Holder's Model in terms of a systems approach, a community-wide approach to how you tackle alcohol use from America. There is more of a focus on drink driving and education but essentially it's the same idea about getting a range of partners involved to look towards a shared outcome. Using the off-sales as the vehicle we are able to tie in a real range of partners from the Health Improvement Team, to the Police, to Licensing Standards, from the Council and then you've got your local Alcohol Prevention Education Project, the Council on Alcohol and then on top of that you have got your youth providers. Alcohol is a common interest for all of these organisations so that in itself has been a good thing to bring people together’ (Strategic support/frontline staff, Individual interview).

Uncertainty regarding ‘fit’ meant that not all staff we spoke with had decided whether to adopt ABIs. Some projects were in a pilot phase or still considering their value.

4.1.2 Goals for adoption of ABIs

A number of goals were reported by project staff underlying their adoption of ABIs including: a belief in the importance of early intervention; the need for a range of effective tools to meet the diversity of need within their services; the view that ABIs were a logical extension of existing work and a natural framework to support alcohol conversations most generally; and the desire to work within a harm minimisation approach. These are now discussed in turn. The extent to which ABIs were perceived to help projects meet their goals was an important aspect of feasibility and acceptability, and this is discussed further in section 7 Discussion.

Interviewees tended to understand ABI work as an early intervention health promotion strategy that would benefit young people later in life. They highlighted how the pervasiveness of alcohol use in Scottish society has normalised it for the whole population and made it a ‘rite of passage’ from childhood into adulthood:

‘...one thing that we have found from talking to young people is that they consider this is what you do to become an adult. Adults drink, I feel like I want to become more of an adult, so that means I need to start drinking because that is what you do in Scotland’ (Strategic support/frontline staff, Individual interview).

Project staff saw ABIs as one component of the work needed to address alcohol issues in their service or setting, rather than the only approach:

‘The brief intervention tool is part of the jigsaw puzzle in the bigger cultural issue that Scotland has in relation to alcohol. I don't think it can be taken in isolation but it is a beneficial tool to some people to enable them to talk about alcohol’ (Frontline staff, Individual interview).

Working with young people on their alcohol use was described by some participants as a logical next step to their existing community-based health promotion role:

'We wanted to use the tools within the drop-in with the young people as a way of measuring and supporting them and then signposting them onto the relevant services. I think we had felt that we had always done it (...) as part of our normal consultations we had been doing it. We just hadn't been recording it in a formal way and perhaps we didn't have the formal questions recorded' (Frontline staff, Individual interview).

Some interviewees viewed the ABI structure as a *framework* supporting teams to initiate and undertake more informed and skilled conversations on alcohol than previously held with young people prior to receiving the training:

'What folk have come back and said is that it's given them permission to talk about alcohol because we are asking them to do that. As opposed to perhaps feeling if someone is here for a pregnancy test, for example, I don't know if it's appropriate to talk about alcohol, they are telling me that they were quite drunk when this unprotected sex happened but (a) I don't feel necessarily that I have got the skills to provide some kind of intervention and (b) I don't know if it's OK to raise this. What the ABI does is provide people with a framework and a set of skills and process to go through but it also gives them permission to ask and raise the alcohol issue' (Strategic support staff, Individual interview).

In some projects, ABIs had become mainstreamed as the 'preferred introduction' to conversations on alcohol:

'We use it as a preferred introduction, when we are having a conversation about drugs and alcohol we would probably, almost certainly, use the ABI techniques all of the time. Rather than have a general conversation about drugs and alcohol we would use alcohol brief intervention because we find that works' (Strategic support staff, Individual interview).

Use of ABIs was driven by the ethos of harm reduction / minimisation rather than abstinence from alcohol. Staff accepted that young people would engage in risk taking behaviours and looked to help them minimise rather than eliminate risk through exploring choices and ways to make safer choices. Strategies included reducing alcohol consumption, consuming lower alcohol content drinks, getting home safely, drinking water and eating food alongside drinking alcohol, knowing first aid / basic life support training, knowing how to phone for an ambulance, taking care of friends by taking turns to not drink or drink less, and dressing appropriately for the weather:

'They have given examples about somebody who has passed out in somebody's bedroom or in a park or something that they have been involved in, sexual activity in a park because they were so drunk and that they felt vulnerable and that they had exposed themselves to that... who were they with, what circumstances, who bought the alcohol, how did that make them feel? And so it's about empowering the young person to take control of the next situation that they are in that they are not putting themselves through that again' (Frontline staff, Individual interview).

Overall, project staff wanted to see young people making changes to their drinking behaviour. They used ABIs to help the young person learn more about a range of dimensions of their alcohol use - consumption patterns, types of alcohol, risks of harm - in order to make more informed decisions:

'The outcome that we would be looking for would be the same as for anybody else – that they have the opportunity to learn something and the opportunity to think about their own behaviour. A brilliant outcome is if they decide to change their behaviour but we don't actually have any control of that. What we are doing is giving them information to help them make a more informed decision' (Strategic support staff, Individual interview).

4.2 Target populations and access / reach

Some projects targeted particular groups, such as young people living in deprived circumstances, or 'wandering the streets looking for something to do'. In others, all young people who accessed their service were screened and followed up with an ABI if appropriate. Sometimes particular times were targeted, such as Friday afternoons if local schools got out early, or particular neighbourhoods where there were particular problems of anti-social behaviour or high off-sales outlet density.

While the projects worked with young people between 11-17 years, or up to 25, the majority of young people attending were 14-17 year olds and this was where much of the work was focused.

Participants had little to say about gender differences in relation to ABI work. Projects focused on diversionary sports, typically football, reached greater numbers of young men, while ABIs delivered alongside drop-in services with a focus on sexual health were more likely to reach young women. Some participants suggested that young women were more open to conversations about alcohol, their emotions and their lives. Weight gain associated with alcohol use was also seen to be more of a concern for young women.

Similarly, very little was said about working with minority ethnic populations. One comment concerned the challenges when a neighbourhood had different population groups with very different drinking patterns. In this project, Aspen, there was a dual language speaking youth worker. At the time of the Phase 1 interviews project staff stated that the Roma population was accessing the programme but white Scottish young men (as defined by staff) were not; however, from data collected in Phase 2, this seemed to have changed and white Scottish young men were attending but at different times.

Schools, social workers, GPs, community wardens, detached youth workers, and police officers all referred young people to projects in our sample. Good local partnerships between the NHS and voluntary organisations meant effective cross-referral patterns. Outreach was an important feature of a number of projects through schools, youth clubs or streetwork. Posters were put up to raise awareness of outreach activity, such as sport alternatives to street drinking.

Where projects were engaged in outreach, they faced several challenges in terms of accessing young people. A key challenge was knowing where young people were going to be involved in street drinking and therefore where to take the outreach vehicle or activity. A number of participants stated that street drinking levels seemed to be decreasing. Some interviewees suggested that parents were supplying alcohol at home as it became harder for young people to buy alcohol in commercial outlets due to, for example, community off-sales campaigns. This was clearly impacting on projects set up to address street drinking by young people:

'We make assumptions that because young people have this pattern just now that in six months or a year's time that that will still be their pattern and that's not always the case. It may well have been that it was a perceived success in that they moved the young people off the streets so that they weren't getting the calls about the young people. But everybody including the police are well aware that these young people haven't stopped drinking. And in many ways when they are drinking inside and they are not visible they may be more vulnerable and more at risk' (Strategic support staff, Individual interview).

Sometimes project staff encountered resistance from young people when going into 'their patch':

'It's quite a challenging environment to go there because sometimes they think, "Oh, are you the police, are you undercover police?" We are trying to give the message to keep yourself safe, a bit of harm reduction so that you look after yourselves but sometimes we get some resistance, they don't want us there, we are kind of there mingling in and about them trying to kind of educate them in relation to their levels of alcohol use and sometimes they just can't be bothered with us' (Strategic support staff, Individual interview).

In addition, as many of the projects' activities were group based, getting access to a young person on their own to do the ABI could be a challenge.

4.3 Context and manner in which ABIs are being delivered

This section examines first of all the context in which ABIs were delivered, including their typical duration and consent issues. It then examines in detail the manner of ABI delivery. These issues are important because they can influence how feasible and acceptable projects are.

4.3.1 Context, duration and consent

Settings for ABI delivery were diverse, including young people's homes, drop-in centres, project vehicles, or outside. One person commented that young people were more relaxed and would open up more readily in their own environment. Project vehicles were perceived to be particularly popular:

'It was something that was getting a lot of people's attention, young people were coming over, so the idea was if they were coming over having a chat with us they could come on the bus, they could have a wee look at it and we would try and have a chat with them about alcohol using the CRAFFT tool and then if they did get a positive screen we can chat to them from there, give them harm reduction information, things like that. A lot of the young people are really willing to come on, it was because it was the bus, it was quite a novelty' (Strategic support/frontline staff, Individual interview).

ABI delivery was often opportunistic. For one project offering sports activities this was typically when 'waiting to get out onto the pitch'. There was a recognition that it was not always appropriate to do an ABI 'in the moment', including when a young person was intoxicated, or if the first contact was in a police station. In such cases an ABI may be offered at school or home if they consented to follow-up.

The length of the ABI varied considerably across the projects, from five minutes to an hour long conversation where an ABI may be one component. Longer conversations were viewed as opportunities to develop a relationship with the young person and understand their needs.

Staff explained that it was not a requirement to have parental consent for conversations about alcohol with young people under 16. The projects operated within frameworks such as confidentiality policies which respect a young person's wishes in relation to informing parents and / or carers unless there are exceptional circumstances where they or others are at risk of significant harm. Young people were always made aware of this, so the process appeared partly negotiated rather than fixed. Two projects (both involving police referral) did require parental consent, but the young person's wishes in regard to parental presence for the ABI took precedence. Sometimes parents had been interested in the ABI process and filled out screening tools or referred themselves to services acknowledging that they had a drink problem.

4.3.2 Manner of delivery

As staff typically believed that young people would only be receptive to ABIs if they were carried out in particular ways, they made adaptations of what they perceived as a 'medical model' to facilitate 'fit' to their setting and client group:

'Initially when we were looking at them the only model around was the NHS kind of very medical model which was for A&E staff and GPs. So we have the workers from the NHS who did the training come in and we did feel it was very medical and quite difficult to do with teenagers especially on the street, but also to do with teenagers in general. (...) Initially we thought you can't say that to a young person that way. If you were at the doctor's you would maybe expect a question like that. If we were to start saying things the way it was initially worded like that to a young person they would run a mile if they didn't tell us to f*** off first and never talk to us again' (Strategic support/frontline staff, Individual interview).

Adaptations made by the projects are described in the following sections:

- dimensions of engagement
- approach and structure
- screening tools and measuring alcohol consumption
- individual versus group delivery of ABIs
- follow-up, signposting and referral.

Dimensions of engagement

Project staff highlighted particular *dimensions of engagement* as essential when delivering ABIs to young people and these have clear implications for the acceptability of ABIs in such settings. Two significant and intrinsically related themes involved being flexible, responsive and opportunistic, and creating trusting, respectful and non-judgemental relationships.

Engagement on young people's terms was viewed as absolutely key. Staff spoke about the need to respond to whatever is going on for a young person at the time. An ABI would be carefully considered as one of a number of tools:

'I wouldn't do it (an ABI) formally every single time with every young person. It would depend on what they have disclosed through the consultation. You know, things like if someone has come in for emergency contraception, when did it happen, or if they came in for a pregnancy test, when did it happen? "OK, so why did you not use a condom that night?" "I was drunk". Alright, so that is an 'in' for me, how drunk were they? Were they able to give consent? Who bought the alcohol? There is a whole load of discussions around that kind of thing, about the risk taking behaviour and that's the one that I might go on and use the CRAFFT tool for' (Frontline staff, Individual interview).

As form filling could be off-putting to young people, the drop-in culture was seen to attract young people to services. Staff emphasised that services needed to be inherently flexible around young people attending school or going out with their friends. If appointment systems were used, a suitable time and place was negotiated directly. It was also seen as important for young people to engage on their terms at whatever level was most appropriate for them at the time, sometimes on a one-off basis. One participant spoke about the different approach of detached youth work (streetwork), compared to centre-based and traditional outreach:

'It's a very different approach when you are out doing detached youth work, you are there in a young person's territory, they don't have to engage with you, they are not coming to seek you out as a general rule. They are there chilling out with their pals, doing what they want to be doing in the space they choose to do it in. You don't have any kind of authority to tell them what to do' (Strategic support/frontline staff, Individual interview).

In youth contexts, conversations about alcohol were generally led by the young people themselves, with staff striking up conversations and responding to cues:

“I am drinking two bottles of Buckie [Buckfast] a week but what’s wrong with that?” It’s not until they meet us and we are out on the streets having a conversation about that then they maybe go, “Oh God, that is quite a lot yeah, I never knew that, I didn’t realise that”. And that’s what they say, “I didn’t realise that was a lot”. So these young people would never, never approach a service to say, “I need to talk about this”. A lot of it is creating that conversation for them to realise, “Oh right, maybe I am drinking an awful lot then”. So it’s very opportunistic. These young people would never approach a service because they don’t see themselves as having a problem until they have had that conversation with us’ (Strategic support/frontline staff, Individual interview).

Staff emphasised that working intuitively was important to build up rapport, offer choices to get involved in activities, and make the contact fun and relaxed:

‘Normally it would be somebody that you’ve seen a couple of times, you wait until they come to the point where they are quite open and chatty about their life, well not chatty but you know at least receptive to talking about themselves and talking about their own experience and when we bring it up so either you know an experience has happened that they want to talk about or they want to reflect on or you know they are just talking about generally using alcohol quite a bit and so then what is it like, so OK let’s work out how much you are drinking’ (Strategic support/frontline staff, Individual interview).

Interviewees spoke about the importance of going at the pace of the young person and referenced work that recognises the stage a person may be at in their motivation to change their behaviour (e.g. Prochaska and DiClemente, 1992):

‘What the staff liked was that there was a journey you could take young people on and some of them will enter into the conversation and the journey with you at different stages but it allowed that. You take the young person along at their pace. Of utmost importance is that we have managed to hold onto young people who were not ready because we didn’t force the issue and then we have got them to the next stage. They respected the fact that we said, “Right OK, you are not ready at the moment however here is some information and you can come back next week or a couple of weeks, we will leave it with you”’ (Strategic support staff, Individual interview).

Project staff emphasised the lack of positive adult relationships for young people using their services, reinforcing the value of working in partnership with them and starting from a place of non-judgement. Conversations about alcohol were placed within the context of a *trusting relationship*:

‘...young people teach you a lot about trust and about communication because they will look at you to see can I trust you? Do I feel comfortable? Are you going to treat me with respect and dignity?’ (Frontline staff, Individual interview).

Staff stressed that, as young people feared being judged, their role was to reassure them that confidentiality and privacy was respected and they were not being blamed:

‘Nobody is telling them they are doing anything wrong, nobody is telling them they’ve been a bad person. It’s just, let’s chat about your alcohol intake, what makes you drink on a Friday night, why Friday night, how do you feel about your drinking, are you eating? It’s sort of open questions and the nurse or worker will have a discussion led by the young person so it’s that informality that works particularly well’ (Strategic support staff, Individual interview).

Staff emphasised it often took a long time to build up confidence with young people, especially in streetwork. They believed young people lacked trust in professionals who go through ‘tick-box’ lists or have short, fixed-time appointments. This has implications for ABIs ‘imported’ from health environments where assessment tools are intrinsic to the consultation. Staff attempted to give control back by keeping the young person informed about the necessary processes:

‘All the paperwork I use I explain to the young people what the paperwork is and why I am using it. That’s just my personal preference because I think that sometimes professionals sit there and fill out things and type things out on computers and people sit and go what are they saying about me? Especially young people, am I being judged, what are they writing about me, what’s my name going down on? So if you explain to them what it is, then that gives them that element of control back’ (Frontline staff, Individual interview).

A number of comments were made about the importance of ABIs being undertaken with open-ended questions, in a friendly, conversational and informal style, to help a young person explore their alcohol use and come up with their own solutions:

‘Very often when you pose those types of open-ended questions, it’s respectful to people, it puts the ball in their court, it’s a bit more empowering, you are not preaching to them. They have thought through the good and not so good things about it and perhaps come up with some suggestions or things that they could do and decided themselves that if they don’t drink quite as much or if they don’t drink as often then they might get on a bit better with other people, they might be able to concentrate a bit more at school’ (Strategic support staff, Individual interview).

Addressing perceived power inequalities between young people and adult staff was frequently raised as a key component in building good relations with clients. Staff wanted young people to feel ‘on the same level’ so they would open up and engage. Street workers emphasised that delivering ABIs in young people’s territory created different expectations of the staff in comparison to delivery in traditional service delivery settings such as drop in centres and thus had the effect of evening up power dynamics. Projects involving the police were more difficult for young people to engage with initially but, over time, relationships improved, with benefits perceived for both the young people and the police officers:

'It worked really well for the young people to actually see the cops in civvies clothing and be able to interact with them as humans, as caring humans, rather than this enforcement thing that doesn't work. (...). It was a change of culture for the police and I guess we had a win, win situation from it because the young people were able to interact with community officers as young people themselves' (Strategic support staff, Individual interview).

In one project where police made the initial ABI referral there was attrition as young people initially agreed but then, when the project worker made contact, changed their mind or said they did not recall being asked. There are implications for the feasibility of such projects, as well as acceptability, if young people withdraw when it is clear there is no compulsion.

Approach and structure

ABI was sometimes described as a *way of working* with young people, and *opening the door*, rather than as a one-off discrete intervention. One project manager talked about it spanning a few sessions as a way of engaging and building up trust, thereby getting young people to a stage of readiness for extended work such as motivational interviewing. Staff spoke about the importance of integrating conversations on alcohol with other dimensions of the young person's life such as whom they were socialising with, relationships, and alcohol use within their families. The approach to ABI delivery – and the relative importance of discussing health impact – was considered to vary depending on professional discipline:

'If you are a social worker and you are talking to somebody about their alcohol consumption then your focus isn't necessarily going to be on the impact it might have on their health. You can certainly mention that, but your focus is more likely to be the impact it might have on relationships in terms of their family or parenting capacity, those types of issues. You know if you are a youth worker and you are having – or you are a teacher and you are having that type of conversation with a young person then again your focus might be on how it's impacting on their school performance, their concentration levels at school, their ability to get on with their peers' (Strategic support staff, Individual interview).

Furthermore, staff viewed ABIs as opportunities to use 'regretted behaviour', rather than traditional health messages, as a lever for change:

'If you are working with a 16 year old well they are invincible. They are unlikely to be experiencing any health-related issues there and then and you can say well you can be storing up some health problems for when you are 35 or 40, that's a lifetime away for them. So what we have tended to focus on is what we refer to as regretted behaviour. And that feels as though it's much more powerful to young people (Strategic support staff, Individual interview).

Staff spoke about the ABI structure and process being particularly beneficial because, rather than focusing the interaction on information provision, it actively involved the young people in *decision making*:

'It really helps to structure a person's thinking, having discussions with them around the things that they like about alcohol, again young people seem to engage quite well with that I would say. They don't expect workers to say 'well what is it you like about drinking?', and once they start to talk about what they like about drinking it's perhaps not that difficult to move them onto so what are the not-so-good things, what's the downside about it? It gives people quite a clear and structured way of thinking about their alcohol consumption and ideas, quite practical things that they can do to get a bit more control of it' (Strategic support staff, Individual interview).

However, some projects also significantly adapted the structure of an ABI. Some staff described the importance of not being 'precious' about adhering to structure nor placing it before the relational dynamics occurring in a particular time and place:

'I do firmly believe that an alcohol brief intervention should have a structure, it should follow a set format, but it shouldn't be so rigid that you can't then adapt that to whomever it is that you are speaking to. So, for example, if you are speaking to a younger person and you think well I am giving some information about long term damage but that is not really hitting the mark here, you know, I think you should be able to adapt it to your audience' (Strategic support staff, Individual interview).

In terms of acceptability, some interviewees commented that young people responded better when an ABI was not described as an 'intervention' as it suggests 'something you would do *to* a person not *with* them', so might create relational distance:

'I don't think that young people are aware of receiving an alcohol brief intervention if it's done properly (...) The term intervention is an adult thing because they would go, "What are you intervening in", you know, "What are you doing?" I don't think young people understand if they have received a service sometimes especially because they have not always come in for that service. They understand that they have received a pregnancy test or if they have come in and asked for support, they understand that' (Strategic support/frontline staff, Individual interview).

Screening tools and measuring alcohol consumption

Staff spoke about focusing on the advisory / educational aspect of the ABI, rather than on formal screening, which sometimes appeared to be overlooked or to go unrecorded. Indeed, it was suggested that structured screening could interfere with the natural flow of conversations with young people and did not fit well with 'client-centred' working. That said, other projects reported using screening tools, such as when registering for an activity, in ways young people had been comfortable completing:

'I think we've got about 40 young people that have kind of registered and filled out the form, all of them have been kind of perfectly happy to go through it' (Strategic support/frontline staff, Individual interview).

Often, project staff had had careful internal discussions regarding the choice of screening tool. Some projects 'tweaked' the language to fit their context and client group. Staff's initial reaction to appropriateness had not always been borne out; for example a question about car use had been more relevant than first thought. They therefore stressed the need to pilot screening tools with young people. Generally the CRAFFT was popular with projects that had adopted a screening tool.

Professional cultures seemed to make a difference, with staff from health backgrounds reported to be more comfortable with screening and assessment tools. Screening was not generally considered essential prior to an ABI. Staff believed that young people may still benefit from the ABI, gaining knowledge to inform choices that might prevent problems developing.

Project staff tried to measure alcohol consumption in different ways when talking with young people. Some projects used their experience to adapt the generic ABI tools. Staff frequently mentioned the predominance of spirits, especially vodka. They made the point that young people may make generalised statements about having drunk 'tonnes' but it might have been very little because the alcohol was consumed in a group. They therefore need to probe what was bought and exactly how many people it was shared between.

A number of staff commented that mainstream resources to measure alcohol were not appropriate for young people. Different patterns of drinking, such as a propensity to binge at weekends rather than have moderate amounts through the week, also made the concept of calculating units less helpful when working with young people. There was a 'wariness' in some projects to measure units because any attempt to quantify use might be off-putting. When staff were calculating units, therefore, they used terminology and informal conversation styles suitable for young people, alongside local knowledge about drinking patterns and the types of alcohol regularly consumed:

'If you are going to deliver an intervention you need to know what the starting point is and how to do that in a young person friendly way. So rather than talk about, you know, glasses of wine we may talk about capfuls of vodka and reckon that is probably a unit. So we would actually do that with young people where we would try to figure out how much is a swig-full from a bottle which is, yeah, not easy to do, and to try and gauge how much people are drinking in a bit more of a realistic and practical way' (Strategic support/frontline staff, Individual interview).

Other project staff found that resources such as unit calculators and alcohol diaries helped to structure alcohol conversations. According to these interviewees, young people were actually very interested in the amount of units they were drinking and such tools helped them develop a better awareness of the amounts they were drinking, and keep track of their units and the impact of different levels of alcohol consumption on their life.

There was a desire within some projects to use technology more effectively for access and engagement, while recognising that not all young people have smartphones or credit. Sensitivity in making contact was also an important consideration. Some projects had started to experiment with interactive and social media. Projects also made adult-focused resources 'young people friendly' and developed games to facilitate engagement with the ABI process:

'We do wee cards where they pick three things that they are going to do to change their behaviour or to make them safer. There are 20 odd choices and one of them is reduce their alcohol, but there are other things like going to take my mobile phone out with me, I am going to have something to eat before I go out, I am going to stay with my friends, I am going to learn a bit of first aid, there are lots of different things. And we say to them, "Right, what don't you do already, pick three things that you want to try and do". And then we do an, "Are you up for it?" game which is where they pick the choices they are wanting to change' (Strategic support/frontline staff, Individual interview).

Projects had very different approaches to information leaflets. Some interviewees had reservations about their appropriateness and the danger of giving a 'dismissive' message rather than working to engage relationally. Others felt it was their responsibility to provide as much information as possible, and used leaflets to signpost other services.

Individual versus group delivery of ABIs

One of the adaptations staff spoke about involved delivering ABIs in groups or pairs:

'... it's often the nurse or the worker having a chat with two or three young people at the one time. So they are having a discussion amongst themselves, they are discussing their alcohol intake, why they drink, the effects, the effect on their safety, the effects on their wellbeing, their health' (Strategic support staff, Individual interview).

Group / paired ABIs were sometimes opportunistic rather than a deliberate strategy:

'It quite often happens because we are out in pairs, sometimes you end up with a couple of people talking to one worker and the rest talking to another. And if you have some interest like that within the group you can do ABIs just in twos or threes which is much easier than doing it in large groups. It tends not to work too well in large groups. You get less bravado doing it in smaller groups' (Strategic support/frontline staff, Individual interview).

In some projects, group ABI delivery seemed to emerge from the peer education approach used generally to make drug and alcohol health promotion messages more effective. For example, one project deliberately used peer-to-peer relationships to create opportunities for more 'robust' challenges on alcohol use:

'We've had a group of young people that came to us for one to one support through a variety of referral processes, from the school and from social work and we built up a relationship with them and we did one-to-one support with them and now we have progressed them. There are six of them because they are all from the same area, they have all got similar issues and they have now formed a group. And we have been doing alcohol brief intervention, education, cycle of change with them in a group. The biggest thing is the peer stuff, you know, the positive and the negative peer conversations that you strike up in relation to having a group when you get them into that place of being open and honest with one another. (...) ... and that's really powerful. Sometimes it's more powerful than you as a worker can do' (Strategic support staff, Individual interview).

Sometimes pairs were accommodated because the young person wanted a friend with them:

'Sometimes it's done as pairs, sometimes young people want to do it together so two young people can sit together and do it. We wouldn't say no to that so if a young person says 'Oh, can I bring my pal on to do it with me?' we would agree to that. Sometimes it would be done together depending on how the conversation went' (Strategic support/frontline staff, Individual interview).

This could generate ideas for setting goals, but there was also the danger of copying. Overall the pair model was used cautiously because of the difficulty working with two different 'agendas' and potential dilution of the ABI. Other staff encountered challenges with a group approach, for example the danger of one person in the group taking over, and the rest of the group agreeing with this dominant view. It was therefore important to have experienced facilitators:

'You have got to be able to manage and facilitate the information that they are sharing within the group and to manage how much of that is bravado, how much of that is real life, how much of an impact that can have on them. When they are sharing these things you need to make it a very safe place because you don't want to be touching too many raw nerves. Because a lot of the young people that we have, an awful lot of them, are affected by parental substance misuse which comes out in our conversations – that has to be managed very, very carefully' (Strategic support staff, Individual interview).

One project had previously delivered ABIs to young people in groups but stopped because of the lack of privacy and the danger of friendship or peer dynamics getting in the way. While no staff member spoke about any specific negative situations as a result of doing ABIs in groups, the interviews did not explore this aspect in depth.

Follow-up, signposting and referral

This was an area where practice ranged considerably and thus is important in terms of the feasibility of projects. Some projects had attempted to identify changes post-ABI:

'What we do just now when we follow the young person up we speak to them again about their units so we know if they have reduced their units. We know if they are putting into place their changes in behaviour choices, you know their safety things. The 'Are you up for it' game, we know if they have managed to do that or not so that is probably the only sort of quantitative figure we put on things. We know they drank this amount on the night we met them, when we did the follow-up they said they had reduced to this amount, so that is probably the two biggest things, that we know it's working or not (...) ...' (Strategic support/frontline staff, Individual interview).

Another project used telephone follow-up three months after the ABI and tried to quantify any subsequent changes in drinking patterns / consumption on a 1-10 scale. Where it took place in person, follow-up at school was popular, at lunchtime or being taken out of class, and young people had seemed amenable to this:

'After the alcohol brief intervention on a Friday night the worker will then make an arrangement to go and see them two weeks later within school so there is that follow-up for me which is absolutely crucial. That's really where more work can be undertaken because they are having the discussion one to one in the school premises where the young person hasn't perhaps had a drink' (Strategic support staff, Individual interview).

Organised follow-up post-ABI delivery was not, however, a feature of all projects and there was reluctance amongst some project staff to develop their service in this way:

'...they are constantly looking at us to evidence it but it's quite difficult to evidence it specifically because we are drop-in as well, you can't force people to come back. That's not the approach we want to take, we want people to come on a voluntary basis so sometimes we will get young people come back with a positive outcome and sometimes it will be a negative outcome' (Frontline staff, Individual interview).

In such settings, any follow-ups that took place occurred on an individual, opportunistic basis where the responsibility for continued support lay with the young people themselves. However, young people were encouraged to continue to engage with the projects, especially where there were concerns about their alcohol consumption.

Signposting was a key aim of a number of projects, who recognised their own limits:

'We did a survey with a group two years ago and there was relationships, school, parents, bullying, you know sexual health, healthy eating, bulimia. The conversations in the campervan will go wherever the young people want to take the conversations and all we can do at that particular time is say to them that we haven't got the necessary skills, experience and training to advise you on that however we know somebody who we can signpost you onto' (Strategic support staff, Individual interview).

Leaflets and laptops with web access facilitated signposting in mobile settings. In one project there was an automatic process of referring any young person who scored positive on the CRAFFT screening to specialist services. Some staff expressed the view that young people may be reluctant to accept specialist help, preferring to receive more generalist support within the projects. Onward referral and signposting could be a 'struggle' because of the lack of specialist services for under 16s, and removal of services following funding cuts. Some geographical areas had counselling, buddying and support services, while others had none. In-house opportunities for more individual support after an ABI were possible within some of the larger organisations.

4.4 Facilitators to ABI delivery in young people's settings

This section of the report examines the facilitators to implementation of ABIs in the young people's settings which emerged from interviews with project staff. These comments relate to effectiveness of implementation (and thus the feasibility of the projects), and not to effectiveness of the ABIs.

A number of facilitators emerged from the data. These are discussed below under three headings: staffing considerations, staff training, and other facilitators.

4.4.1 Staffing considerations

A variety of professionals delivered ABIs to young people including sexual health and health improvement nurses, youth workers, community learning and development workers, health promotion workers and sports coaching staff. A number had come from adult addiction and training roles, mental health, social work, school nursing, counselling, community learning and development or health promotion. Because this prior experience varied considerably, projects were notably multi-disciplinary: *'everybody comes from a different perspective'*. Some workers had project-specific skills, for example in sports, and many had extensive experience working with young people. Given the importance of relationships, recruiting good staff experienced and skilled in working with young people was seen to be vital:

- Able to build supportive relationships that took account of power inequalities and helped strengthen resilience.
- Effective in helping young people with goal setting and motivation to make changes in their lives.
- Dedicated, with a passion and belief in working with vulnerable young people and families and making a difference.
- A confident and skilled facilitator, especially in managing group dynamics.

Managers spoke about the importance of creating staff teams that were explicitly multi-disciplinary to draw on the strengths of different perspectives and skills. Having health staff integral to ABI teams was thought to be of significant benefit because of their expertise on alcohol and its relationship to other health issues, and knowledge of specialist services. Although some participants felt that having police officers involved was a challenge because their perceived hierarchical culture, professional image and responsibilities were so different, participants generally found that joint working with the police held many benefits, and was more effective in tackling youth drinking than when agencies worked separately. Police officers did not deliver ABIs, but some had received the training, and they worked within projects as team members or referrers to project workers who then delivered the ABIs (see Appendix

C for information on how police were involved in a number of the projects in our sample).

Consistency / continuity of staff was considered important, largely because so much of the work involved follow-up after the first contact. Having the same staff member following up was seen as beneficial to the development of trust and relationships (see section 4.3). A lack of consistency was noted most specifically with police officers who could not be individually attached to projects because of shift systems.

4.4.2 Staff training

Some project staff had received bespoke ABI training, based on NHS Health Scotland national training resources but adapted to be relevant to work with young people. One project had developed a training pack for youth settings, and the SALSUS resource (see Glossary) was described as excellent for training around alcohol and young people. NHS trainers made it clear that the evidence base for ABIs in young people's settings did not exist so any implementation was best understood as a pilot. They emphasised the importance of not lecturing young people, of engagement, and of focusing on negative consequences rather than alcohol units. Skills practice was important, alongside attention to language appropriate to the age group. Trainers tried to deliver setting-relevant training, but relied on project staff to use their core skills and knowledge to incorporate the generic ABI process into the wider goals of their team:

'It's a challenge for trainers to be able to stay true to the approach, to the structure and, you know, be able to adapt it to different types of settings' (Strategic support staff, Individual interview).

There were also general challenges of meeting the needs of a diverse range of participants and making the training concise enough for staff to get time away from work to attend. However, positive experiences of ABI training seemed to '*change the mentality*' of staff with some reported to have '*absolutely loved it*'. It worked best when the training reinforced what project staff were already doing but provided additional dimensions to think about such as ways of calculating units, using screening tools, and knowing where to signpost clients. Some projects had made ABI training mandatory:

'Now it's part of our core training in relation to when new staff come in, part of their core training would be ABIs along with safeguarding, child protection, equality and diversity... we've now embraced it and found it so beneficial that we use it as core training for all our staff' (Strategic support staff, Individual interview).

Maintaining staff skills was raised as an issue. Some teams focused on training a few key staff, but this relied on staff not frequently needing to be replaced. Keeping staff up-to-date with refresher training was viewed as important; participants highlighted that training should not be a one-off but should have a follow-up where workers could explore if, how and with what quality ABIs were working in their setting. One area had developed an ABI Learn Pro module as a 'refresher' tool.

Staff said they valued the opportunity to access on-going specialist advice or support on alcohol work. Interestingly, the trainers interviewed were very amenable to this, and saw it as part of their role. Some trainers would attend team meetings, answer queries and support the recording process. Keeping the momentum going was essential given the other demands on staff. The use of buddying, peer to peer learning, regular supervision and the importance of reflective practice in developing the confidence of staff was also highlighted:

'I talk to staff about reflective practice and I call it reducing resistance with young people. And it's about using motivational interviewing skills, open questions and we can get into a habit where we forget about these skills. Motivational interviewing is a fantastic tool and technique if they use it all the time. So it's about just taking the staff along on the journey and giving them that additional training and experience and confidence to be comfortable with asking open questions. So you enter into that dialogue with young people' (Strategic support staff, Individual interview).

Continued additional support for those delivering ABIs, and more active 'championing' at a local level, were considered necessary components of the work:

'Training alone probably isn't enough. I think coaching, you know, more of a coaching approach, whether there would be people that would champion it and part of their remit is that they would coach colleagues. Although I've been involved in training for years I worry that people come to a one-off session and then the expectation is that they have got it, that they will just deliver it. To me, if we were really serious about changing the culture in Scotland, if we felt this was something that we really want to do in terms of early intervention then we would have to invest in it and to really invest in it, having frontline coaches or champions for it that were able to work alongside colleagues and demonstrate how it might work. It might be more expensive but I think in the longer term it would probably be more effective' (Strategic support staff, Individual interview).

4.4.3 Other facilitators

The *coherence or 'fit'* between ABIs and the setting / context was a major factor facilitating the adoption of ABIs into new or existing multi-component approaches. The extent to which staff teams collectively perceived the concept as potentially *helpful and relevant* to young people, and the freedom they had to take *ownership* of implementation in their own setting, both seemed to be important.

Previous experience of *cycles of change* and *motivational interviewing* work, a generally *reflective and person-centred* approach to practice, an interest in *developing and sharing resources*, and on-going, supportive *relationships with ABI trainers* also featured in projects where ABIs appeared to have been implemented most successfully. It is possible that these factors are closely related to awareness of the need to balance 'fit' with fidelity.

All projects involved levels of partnership working between different sectors (NHS, local authority, third sector) and agencies (police, nursing, social work, schools, community learning and development, leisure services). Such partnerships were

described as both facilitators and potential barriers. They were not always easy to get off the ground, and interviewees described them as uncomfortable and challenging at first. Staff spoke about excellent partnership working but also interagency tensions negatively impacting on innovation. In terms of police partnerships, some interviewees spoke about initial cynicism, fear or reluctance but said their approach had changed as they realised the benefits. While *leaders* and lead agencies were appreciated as important, these champions strived to generate *distributed ownership*. Good *working relationships* at and between both strategic and operational levels were viewed as essential to successful delivery of ABIs on the ground, and seemed to be most enabling when these positive *connections already existed*. In some instances, the ABI project itself seemed to have been a conduit to better partnership working.

Support to develop the evaluation potential of existing ABI work from NHS Health Scotland and the Scottish Collaboration for Public Health Research and Policy was well received by those projects who mentioned it. As well as contact and cross-fertilisation of ideas, it placed what they were doing in a national context.

4.5 Barriers to ABI delivery in young people's settings

A number of barriers emerged from the data, and these are discussed below under three headings: staffing issues, project funding and sustainability, and other barriers. As described in the previous section, some factors could be both facilitators and barriers, such as partnership working.

4.5.1 Staffing issues

A number of comments were made in the interviews about the general unsocial hours and uncomfortable working conditions that staff faced in working in some of the projects (e.g. outdoors in parks). This alongside the short-term sometimes sessional funding of the posts created additional challenges for staff working in such projects.

Staff discomfort and fears are a barrier to ABI delivery in young people's settings. For some, there was a stigma associated even with raising the issue of alcohol:

'It's a very emotive topic talking about alcohol, about why somebody drinks you know. So it's a really hard one, it's a really, really hard one'
(Frontline staff, Individual interview).

One reason may be that staff have to reflect on their own relationship with alcohol:

'Nobody wants to think of themselves as being a problem drinker so it is quite hard to be involved in any kind of training and not go away and reflect on your own drinking given the information that we are equipping folk with' (Strategic support staff, Individual interview).

Staff in a couple of the projects were not much older than the client group. This was thought to be challenging given the general sensitivity of conversations about alcohol and drugs.

Some staff, particularly in non-health settings such as diversionary projects, were concerned that conversations about alcohol would open a 'Pandora's box' of personal and health issues they were not equipped to deal with. These staff needed reassurance that this work could alert them to problems and to suitable specialist services.

Another source of discomfort was that delivering ABIs would make work with young people too clinical. Some staff, both those on the frontline and in strategic support roles, viewed ABIs as they are expected to be delivered in primary care settings as too formal. Overall, staff had to 'buy in' to ABIs through seeing the benefit for their clients and settings. In some projects, teams had received training and were in the early stages of considering adoption. Concerns about the ABI process changing a project's dynamics or ethos was key to such decision making. The risk of losing the rapport and trusting relationships that had been developed was a significant factor:

'We are in the youth work game. We've got, we build up rapport, relationships. We definitely have a concern for the young people. They know that we care and if they know that we care then they are willing to come with us. But we are going to have to look at the balance between, is the ABI something that is quite clinically done, or is there the opportunity to bend it a little to make it fit with youth work methodologies and models?'
(Frontline staff, Individual interview)

Despite attempts to adapt ABI training noted in the discussion of facilitators above, not all project staff engaged. Less positive comments related to it not being sufficiently relevant. Some participants felt the training assumed workers were going to be in a one-to-one interaction in a private room, so came away with feelings of anxiety and scepticism. One participant felt the training video footage was dated and distant from their own experience and setting; being able to relate to example scenarios is therefore important. Trainers perceived an attitude of 'we know this already' as defensiveness amongst those who had the potential to reflect on and improve their practice.

4.5.2 Project funding and sustainability

The way projects were financed included funding from their local authority under educational and advisory budgets, generic funds for addictions work through their local Alcohol and Drug Partnerships (ADPs), and core funding to provide drug and alcohol services to children. Often projects had mixed sources of finance from, for example, local Health Improvement Teams, Scottish Government, Alcohol Partnership Projects, local authorities, local NHS boards, funds to address anti-social behaviour in particular towns, and charitable foundations. This complexity was stressed by interviewees:

'The funding is very complex, we receive some local authority funding and some NHS funding but an awful lot of funding from discretionary funders which is usually awarded for a fixed duration anywhere from one year to five years' (Strategic support staff, Individual interview).

One project reported 12 different sources, and for some there were no additional funds:

'The organisations taking part are not receiving any extra money to deliver ABIs or to even take part in the training' (Strategic support/frontline staff, Paired interview).

'I am now paying for the nurse out of my own budget so I don't get any monetary compensation for that. I feel hopefully that I've managed to mainstream it into my own team although it's still a sessional nurse that I use from the NHS nurse bank' (Strategic support staff, Individual interview).

While some projects considered that implementation required extensive resources in terms of staff time (to attend meetings, develop guidelines and carry out the ABIs), others believed the costs need not be substantial if partners came together to provide the service. Funding sources could dictate the age group the project was able to work with. Some organisations had attracted core funds because they had mainstreamed and built ABIs into their service level agreements. However, short-term and precarious funding was significant in preventing the development of more sustainable work: *'it's just part of our life'* in the third sector. While most projects were actively working on sustainability through gathering evidence for funders of their effectiveness, one project's funding was not renewed during our data collection period.

Interviewees, particularly those working in less financially stable environments, highlighted a chicken and egg situation whereby commissioners need evidence to support initiatives but sustained funding is required to develop that evidence. Time is also needed to start up projects and translate strategic decisions into new and trusting working relationships on the ground across diverse sectors:

'There is an assumption that because there has been a strategic decision made that everybody is actually buying into it. And on the ground that is very often not the case at all. It takes a fair amount of time, sometimes up to three years just to get a project established which is usually just about the time that the money is running out. There is a lot of work that needs to be done perhaps not around the topic of the project but building relationships in order to make your project a success. I would imagine that there would probably have been a little bit of resistance because some people might have felt that it was another thing for them to do and they had enough to do. That's just how people feel when they are being asked to do something else and perhaps don't understand the value and the impact of it' (Strategic support staff, Individual interview).

Participants expressed disapproval of the financial reimbursement GPs receive for carrying out ABIs, which they considered to be part of their job. When projects were funded specifically to provide ABIs, staff commented that any associated targets could be difficult to achieve within their model of working where the number of potential candidates and suitable 'moments' for intervention (retaining control over the decision to use an ABI when appropriate for an individual young person) could fluctuate markedly. Interestingly, although it was not clear that this could be an

explicit driver to become involved in the work, delivery of ABIs seemed to help some projects become more attractive to funders:

‘The term ABI is really useful for us because we can package that when we are speaking about alcohol into something that other people understand, funders understand, so in some ways it’s giving us credit for the work that is going on but in other ways funders really like that because they can understand it a bit more and so they push for it’ (Strategic support/frontline staff, Individual interview).

4.5.3 Other barriers

More widely, the pervasiveness and normalisation of excess alcohol use in Scotland was perceived to be a barrier to this work because of the extent to which young people were influenced by family members and wider society (see section 4.1.2).

Furthermore, all services were challenged by the need to adapt quickly to address changing patterns of drinking behaviour (for example, young people choosing to drink in their own homes and at parties rather than on the street), particularly when they depended on short-term funding and are highly vulnerable to budget cuts. The challenges inherent in the contexts that projects were run should also not be underestimated.

Overall, ABIs were less likely to be implemented where staff viewed ABIs as unsuitable for their setting and potentially harmful for their client group, were cynical, felt uncomfortable about raising the issue of alcohol, perceived the training as top-down and driven by targets and other people’s agendas, or lacked confidence and questioned whether it was even legitimate for them to do this work. Similarly, interagency or interpersonal tensions, lack of support at a strategic level, under-resourcing and competing demands had an effect.

4.6 Data collection and measuring outcomes

This section examines first of all the different approaches and practices in the projects concerning data collection, and secondly examines project staff’s views on and approaches to measuring outcomes and documenting impact.

4.6.1 Data collection

Data collection practice ranged from projects that had attempted to understand baseline levels of consumption and follow up ABIs, to those where no data were routinely collected. Some projects used SurveyMonkey to collate ABI activity, and some completed initial registration / assessment forms. One project produced session summaries, and another collected ‘anecdotal anonymised stories’.

One streetwork project had developed their intervention through collecting baseline data in schools and while doing streetwork using adapted questions from the SALSUS:

'It gave us a really good indication of what young people were drinking, how and when, which gave us our best indication of when to go out on the street. And it gave us a bit of an indication as well of what games and tools to bring out as well. Young people were saying that they want to do activities so we took out bean bags to play games and footballs and things like that so those were kind of our wee initial diversionary activities' (Strategic support/frontline staff, Individual interview).

Some projects collected data on the issue the young person came with, topics covered, and feedback on the service. One project recorded every contact and screening on paper; this was kept in a young person's file to enable follow-up if they returned, as well as within an electronic system used for quarterly reporting purposes. Another project kept all anonymised paper screening records in a folder in case another agency such as the local ADP was keen to use them. They reported that despite offering this data no other agency had shown an interest in it.

A number of staff perceived a need for more robust processes to capture activity and evaluate outcomes. In one project efforts to improve monitoring of screening data were evident following recent intervention by the local NHS addiction team perhaps due to the HEAT target returns allowing inclusion of numbers from wider settings. In some instances ADPs only recognised these numbers if the staff involved had received the national training from NHS Health Scotland recognised trainers.

A number of staff spoke about the importance of negotiating required data with funders, and having conversations about the appropriateness of tools such as particular screening assessments. Some project staff believed the NHS approach to data collection was too structured and prescriptive, and failed to take adequate account of the way project staff worked with young people. Lack of time and capacity to undertake more systematic recording and reporting without additional resources was mentioned, particularly where the ABI work was an 'add-on' to existing practices.

One of the most significant data collection issues was fidelity; how to differentiate an ABI from other more general conversations about alcohol:

'We do quite a lot of alcohol awareness work with groups and also with individuals and how to kind of define that as being different from an ABI can be a challenge and I suppose we have heard different messages from other people that are involved with either the delivery of the training or other aspects of alcohol brief interventions and so it's hard to find out what you are defining as an ABI versus what you are defining as just kind of alcohol awareness raising. If we are speaking about somebody's own alcohol use, if we are finding out either what risks they have taken or how much they are using and if we have discussed any kind of changes and stuff that they could be making for the future, any kind of adaptations to their behaviour then that is what we call an ABI' (Strategic support/frontline staff, Individual interview).

Conversations on alcohol with young people clearly went unrecorded if they were not considered to be formal ABIs:

'They are outside the unit having conversations with... it might be 20 young people, 30 young people, and those conversations aren't captured, so there is a lot of good work that goes on informally that's not an alcohol brief intervention and at the moment I don't think the project is recording all that good work, they just see it as well that is what we do. But really it is excellent work and we should be managing to record that in some way' (Strategic support staff, Individual interview).

Staff said they discussed in their teams what differentiated an ABI from an informal conversation about alcohol. Some described ABIs as quick 'one off' interventions, in comparison to more in-depth work or less structured conversations. This was not consistent, however, and it is possible that informal conversations were recorded as ABIs in other projects. While many adaptations (see section 4.3) were described as 'slight tweaks' to make ABIs 'more palatable', others meant the intervention being delivered – for example the group model - may no longer be recognised as an ABI by those outside of that setting. Some trainers commented that they would not consider what was actually being delivered within some projects 'on the ground' as ABIs. Overall, variation between projects in what is recognised and recorded as an ABI had obvious implications for feasibility (are ABIs actually being delivered?) and for evaluation (is the same activity being compared across projects?).

4.6.2 Measuring outcomes and documenting impact

A number of staff believed ABI work was having a positive impact:

'We've also had a lot of young people when we've done the follow-ups that have said that the ABI was enough to make them think about their alcohol. So if I hadn't had that conversation that night... they've not needed any more support after the ABI. It's not just about their alcohol intake it's about their safety and changes in their behaviour' (Strategic support/frontline staff, Individual interview).

However, they realised it was hard to generalise given that they may not be hearing from those who had not benefited:

'It's really hard because generally somebody will tell you if they have changed in a positive way because that's kind of what we do here; we try to encourage people to make positive changes about their health. You don't always see the people that maybe it hasn't worked as much for' (Strategic support/frontline staff, Individual interview).

Questions were also raised about the accuracy of self-reported behaviour and its value for evaluating effectiveness. To ascertain the impact of ABIs, people – whatever their age - need to be honest about their consumption both before and after the intervention.

Some participants stressed that secondary as well as primary outcomes to ABI delivery should be taken into consideration when assessing the value of the work as a whole:

‘...how do you record (...) that yes maybe they have gone home and put a coat on or sensible shoes or they have gone for something to eat and not had that extra half bottle of vodka you know. That’s the whole problem with health improvement work is capturing outcomes’ (Strategic support staff, Individual interview).

Other staff members were less convinced that delivering an ABI in and of itself would make a difference to a young person’s alcohol-related behaviour. Instead, they saw ABIs making a contribution to a ‘multi-component approach’. In a project where the police were key partners, indicators such as the number of calls about alcohol related problems were used in a before-and-after analysis of anti-social behaviour. While this is an important attempt to investigate outcomes it cannot take into account changes in young people’s drinking behaviour, such as drinking inside rather than on the street. That said, participants spoke of ‘seeing the results’, with changes in neighbourhoods:

‘It’s tangible by the results. Back in 2007 when we started off we would have regular fights, numerous calls a night for youth disorder to now where you know officers are complaining if there are a couple of calls on a night (...). Whereas in 2007 we had 10, 20 calls a night for youth disorder so I think community safety team officers realise the benefits of these operations’ (Strategic support staff, Individual interview).

While staff and managers were keen to know whether the ABI work was having an impact, evaluating such activity was definitely viewed as challenging. In part this was due to the difficulty of quantifying support and ‘input’, and measuring impact in isolation:

‘Part of the frustration of youth work is that you can’t tick a box in the same way that you can do a blood test and ask somebody to come back and get the results. You can’t evaluate that in the true sense of, I saw a young person when she was 14 and then she came back and saw me when she was 15 and a half and then she came back and saw me when she was 17. How do you record that? How do you evaluate that? How do you know that what you are saying has made a difference at that time?’ (Frontline staff, Individual interview).

As it takes time to embed processes and relationships that facilitate ABI delivery, and public services are facing financial constraints, most projects found it very hard to track outcomes and demonstrate the necessary impact within short timescales:

'I really want there to be robust evidence that ABIs out with the health service work. If we can get that then it's going to be, it's going to be easier to convince the health partners of the Alcohol and Drug Partnership that it's a worthwhile use of resource. They need to know that the resource is going to be well used. Not just that you will get sufficient numbers going through but that you will get a significant return on your money if we are. And we are not going to know with young people with brief interventions for a number of years whether we do that, and that's, that's quite difficult. (...) I feel that in order for us to get the evidence that we need, we need to invest quite long term' (Strategic support staff, Individual interview).

Participants were clearly aware that the evidence does not currently exist for extending ABIs into wider settings. This created a perception of a generalised lack of support for the work from some quarters, particularly within the NHS. Participants were encouraged that this study was developing a better understanding of work in wider settings taking place in Scotland.

Constant evaluation of effectiveness characterised a number of organisations in the study. Staff spoke about the need to respond constantly to the changing needs of their client group and to demonstrate the value of what they were doing. Some projects had commissioned external evaluations to help develop their service and provide a better understanding of impact. While some projects did not have the time or resources, case studies were also used to explore how a contact with a young person started, the work undertaken and how it concluded.

4.7 ABI delivery in the social work setting

As described in section 3, only one project delivering ABIs in a social work setting was able to be included in Phase 1 of the study, and this is described in more detail in Appendix C. Other projects in social work settings were known to be in operation during the evaluation period but did not indicate an interest in participation in line with the timetable for completion of Phase 1.

As only one project based within a social work setting was able to be included in Phase 1, and this same project declined to participate in Phase 2 (see section 2.3), it is difficult to draw useful conclusions as to the feasibility and acceptability of ABI delivery within a social work setting. As this project took place within a criminal justice social work setting, it cannot reflect possible delivery in other areas of social work such as child protection or elderly care and support. Moreover, the experiences of this one project cannot be presumed to be representative of other projects that may occur in other criminal justice social work departments across Scotland. However, there were also elements of this project which will be common to other Scottish criminal justice departments and provide opportunities for ABI delivery in this setting.

In the project concerned, extensive work was carried out prior to the project beginning to set up data monitoring and reporting systems. Staff from the local alcohol and drug partnership worked alongside the local authority's IT staff to integrate data collection on ABI delivery into the council's client management database.

Despite the effort involved in setting up data collection and related processes, the presence of an established database system that could be adapted to support the evaluation of ABI activity is a significant advantage within this setting and one that is highly likely to be replicable in other local authority areas. Moreover, within this local authority, there was established resource for administrative support with social workers able to pass on data input tasks to social work administrators, further reducing the possible negative impact of recording ABI delivery. In this project, ABIs were envisaged as being delivered as part of the interview process for a Criminal Justice Social Work Report, which is requested by a court in order to inform sentencing of offenders. The process behind this reporting, which is standard practice across Scotland, provides an environment that is conducive to the delivery of an ABI due to both its one to one format and the length of time social workers can spend with clients. It may not necessarily be the case in every local authority but in the project examined here, interviews with clients at this stage also took place within dedicated interview room offering a high level of privacy.

Another strength of this interview process is the focus upon examining the possible causes of and context for offending behaviour which encompasses discussion of clients' circumstances. Social workers are therefore skilled in broaching sensitive topics with clients, that often may include substance use and so the premise of ABI delivery within this interaction is not likely to be extraordinary to social workers. Additionally, the criminal justice process also allows opportunities to follow up clients that have received an ABI at the court report stage. Although it is only a minority of criminal justice clients that will be followed up by social workers at a later stage, this provides some advantage over other settings.

As the project conducted in a criminal justice social work department highlighted possible opportunities for ABI delivery within this setting which may reasonably be applicable in other local authority departments, it also highlighted challenges that could be encountered elsewhere. Social work staff working within the included project were doubtful of the added value of using ABIs within a conversation that already addresses alcohol use as a way of exploring offending behaviour. There was also a sense that staff questioned whether the impact of receiving an ABI delivered at the court report stage could be meaningfully measured some months later, as this would be a time when clients may already be looking to make important changes to their life to address their offending. These challenges to delivering ABIs within the court report interview may only be representative of this particular criminal justice department, but attempts to implement ABI delivery within the court reporting interview process may present similar barriers where staff feel their current approach to addressing alcohol use is sufficient.

5. Findings: Young people's perspectives

This section of the report explores the feasibility and acceptability of the projects from the perspective of individuals who have participated in the projects and who may have had an ABI or discussed alcohol with project staff (research objective 4). Implications of participant data for acceptability and feasibility of conducting an outcome evaluation for these projects (research objective 5) are discussed in section 6 alongside relevant data from the Phase 1 interviews with project staff and desk analysis of project monitoring tools.

Findings in this section relate to the six projects which participated in Phase 2 of the study and provided access to their client group (see section 2.3 for more on how the six projects were selected). The data for this analysis is drawn from Phase 2 interviews with young people who engaged with the projects under investigation, and from field observations of how young people interacted with the projects and their staff. As tabulated in section 2.3, 61 young people were interviewed primarily in paired interviews (one young person was interviewed individually) and focus groups. The discussions focused on the young people's experiences of attending the particular projects and of ABIs or other alcohol-related conversations.

Firstly, contextual insight is provided into young people's drinking behaviour and experiences, and their attitudes towards the projects. Secondly, the section describes how young people first became involved in the projects and how easy the projects were to access. This is followed by an examination of project atmosphere and young people's relationship with project staff. Finally, young people's experiences of ABIs and other discussions with project staff about alcohol are explored, and how these discussions may have affected their views about alcohol and alcohol use.

5.1 A contextualised background to the young people's alcohol use

There was a considerable range in the amount of alcohol young people described consuming and the frequency of this consumption. It is important to recognise that several of the young people interviewed indicated that they drank very little alcohol and sometimes mentioned others who also did not drink. In some cases, this relative abstinence related to a young person's commitment to and enjoyment of sports. For others it related to broader cultures or previous experience. Indeed, some of these young people had rarely ever drunk alcohol or had never been drunk and also described others for whom this was the case.

For those who did drink, one of the most popular drinks was vodka:

Interviewer: 'Is that what most people drink?'

Young person: 'Aye, cos vodka gets you drunk...it's quite dear but that's the most popular drink...and you cannae really like mix cider with anything except like currant juice so it's like minging (nasty) but you can mix it [vodka] with any like fruit twist or coke or something' (Young woman, age 15).

Wine, Buckfast and cider were also mentioned, the latter primarily in relation to its low cost:

'With half a bottle of cider, it's £2, that's how easy it is for people to get drunk' (Young man, age 15).

Further, though nearly all interviewees were under-age, alcohol was not seen as difficult to obtain:

'You just find a junkie and they'll get it' (Young man, age 15).

For many of the young people, drinking was a weekend and summer holiday activity undertaken at parties or outside. This drinking was related to pleasure, to getting a 'buzz': *'You can't get a buzz or a laugh if you don't drink'*. Being sober while friends were drinking was seen as unattractive: *'just like they're all hypered up and we're just sitting there and we're like no, this isn't great'*. Drinking outside was related to trying to keep warm in cold weather: *'Because it's cold you gotta drink or get drunk so you're not cold...sometimes it's good, like you forget about everything else'*, but was also seen as a pleasure in the summer months. In an interview that took place in the week before the summer break when the weather was very good, one young person recalled the previous summer holiday:

'Next Friday it all begins...non-stop alcohol ... till like the day before you go back to school. Last summer I used to be out the door for 10am, got my drink by 10.30, drunk by 12' (Young man, age 15).

He would then try to get hold of money to drink again in the evening. These young people mentioned other activities they enjoyed over the summer including going to swimming pools with flumes, or to larger cities to shop. They had free access to swimming pools in the area over the summer. However, transport costs to the pools inhibited their access to these activities to some degree, and in some areas, few other activities were available. Those clubs that were available had very strict operating policies; several young people described being excluded from other youth groups because of their alcohol use or because of what they perceived as relatively minor disruptive actions. There was also a financial cost to drinking. Indeed, running out of money was the major inhibitory factor for some. However, drinking was perceived to be cheaper than other activities, and also had the perceived advantage of taking place out of the sight of adults and their regulations.

Some of the drinking behaviour described by young people involved severe binges at weekends or over the summer, while a minority of the young people interviewed drank more consistently. One young man described how he had ended up sleeping in bushes after drinking the previous weekend: *'I just woke up in some bushes...I thought I was in a nice comfy bed'*. One young woman referred to a period *'when I was total drinking'*, an 'alky', while another was described as such by her friend in a paired interview. This young woman, 'Katy'¹, recounted her first experience of drunkenness when she was in school year Primary 7. Thinking back over the two weeks prior to the interview, she related:

¹ Pseudonyms are used throughout this section to protect young people's identities.

First young person: 'It was my mum's birthday and the day before I was just drunk. Oh, I was at a party the day before too...I don't drink that much honestly...don't think I'm like an alcoholic!'

Second young person: 'She is!'

First young person: 'When was the last time I was drunk?.. Saturday.'

Second young person: 'That's only four days ago!'

First young person: 'But when was the last time I was drunk before that though? Before Friday I mean [laughter]...I actually was drunk the weekend before that ...bebies'.

Interviewer: 'Was it parties or people's houses?'

First young person: 'Whatever...I wouldn't do it on the street...'

Interviewer: 'A-ha'.

First young person: 'Well if it's a nice day then I will [laughs]!' (Young women, both age 15).

Possibly the heaviest use recounted by an interviewee was by a young man (aged 17) who described drinking a bottle of wine each night.

It was also clear that several interviewees had had bad experiences with alcohol, or were aware of and described friends' bad experiences. One young man ('Harry', age 15) had moderated his drinking since being sick and falling unconscious:

'When it actually happens to you, you just cannae feel it because you just cannae.. when you're spewing and that you don't really care. It's when you go home and you get yelled at...and you just cannae be bothered with it because you're rough...that's why I don't drink' (Young man, age 15).

In the case of others, such drinking was sometimes related to depression or being in care. 'Katy', who described relatively heavy drinking patterns herself, implicitly compared her own use of alcohol to that of a friend who she considered to have a problem:

'She'll start drinking from when she wakes up and she doesn't anymore because she got like help basically...But she used to wake up and felt depressed and that because she'd got taken off her mum and ..she just always wanted to drink but I suppose her mum was like that, her mum always drank...she always just wanted to get drunk and she used to take a litre to school and drink half of it there and then drink the rest of it after and get drunk' (Young woman, age 15).

Interestingly, in several of these accounts, even though the young people had drunk very heavily and reported passing out, they had not gone to hospital, suggesting that only a proportion of those drinking to excess report to NHS services. Further, several respondents suggested that such heavy drinking was primarily associated with

younger (12-14) rather than mid-teenagers (aged 15 and above) who had learnt from their experiences and moved on:

'I think they're past it now, they're too old to be doing stuff like that because they're not wee stupid boys anymore...I think they've grown up' (Young woman, age 16).

These findings raise interesting questions as to where resources around alcohol may need to be focused.

There was also some discussion with young people about the best places for projects to operate and the places that projects needed to go in order to find young people who were drinking alcohol. There was a consensus, reiterated by project staff, that young people were less likely now than in recent years to be on the streets where they were easily spotted by the police. Instead, they tended to venture into less accessible areas such as woods or near rivers, or go to friends' or stay in their own families' houses to drink.

'People hardly drink on the streets like they used to last year. Now if there's a party they'll have a drink but I wouldn't think there's drinking on the streets anymore. The Polis come in and get your drink taken off you. And taken home' (Young woman, age 14).

The potentially negative effects of displacing drinking to less visible areas raises some concerns about these policies. Further, young people's efforts to avoid police actions when drinking outside could lead to problems. This account was from younger respondents than those who made the previous point:

'Saturday...we were all drinking on the walkway and then someone shouted 'the polis' and we all ran and kind of got lost...See the girl there, she was reeking [smelling of drink] and I was looking after her because I wasnae that drunk and then everyone shouted 'the polis' so she started running and she fell down the stair and whacked the back of her heid...and then we ended up losing half of the other people cos we went to the park and they went the other way and we kind of split up and tried to take the drunk people with us' (Young woman, age 14).

The issue of relationships with adults around alcohol is also important. Mothers were recounted as taking a key role in trying to 'police' drinking. Several young women related a penalty of being grounded for a month if found by their mothers to have been drinking under the age of 15 or so. One of the reasons 'Harry' gave for no longer drinking was that he could not stand the rows at home, while others recounted how siblings and friends helped avoid detection by mothers. As such, most young people said that they would find it hard to talk with their parents about alcohol use. Some, however, including those interviewed at one of the sports projects, said they would talk to their parents, but, for the most part, these young people were not drinking alcohol in large quantities.

Similarly, with a few exceptions, school teachers were not seen as good sources of advice [although some schools were the location of some important services].

Although some police officers were described as 'alright' if they had made a relationship with young people, in some areas, relationships with the police tended to be negative. Indeed, some young people, including the two young women in the following conversation, described how they felt they were under constant suspicion as residents of a 'ghetto':

- First young person: 'If you were just hanging about in a big group of people like you just got stopped automatically and obviously when you're young you'll hate that...'
- Interviewer: 'How were they when they stopped you?'
- First young person: 'They just ask questions and ask to take your details and all that even if you've done nothing wrong so it's...name, school, address, age, everything, phone numbers just in case, I think'.
- Second young person: 'If anything comes up'.
- First young person: 'If anything comes up in that area'.
- Second young person: 'And then they ring'.
- First young person: 'And if we've been in that area a lot they'll think it's us'.
- Interviewer: 'And have they accused you of stuff in the past?'
- Second young person: 'Not me no'.
- First young person: 'I know people they have accused'.
- Interviewer: 'That's interesting cos I don't think that would happen round where I live'.
- First young person: 'It happens around here'.
- Second young person: 'It's cos it's like a ghetto though'.
- Interviewer: 'Is that how you feel it is?'
- Second young person: 'I dinnae really go out so'.
- Interviewer: 'Is that a reason you don't go out though?'
- Second young person: 'A-ha' (Young women, age 15).

Other young people described having been detained and then released with no charge for what they saw as trivial reasons such as running or kicking a ball across a street. Relatedly, some project workers also worried that the replacement of local forces by Police Scotland would lead to a decline in emphasis on preventive work through which police officers could build better relationships with young people. As such, it is important to emphasise that for many of the young people we spoke to, the relationships they had with youth workers were unusual in that they were relationships with unrelated adults based on mutual respect and trust. Further, a few respondents also mentioned not using hospitals or other medical services after bad experiences with alcohol. This finding highlights the need for projects and places for young people to go where they can feel safe and where they can confide in and receive advice from trusted adults.

5.2 Young people's experience and views of the projects

The six projects at which discussion groups and interviews with young people were held varied in their approach and can very broadly be described as representing three types: (a) mobile outreach (b) diversionary and (c) hybrid which includes drop-in, outreach and centre-based work.

The activities that took place at the different projects, and the sites and spaces which the projects used to undertake their work with young people, varied considerably. Some projects made use of public spaces or areas used by other organisations, such as schools, sports facilities on school grounds and football pitches within public parks. Others used sole purpose buildings which house meeting rooms, drop-in facilities, and offices and spaces where activities could take place (although often these project staff also spent some time in schools). One project also employed a bus which went out to young people in the places they congregate.

Three of the six projects used ABIs as a distinctive intervention, usually at an early stage of broader work with young people about alcohol use. Two projects used them opportunistically and one project was considering how to use them in a way which fitted best with their method and style of working with young people.

5.3 Access and first approaches to projects

The ways in which young people accessed the projects varied, as described in Phase 1. Some of the projects, particularly the sport-related ones, operated a system whereby young people participated on an ad-hoc basis, and they described how they came to be involved with it in those terms:

‘It’s talked about at school and there are posters up; our friends come along so we come with them’ (Young woman, age 13).

Similarly, in relation to the drop-in type projects, young people told us that they heard about them at school and then started to call in, often because they could ask for ‘freebies’ such as condoms and soft drinks. Other respondents recounted having been approached by workers who had arrived on the bus which a local project used to approach young people:

‘We were up at the primary school in the evening and they showed up in their van, all piled out and started talking to us. When they all jumped out, you didn’t know what to think – you thought let’s just run but they were very friendly so you didn’t feel paranoid or anything’ (Young man, age 16).

Other projects took a more individually targeted approach and in some cases there was a semi-formal referral process, through agencies such as schools and the police:

‘We were referred by the school so the project staff came to see us there’ (Young woman, age 15).

‘I got referred by the police after getting caught shoplifting alcohol’ (Young man, age 15).

Such a referral was discussed with the individual young person and they were asked if they minded project workers seeing them in school, both initially and on an on-going basis. The perception of some of the young people in such cases, however, was that there was an element of compulsion in their attendance at the project; one young man talked about being ‘discharged’ soon. Some reported that attendance at

training programmes run through the projects they attended was linked with receipt of benefits payments.

5.4 Project accessibility

In general, participants attended a particular project once a week, although several projects ran drop-in or activity sessions two or three times a week or more, and some young people came as often as they could. At one project there were training schemes operating and young people attended these on one or sometimes two days each week. Some young people had been attending projects for as long as two to three years.

Most of the young people reported that the projects they attended were easy to get to, although some organisations covered a wider area than the immediate locality and transport had to be provided. Most young people thought that the opening times were frequent enough, though in relation to the mobile service, there was a comment that *'we need the van to come out to our estate more often'* (Young man, age 15). In this case, the project worker confirmed that there was only money for the bus to go to particular areas once a month. Some young people would also have liked more sessions at one of the sports projects. These young people valued the project greatly as the presence of the coaches made it a safe place to come together and play football. Even though they lived nearby, tensions in the area between different groups made this otherwise difficult for them. Similarly, some of those attending a hybrid project would have liked more sessions than once or twice a week. Workers here were trying to find money to provide more services and pointed to their attempts to obtain funding from various sources for energetic summer activities lasting into the long evenings for young people who had little money for other options.

The projects with links in schools were reported by young people to have high visibility within these institutions. They perceived the project staff to be frequently in the schools enabling the young people to pop in if they wanted a chat. Some of these workers were also contact-able at other times – including very unsociable hours - by mobile phone. These projects were of course less available during the summer holidays when schools are closed and, as noted, few other activities may be available for young people with little money during this period.

5.5 The importance of project atmosphere

The young people were positive about the places and spaces that projects operated within. Clearly, a project which young people attend primarily to play football will have that as its main function and any other discussions can only take place at the side of the pitch. However, the projects which aimed to provide a relaxed and welcoming environment, in which young people felt comfortable discussing issues affecting their lives, had generally succeeded in doing so. Young people made comments such as these about the projects they attended:

'I come here every time it's open...It's just a chill, somewhere to sit...It gets you off the streets and out of trouble' (Young woman, age 14).

'It's nice...you feel totally relaxed when you're in there cos it's all the project workers and you can go and speak to them down there' (Young woman, age 15).

The informal aspects of staff-young people relationships contributed to the creation of atmospheres in which sensitive issues could be discussed. When asked about the best times at which to discuss what was going on in their lives, one focus group member pointed to cigarette breaks. A worker agreed that travel and food preparation times often presented better opportunities for discussion than more formal sessions would:

'We have about half an hour 45 minutes in the morning when we kind of sit down and have our rolls...discussion from the (mini)bus is continued over the rolls...and then they have a cigarette break and then we start'.

Many of the projects were noticeably gendered spaces – one of the sports-related projects attracted young women but primarily as spectators, and the other was very much a male-only environment, although young women would not be excluded if they came along. One of the projects which featured a drop-in service tended to be mainly female; young women who attended this project said that young men would see attending somewhere where you talked about relationships and similar things would be seen as 'too gimpy [soft]':

Interviewer: 'So it's equally good for lads and lasses here then?'
Young person: 'I think it's more lasses - cos lasses come for chlamydia tests and all that and laddies just play football and that and dinnae care' (Young woman, age 15).

The other projects, those that were broader-based youth work projects and the arts based project, were more mixed in terms of gender participation. Whereas the former had previously attracted young men, it now reported a more equal percentage of young men and women at drop-in sessions.

The young people attending sports-based projects mainly said that these organisations met their expectations. Most of the young people said that the project they attended was much better than they thought it would be and that the prior apprehension which some of them had felt was unfounded, mainly due to the good relationships formed with project staff and the approach taken to discussing alcohol use (outlined below).

'I was just like I dinnae want to go because I didnae like ken any of them but when I came and when I like spoke to them, it wisnae as bad as I thought it was gonna be. And I've just came ever since' (Young woman, age 14).

'I thought it would be like 'filling in forms' too but the games and exercises made it easier to understand. Liked it being with pals...a laugh...you feel welcome, not nervous' (Young man, age 15).

5.6 Relationships with the project staff

Many of the discussions held with young people as part of the evaluation focused on the positive relationships which project staff had been able to build with them and which enabled conversations about alcohol use and other important personal

subjects to take place. The nature of these relationships is of key importance to the ways in which young people reacted or might react to the use of ABIs.

The often difficult relationships between the young people and adults in authority, particularly police officers, have been discussed above. As such, many of the young people had few relationships with adults based on respect and mutual trust. Young people were generally very wary of adults and what they valued in the staff of all these projects was the care and sensitivity with which they initially approached young people and their ability to build relaxed and respectful relationships with them. Such a careful, non-judgemental, initial approach was important to building up trust and confidence with young people who often felt judged or cajoled or who expected 'to be given a row' by adults.

'I was scared because I thought I was going to get into trouble. I thought 'R' was going to be a big scary monster but she's so nice' (Young woman, age 16).

'Youth workers are more like your pals – they have a laugh with you. You can tell them what you were doing at the weekend and they don't shout at you, they find other ways to speak to you' (Young man, age 18).

Young people generally felt that they could talk to project staff and that staff would understand the pressures they were under in their lives. The staff were perceived as taking the time to listen, as taking a real interest in their lives and giving advice in ways young people found easy to accept.

'Here (at the football pitch) would be fine – we see the coaches every week so we could talk to them' (Young man, age 17).

'It's good because you've got someone to speak to other than your pals. I can tell 'P' about anything and it won't go any further. She'll give you sensible advice rather than you getting advice off your pals – friends'll say just drink and 'P'll say you've got to think about it' (Young woman, age 16).

'You can sit and chat like you've known them for ten years' (Young man, age 17).

Interviewer: 'What do you do when you come here?'
First young person: 'Speak to the workers and ask what they've been up to and just normal conversation'.
Second young person: 'Aye because you can't really do that with no-one else'.
Third young person: 'Because see when you're like at ***[the local youth club] they ask you what you're up to – [you say] nothing - and that's the conversation over' (Young women, aged 13 and 15).

An important aspect of building these relationships of trust was confidentiality:

'It's just knowing it's confidential and knowing it's not going to go anywhere else' (Young woman, age 13).

'Because if you told the school they'd be straight on the phone to your mum before you'd even finished your sentence' (Young man, age 15).

5.7 Young people's experiences of an ABI (and other conversations about alcohol use)

The extent to which young people were aware that they had been involved in an ABI varied across the six projects. As previously mentioned, three of the six projects used ABIs as a distinctive intervention, two used them opportunistically and one was considering the best ways to use them. Even in the three projects which used ABIs as a recognisable intervention, they sometimes blended in with the wider work about alcohol use or other issues which the project staff were undertaking with young people, who were therefore not always clear about what actually constituted the ABI. In some cases this was also because the ABIs took place when young people had been drinking. As such, this section will explore both the young people's experience of ABIs and their thoughts as to how ABIs might best be implemented with young people such as themselves.

Some young people at these three projects told us that they remembered having a one-to-one conversation with a youth worker and that *'forms were filled in'*. Young people said they liked the 'one-to-ones' and that project workers tended to suggest such individual sessions as *'they feel it's like better if nobody else knows'*. It was sometimes difficult to differentiate however, from the young people's perspective at least, whether the 'one-to-ones' followed the ABI format or were integrated within a wider, more informal conversation.

'There was a sort of screening and they brought it up, but not too 'in your face' not in that sort of way. Think it was an ABI – it lasted 10-20 minutes and then it was a group discussion after. The ABI bit was important to do on your own as it's confidential and you might not be so honest in a group' (Young man, age 17).

For some young people, this more individualised element was therefore considered important. Similarly, another young person commented that the individual one-to-ones were more likely to lead to an accurate assessment of quantities consumed:

'I think it was better the way we done it because when you were doing it, like every question had like well 'how often do you drink weekly, every day a week a certain amount, how much would you drink on a certain weekend' or something then...you'd be able to judge it a wee bit better otherwise you're sitting going well how much do you drink --- two bottles of wine, a couple of bottles of vodka...' (Young man, age 16).

In one project the ABI was started in a group format with individualised information gathered later, before returning to group discussion and other projects also incorporated group discussions. These group elements were also appreciated:

- Interviewer: 'How did you guys find it when (the project worker) brought out this paper and went through it with you?'
- Young person: 'Half the folk cannae even read it; we went through it as a group'.
- Interviewer: 'What made it easier as a group?'
- Young people: 'Cos we're all lazy; because you can laugh and help each other through; you can talk; have a giggle' (Young men, age 15-17).

There were detailed group discussions about this at one project where ABIs were role-played as a way of teasing out the strengths and disadvantages of different settings and approaches. Here the young people made the following similar points:

- The ABI would need to be introduced casually, as part of general conversation (and as such the informal atmosphere of the youth agencies was helpful).
- The language used in an ABI would need to be informal and the person delivering it able to improvise according to the response; open questions worked best so that young people didn't feel 'boxed in'.

Several further points were made here and elsewhere in relation to the person leading the ABI. A small minority of the young people felt that it could be easier to talk to someone they did not know because they thought they could be more honest in such circumstances:

'You don't care so much about what they think about you...so you're straight up and honest with them. It's no as if you've got to see them every day or they know your best pal so...I mean you like them but you don't care if they think like that's a disgrace' (Young man, age 20).

However, the general preference expressed was for a different and less professionalised type of exchange with someone they knew. The group cited above further added that it might help if the person delivering the ABI was someone who had experience of excessive alcohol use when young and was a similar age or a bit older, although this point caused amusement among the current, trusted, project workers who concluded that they should therefore '*be sacked*'. Other young people emphasised that youth workers being honest about their own experiences with alcohol when they were young was an approach that helped them to relate to adults more easily and be more inclined to accept their advice:

'I think if it's like a youth worker they should tell you like the stuff they done when they were our age 'cos then you wouldn't feel like they are judging you and what you're doing, if they look to their experiences of drink like. They need to have like experiences themselves because what's the point if they've never like experienced it?' (Young man, age 18).

Overall, the most important point in relation to ABIs was that most of the young people felt that it was easier to talk about alcohol and other personal issues with an adult that they knew well:

'You see them [the youth workers] more often like so you've got to know this face and what they're like' (Young woman, age 16).

Similar points were made in relation to broader discussions around alcohol. In general the young people were not averse to youth workers and sports coaches talking with them about alcohol use. Both workers and young people had a strong sense that alcohol was an important issue for them that cut across many other areas of concern, such as sexual assault and violence including domestic abuse. It was important, however, that such discussions were approached in a way which was acceptable to them.

'They [the youth workers] have the right approach – they don't threaten you with the police or give you a lecture or use scare tactics and they give you advice' (Young man, age 17).

The young people further appreciated what they perceived as a genuine interest on the part of youth workers in their well-being:

Interviewer: 'So the staff pick up on that (young people being out for the night) and ask you what happened?

Young person: 'A-ha...what did you drink, who were you with, where was it? – just making sure you're OK'.

Interviewer: 'And how do you feel when that kind of thing comes up?'

Young person: 'Em...I'm not really bothered by it – they're just concerned I suppose' (Young woman, age 17).

Such comments highlighted the willingness of young people to discuss alcohol and other potentially difficult circumstances and issues with youth workers. It seemed that such questioning, when coming from youth workers who were trusted and liked, was interpreted as a sign of 'really caring'.

In addition to the points made above about the importance for most young people of an informal initial approach and building respectful and trusting relationships, young people, including both those who had had ABIs and those who had not, made useful comments as to the type of discussion they preferred. Notably, many felt that discussions were most effective if 'hands-on' activities were used to make the conversation more interesting and lively. For example, young people described card and board games which focused on alcohol and which were effective in some cases in getting young people to think about the effects of alcohol use.

'I think they approach it in the best way because it's informal and they do it with activities and games and talking' (Young woman, age 15).

'You can do stuff on the van like with cards where you look at 'what would you do if your friend was drunk?' and chose a card and look at what the outcome might be. And work-sheets...' (Young man, age 16).

'Activities are good – they help more than boring facts' (Young man, age 17).

In contrast, more formal approaches when project workers brought out forms and 'bits of paper' could be off-putting. Further, many felt that an ABI was less likely to work if introduced 'cold'. Young people (and youth workers) felt that there was a warm-up, pre-ABI stage which needed to take place – similar to the conversations on the way to projects in minibuses or cars or while having a cigarette or preparing food discussed earlier.

5.8 The effects of ABIs and alcohol discussions

As many of the young people were unclear about whether they had had an ABI or completed the screening, it was difficult for them to differentiate whether it was the ABI *per se* or more general discussions about alcohol which had had any impact on their thinking around alcohol or on their alcohol use. Further research would be required to make such distinctions.

A few young people had been shocked by completing the ABI and indicated that this had affected how they thought about alcohol:

- First young person: 'She asked me how much I'd drunk and it was quite scary when I said it out loud...total shock because you don't think about that'.
Second young person: 'Because you just think about how much percent is going to get you drunk' (Young woman, age 16 and Young man, age 15).

They were sure they were drinking less alcohol now as they no longer went home drunk and were saving more money.

In many cases however, young people said that seeing the amount they were drinking written down on paper was not enough to have an impact on what and how much they drank. Overall, there was a general feeling that an ABI, as far as young people understood it, was not sufficient on its own and other ways of reinforcing the message were needed. Young people who took part in the role-play and discussions told us that an ABI might make them think a bit more but that, young as they were, the risks seemed a long way off and that repeating the same messages too many times would just make them 'switch off'. We also heard from some young people that alcohol misuse was also discussed at school, as part of Personal and Social Education Classes and there was a danger of 'overkill'; however, others felt that it was important to hear the messages about alcohol misuse as frequently as possible.

The young people who role-played the ABIs and then discussed what might make them work best commented that ABIs might work for some people but not for all, and would not work where young people did not perceive their drinking to be problematic:

- 'It won't actually work if you don't want to change. If they're not wanting to change there's actually no point in it at all' (Young man, age 17).

In such cases, however, an ABI – potentially augmented by wider discussion - might make a difference. At another project, two young people who had already started to worry about their drinking felt that receiving an ABI had helped them think about the extent of their alcohol use:

'I was already worried me and my friends were drinking too much so speaking to them (the project staff) was a help. It had a big effect on us, because of the health risks and the effect it can have on your brain. We just talked to them and we knew it wasn't a good idea' (Young woman, age 16).

They continued:

'I think it helps because I never used to know anything about drink until she told me... and now I know quite a lot. It's quite educational. How many units of alcohol and how long it takes one unit of alcohol to get out of your system. We're drink experts!' (Young woman, age 16).

'It makes you think how dangerous it is! Cos when you're doing it you dinnae really think about it – all you think about is getting drunk and having a good time' (Young man, age 15).

These comments chimed with those of project workers for whom using the ABI format can be a useful tool in young people taking the first steps in thinking about changing their drinking habits.

Another area discussed was risk management while drinking. Some risk-management strategies were not linked to having had any advice from agencies. For example, the young women who recounted running from the police explained that in their group of friends:

'We like choose the days that we're gonnae drink and the boys choose the days that they're gonnae drink so we're like half and half' (Young woman, age 14).

This strategy ensured that those who remained sober could look after the rest. These young people emphasised that these practices had nothing to do with the agency they attended. However, the risk-minimisation strategies which project workers talked with young people about, in some cases as part of or following on from an ABI, were seen by some young people as having had an impact. Some pointed to advice to eat before drinking and not to mix drugs with alcohol as having influenced their behaviour:

Young person: 'So if you told them [the project workers] like you were going to drink they'd be like well just watch what you're doing and be safe...and don't overdo it and then they'd ask if we were going to be in a safe place and all that'.

Interviewer: 'And has that affected the way you drink at all?'

Young person: 'A wee bit cos like after finding out that people had been raped and all that we need to watch what we're doing and all that...can't be by yourself and that, have to be with someone' (Young woman, age 15).

However, while some young people had taken in the messages about drinking in a safer way they thought they were still drinking the same quantity of alcohol as before.

Several young people felt that alternatives to drinking, even if provided only on some nights of the week, were a crucial part of reducing alcohol use. These alternative activities took a range of forms and included:

- sports
- arts and creative activities such as theatre
- outings and residential week-ends
- employment and training related activities.

'We did the one-to-one about our own drinking then it was group courses like the '*** group' and occasional meetings – like one where we talked to a Community Group meeting, we've done bake sales, clay-pigeon shooting, painted a mural on a Primary School - it's all alternatives to drinking' (Young man, age 17).

Young people also told us that being involved and serious about sport made it difficult to be a heavy alcohol user as it was not good for their fitness and they were more aware of the importance of what went into their bodies.

Showing the effects of drinking excessive amounts of alcohol was thought by some to be one way of having an impact on young people's use of alcohol. One young person mentioned the potential impact of hearing from someone affected by drinking in the family, such as a mother who had lost their son or daughter because of something had happened when they were drinking. She felt that it would make her think about how her own mother might feel if this had happened to her. Holding workshops run by adults in their twenties who had misused alcohol when they were younger and come through it was another idea discussed.

As discussed in the section on their alcohol use however, perhaps the strongest disincentives recounted related to having seen the effects on other young people or having experienced them themselves. 'Harry's' account of severe vomiting and its fallout with this family is included above. Another recounted:

'We do have friends who drink and they think it's fun and they do it because their friends do. But it puts us off, the way they act – we want to keep ourselves smart and not fall around all over the place and get on in life – that's why we don't drink' (Young woman, age 13).

There was also a sense of young people growing out of alcohol misuse and taking on responsibilities such as work which made it difficult to drink very regularly. Earning their own money meant that they often begrudged spending their income on alcohol. As also discussed previously, several young people in their mid and later teenage years (15 and above) said that they now worried more about the younger age groups' (11-13 year olds) drinking than about those in their own age bracket.

6. Feasibility of conducting an outcome evaluation

This section of the report explores issues around the feasibility of conducting a future outcome evaluation with one or more of the projects involved in the current study. In doing this, it draws on three sources of data:

- Phase 1 interviews with staff.
- Phase 2 interviews with young people.
- A desk-based analysis of project monitoring tools.

First, the mechanisms or ‘theories’ of change identified for each of the projects selected for inclusion in Phase 2 of the study are examined, providing an important context for future decisions for evaluation depending on what key outcomes and processes of change projects themselves were trying to achieve. Secondly, the approaches to data collection in each project, as reported by staff, are summarised. This is followed by results from the desk-based analysis of data collection tools. Finally, the feasibility of a future study is discussed and options for its design are explored.

6.1 Mechanisms for change

One of the aims of the study was to explore the extent to which a ‘theory of change’ for each project could be developed in a simple form, drawing in particular on key questions asked of staff in the Phase 1 interviews. These questions explored what they felt ABIs would achieve in the longer term and then working back from that what short and medium term outcomes might be achieved and what organisational changes and activities were needed to achieve these outcomes.

As is not uncommon when trying to elicit theories of change, staff found it relatively straightforward in the Phase 1 interviews to identify longer term outcomes for their work both in general and when using ABIs, and were also able to describe key activities or action needed. In the original research plan for the study, it had been intended that a second round of interviews with project staff in Phase 2 would explore in more detail staff perceptions of the intermediate steps (short and medium term outcomes) needed to achieve longer term outcomes. However, as explained in section 2, this second round of interviews was not conducted in order to focus more fieldwork resources on the interviews with young people and to reduce the research burden on projects. As a result, further data were not collected which could potentially have shed light on the mechanisms of change as perceived by the project staff. However, from the Phase 1 interviews and the project documentation, it was possible to suggest the main mechanisms for change for each of the projects that participated in both phases of the study. These are set out in Appendix D.

As the Appendix shows, most project staff felt that ABIs, when delivered successfully, could: enable young people to consider and discuss the risks associated with their alcohol use; make them more aware of the alternatives to use; and provide an opportunity to consider and plan changes regarding alcohol use. Some project staff were more specific indicating that for those drinking, a key outcome would be a reduction in units of alcohol consumed and in the incidence of risk taking or anti-social behaviour. All of these outcomes could be assessed in a future study. The ways in which these outcomes would be achieved within particular projects varied depending on the focus of the work, as set out in Appendix D. For

most projects an important element was the use of a screening tool as a way into a conversation about alcohol. Follow-up did not figure prominently in staff accounts of mechanisms for change, primarily because very few projects were able to accommodate any follow-up within their existing programme of work with young people. A future study should examine in more detail the links between main outcomes and particular activities that a project or service can invest in to deliver ABIs.

6.2 Data collection

Projects adopted a number of approaches to data collection, and project staff's perspectives on these have been discussed in detail in section 4.6 above. In summary, data collection practices varied widely, ranging from projects that had attempted to understand baseline levels of consumption and follow up ABIs, to those where no data were routinely collected. Project staff described a range of approaches including:

- using SurveyMonkey [online survey tool] to collate ABI activity
- completion of initial registration and/or assessment forms
- use of questions from the Scottish school health survey SALSUS
- recording of all contacts and screening, on both paper and electronically, linked to each young person's file
- anonymous recording of all screening in case other agencies were interested in the data
- collection of data on the issues presented by young people, along with topics covered and feedback on the service
- use of written session summaries
- collection of 'anecdotal anonymised stories'.

A number of issues were raised by staff in relation to data collection. One was the importance of negotiating required data with funders, and having conversations about the appropriateness of tools such as particular screening assessments. For some project staff the NHS approach to data collection was too structured and prescriptive, and failed to take adequate account of the way project staff worked with young people. Lack of time and capacity to undertake more systematic recording and reporting without additional resources was mentioned, particularly where the ABI work was an 'add-on' to existing practices.

A particularly important data collection issue was fidelity; how to differentiate an ABI from other more general conversations about alcohol, which were likely to go unrecorded. Staff said they discussed in their teams what differentiated an ABI from an informal conversation about alcohol. Some described ABIs as quick 'one off' interventions, in comparison to more in-depth work or less structured conversations. This was not consistent, however, and it is possible that informal conversations were recorded as ABIs in other projects. Some of the adaptations made to ABIs (see 4.3) may have meant that the intervention being delivered would not be recognised as an ABI by those outside of that setting. Overall, variation between projects in what is recognised and recorded as an ABI had obvious implications for feasibility (are ABIs actually being delivered?) and for evaluation (is the same activity being compared across projects?).

6.3 Data collection tools

Copies of monitoring and screening tools were obtained from six of the projects in the study. Others were not formally collecting data on the ABI process or were not delivering ABIs, as outlined earlier in this report. Table 4 describes what documentation was obtained and what form it took.

Table 4: Project data collection tools

Project	Forms	Comments
Aspen	List of data collected by the project, Client monitoring form, CRAFFT screening tool form, Drug and Alcohol screening assessment guidance document	List of data collected from young people is demographic data, screening score, units of alcohol consumed, and then data at follow up. Client monitoring form includes details of the young person and attendance details. CRAFFT screening tool form allows for initial screen, two follow ups, whether a conversation about alcohol took place, and other relevant information (such as where alcohol bought etc).
Bracken	Assessment Form to record ABI Referral form, Guidance document for health improvement nurses working with the project	Assessment Form is designed to record ABI delivery, CRAFFT scores and young person's personal details. Referral form is detailed in terms of the young people and location of contact. It focuses on whether a referral is accepted or declined, however, and not on the ABI element of the project.
Elder	The DUST screening tool	A generic DUST screening tool form, explaining the tool, including its questions and a number of sections for data collection. It has not been modified for use by Elder. Other data from young people is collected by the project but not routinely on the ABI elements.
Fir	Client monitoring ('evaluation' form), Project pathway diagram, Evaluation action plan framework. ABI training follow-up document	Staff try to routinely collect information on each young person including 'reaction to the ABI, awareness of risks, awareness of alternative activities and when and if follow up will be conducted The project also produced a training revisited report to reinforce what constitutes an ABI, aims and approaches, screening tools and evaluation.

Pine	Form that includes: CRAFFT screening, 4 additional questions on drinking, and a drinks diary for the young person. Additional 2 page document summarising the wider service that delivers the ABIs.	A useful form that collects a range of information about the young person's drinking. 4 additional questions take the form of statements: 'I know how to keep myself safe with drink' (strongly disagree to strongly agree, 5 point scale), 'I plan to reduce my drinking' and 2 other statements.
Rowan	Screening tool (FAST), letter published in a journal describing the wider project that ABIs are delivered within.	The FAST test is outlined on a monitoring form including its 4 questions and guidance on its use. The form does not include a space for the name of the young person or other identifier suggesting the form is used as a tool by staff and not a data collection instrument.

Despite six projects providing some form of data collection documentation to the research team, assessment of these is difficult as even where some forms were in place it was not always clear how consistently they were used, as touched on above. That said, four projects did have screening tool documentation in place (CRAFFT in Aspen, Bracken and Pine, DUST in Elder and FAST in Rowan). Aspen, Bracken and Pine clearly linked information about the young person to whether the screen was undertaken. Projects that provided additional monitoring forms about the young person were clearly collecting a range of demographic and in some cases, alcohol consumption-related information which could be valuable. The most detailed tools were developed by ASPEN and if used could provide the basis for evaluation if consistently applied. Willingness to use monitoring forms, ideally developed with a research team and linking screening to the young person's details and outcomes, would need to be a prerequisite for future evaluation.

6.4 Outcome evaluation feasibility

The significant diversity of the projects for young people in our sample (see summaries in Appendix C) presents challenges for designing an outcome evaluation.

At the time of the Phase 1 interviews, Bracken, Fir and Pine seemed to be sufficiently well-established for an outcome evaluation in terms of the factors considered in the project summaries (number of clients, sustainability, staffing, training, reach, acceptability, data collection). Aspen was about to move the model to a new geographical area, so the effect of a different context on these factors was unknown. The future of Rowan was uncertain as fewer young people were being identified through street drinking. However, the partner organisation which provided ABIs to Rowan carried out a far greater number of ABIs in its other project work. This work would require further investigation to assess its potential for future evaluation.

Aspen, Bracken, Fir and the Rowan partner were all keen to be involved in a suitable outcome evaluation, and Pine intended to make a decision based on the 'fit' of the research design for their practice. Myrtle was also interested in contributing to an

outcome evaluation, but the project presented particular challenges as ABI had become an embedded way of working as well as a discrete intervention. At the end of Phase 1, Juniper's funding was not being continued, it was not sufficiently clear to what extent Elder had adopted ABIs, and Hawthorn was at too early a developmental stage to assess its readiness for an outcome evaluation.

Staff interviews during Phase 1 identified four general factors which would affect feasibility of an outcome evaluation, which are discussed further below:

- the expectation that there was potential for positive outcomes
- sufficient throughput
- robust data collection
- the fidelity of ABI delivery.

6.4.1 Positive outcomes

Some staff clearly believed ABIs in their settings had worked, and had had the intended impact of supporting young people to reduce their drinking, make safer choices, and lower their risks and vulnerability.

6.4.2 Throughput

Projects targeting street drinking had noted a change in drinking behaviour, with young people moving from the street to drinking at home. They therefore had fewer potential candidates than before. Overall, numbers of positive screenings in projects were often small, and as discussed in section 5 above, some young people participating in project activities did not drink. There was also significant attrition in one project where the initial referral was by the police, with a project worker following up later.

6.4.3 Data collection

Given the challenges and range of data collection in these settings, processes for the more robust and standardised methods needed in an outcome evaluation would need to be carefully negotiated with projects.

6.4.4 'Fit' versus fidelity

While staff in many of the projects felt that ABIs '*made sense for the work that we do*', all projects made 'young-person friendly' adaptations to the ABI prototype model to make it 'fit' their setting. While these adaptations were critical to the adoption of ABIs, they meant it was not always clear that ABIs were actually being delivered as distinct from other conversations about alcohol. Furthermore, some projects were stricter than others in their definitions. There are implications for evaluating ABI fidelity and assessing outcomes when central aspects such as (validated screening, measuring consumption, structure, one-to-one delivery, follow-up) are changed or dropped. However, it should also be noted that there is not necessarily a consensus in the ABI literature on how the core aspects of an ABI are defined.

Phase 2 data yielded valuable information about the feasibility of outcome evaluation from the perspective of collecting data from young people. The ways in which projects included in Phase 2 collected information about the young people they worked with varied considerably, as the review of project documentation above shows. This was partly influenced by the environment in which the projects operated and whether project staff had an on-going relationship with young people or whether

the informal, drop-in nature of the work made this impracticable. The projects which included a youth centre element tended to have more structured systems for collecting information about individual young people including name, date of birth and contact information and in some cases ABI-related recording. Most of these projects were already collecting follow-up information to try to measure the impact of their work on young people's alcohol use.

Information gathering processes in place in the sport-based settings tended to be limited and less structured, perhaps because young people were likely to attend on a more ad hoc basis. In one such area, there were significant language and communication issues with some of the young people who attended and although basic forms (name, signature and date) were completed, much depended on who was on site – often younger children with a better grasp of English - to translate. At this project, where sessions varied seasonally, it was hard for staff to predict which group of young men would appear at any one session.

Taking into account the above differences across settings of the feasibility of follow-up information collection, all the young people interviewed expressed their willingness for follow-up information collection to take place. Some young people explained that project staff needed their contact information as they were involved in activities outwith the youth work base, such as residential weekends and permission forms were required - this was seen as a legitimate reason for collecting contact information, at least. These young people said they would feel comfortable about being asked questions about whether their involvement in the project had led to a change in the patterns and quantities of their alcohol use. This was also the view of the young people interviewed at one of the sports-based settings; at the other sports based project, the young men who were interviewed said that alcohol use was not part of their culture so follow-up in this instance might be related to confirming whether or not this remained the case. This is likely to be different for the group defined by staff as white Scottish involved in the project but this would need to be explored further.

Self-report follow-up information only might well not provide reliable results and would need to be enhanced with information from professionals in contact with young people such as teachers, youth workers and police officers. The main challenge in measuring the impact of an ABI on a young person would be in differentiating between the ABI as a discrete intervention and the broader 'package' of alcohol awareness work and diversionary activities within which the ABI is only one part.

6.4.5 Summary

Bringing the findings on evaluation feasibility together from Phase 1 and Phase 2, seven key issues and barriers to evaluating impact of these types of projects in the future are identified in Table 5 below. These issues and barriers affect the projects in the current study to varying degrees, with some projects facing considerably more challenges in terms of potential outcome evaluation than others. The issues and barriers are also more widely applicable to any future outcome evaluation in similar settings. Section 7 below discusses potential ways forward for evaluation research in this area.

Table 5: Issues and barriers affecting the feasibility of an outcome evaluation

Issue	Barriers to overcome
Client access	Barriers to accessing young people who have received an ABI. E.g. in outreach projects where young people may only attend the project once
Sample size	Insufficient numbers/positive screens coming through the system; could be related to local changes in drinking patterns
Recording	Absence of a robust system or culture of recording; inconsistencies in recording practice
Screening	Limited or no use of screening tools; lack of appropriate screening tool; doubts about efficacy of screening tools
Follow-up	Limited ability to follow up young people who have received an ABI
Attribution	Difficulties isolating the impact of ABIs from a broader package of intervention measures
Fidelity	Difficulties in establishing when or how ABIs have been delivered

7. Discussion and conclusions

This discussion section pulls together and reflects on learning from across the study, under five headings:

- How delivery of ABIs in young people settings differs from ABIs in primary care and adult settings.
- The feasibility and acceptability of ABIs in young people settings.
- The feasibility of an outcome evaluation and recommendations for future evaluation of ABIs in young people settings.
- Strengths and limitations of the study.
- The perceived value and benefit of ABIs in young people settings.

7.1 How delivery of ABIs in young people settings differs from ABIs in primary care and adult settings

This study has examined how ABIs, originally developed for delivery in health care settings with adults, are now being delivered in young people settings (and in social work, although the study was limited in the amount of data it could collect in this setting). When compared with how ABI delivery has been defined and described in primary health care settings and with adults in the Scottish national ABI programme (Scottish Government Health Department, 2008), a strong theme running through this current report is that delivery of ABIs for young people differs in several key ways. The differences reflect differences in the setting, in the wider context in which ABI work is situated, in the ethos and values of work in this setting and in the perceived needs of young people receiving ABIs compared with adults.

The ABIs examined in this study were delivered in a wide range of heterogeneous settings, both 'office-based' and non-office based. Some ABIs were being delivered in centres which young people visited for one-to-one health and other advice; this kind of office-based ABI delivery is perhaps closest in similarity to ABI delivery in health care settings. However, unlike in primary health care (although somewhat similar to the A&E setting), clients often attended on a one off or drop-in basis, and the often unscheduled and unpredictable nature of young people's attendance at projects and services raised particular challenges for structured follow-up. Other settings for ABI work with young people described in this report were considerably more diverse than one might expect to find in health services delivery and included mobile vans which visited communities, the side of sports pitches, young people's own street 'territory', and so on. These diverse settings raised challenges relating to the consistency of the ABI process (Williams *et al*, 2013), practitioners' ability to control the intervention (Désy and Perhats, 2008; Johnson *et al*, 2013), privacy concerns (Désy and Perhats, 2008; Anderson *et al*, 2001), a need for flexibility on the part of the worker delivering the ABI (Kennedy *et al*, 2004), and potential difficulty in formalising and recording the intervention (Johnson *et al*, 2013). While many of these challenges can be present in health settings (see references cited above), they are arguably more difficult to overcome in the more unusual youth settings than in typical adult health services.

Another important difference between the health services in which ABIs are generally delivered with adults and some of the settings where ABIs were delivered in this study with young people relates to the efforts made by practitioners to make contact with clients. In the case of the young people projects in this study,

practitioners made a great deal of effort to find out where young people were meeting in order to go to those places rather than expecting young people to come to them. This required them to keep abreast of changes in local drinking patterns and drinking locations in order to be able to find young people with whom to work. This is very different to how adult health and primary care services generally operate, although the principle of bringing services to people where they are is recognised as important for tackling health inequalities more generally (e.g. <http://www.healthscotland.com/keep-well.aspx>).

While the use of a screening tool or consumption question is generally considered a prerequisite for ABI delivery in healthcare settings, this was less the case here. The projects in the study generally used less form-filling, as this was perceived to be off-putting to young people. In some cases this meant that screening tools were not used, or were used verbally and then transferred to paper afterwards, or were adapted for use with the young people. Generally project workers felt that there was a lack of suitable screening tools for use with young people in these settings, although some projects had adapted tools that they described as having a good fit for their projects. Difficulties with recording screening and brief intervention delivery have also been documented in healthcare settings (Williams *et al*, 2010), particularly in A&E (Johnson *et al*, 2013). The problem of accurately recording screening and brief interventions also figured as a key finding in the national evaluation of ABI implementation across all three settings of primary care, A&E and antenatal settings (Parkes *et al*, 2011). This has implications for any future outcome evaluation in this setting, discussed further below.

In the projects studied, ABI delivery also tended to be opportunistic, and perhaps conversations about alcohol were initiated by young people more commonly than would be the case in most health services. For workers, this meant that they felt they could not plan to deliver an ABI as such, but rather had to be ready to offer one when the situation arose. In other healthcare settings, such as A&E and antenatal, guidance is available on when to raise the issue of alcohol in a way that relates it to the client's presenting issue (e.g. the 10 presenting signs of the Paddington Alcohol Test designed for A&E settings; or the indicators provided in SIGN guideline 74 for primary care). These settings are also expected to screen and/or deliver ABIs opportunistically based on each individual presentation. It is conceivable that similar guidance on presenting issues could be developed specific to different youth projects or services. All of the issues in the last two paragraphs decrease the strength of the projects' ability to evaluate outcomes and make it impossible to know whether they reduce alcohol consumption, or any other outcomes.

Use of ABIs with young people was driven by an ethos of harm reduction and minimisation: staff accepted that young people would engage in risk taking behaviours and looked to help them minimise rather than eliminate risk through exploring safer choices such as drinking water, getting home safely and looking after friends. In some cases, where police or criminal justice staff were involved, these behaviour changes were not always viewed primarily in terms of improving health but rather as means to minimise social disorder. This in turn could have an impact on how the success of initiatives was perceived (e.g. fewer reports of young people creating disorder on the street, rather than reductions in drinking *per se*). This has implications for the choice of screening tool used, in that screening tools developed

to determine levels of consumption, health risk or risk of alcohol problems may not be the most suitable for determining a need for harm reduction advice or a risk of criminal behaviour. While a screening tool may provide prompts for discussion on these issues, a tool designed with these goals in mind from the start may look very different from AUDIT for example, but would require equally robust validation. In addition, it is worth noting that the national ABI training programme designed for health settings explicitly included the provision of advice and information on harm reduction (Fitzgerald and Winterbottom, 2009).

Thus there are both similarities between ABI delivery in youth settings and in adult health services and important differences and challenges. A particularly important point to emphasise is that there is no single homogenous 'youth setting' but rather a wide heterogeneity of settings, some of which share some features and working approaches with health care settings and some of which differ widely from them. Future development and support will need to reflect this diversity.

7.2 The feasibility and acceptability of ABIs in young people settings

The study set out to examine the feasibility and acceptability of ABIs in young people settings, from the perspectives both of the staff delivering them and of the young people receiving them. Feasibility and acceptability can be seen as closely related: if an approach is not regarded as acceptable to those using or receiving it, its wider adoption is unfeasible, and if it is difficult or impractical to adopt, its value and acceptability are likely to be questioned. Below some of the key learning points regarding feasibility and acceptability are discussed.

7.2.1 Acceptability to staff

The acceptability of ABIs to workers in these settings is strongly influenced by the perceived value and benefits of ABIs and the extent to which they are perceived to fit coherently with the aims and ethos of the wider context of work with young people. It is likely that ABIs are more likely to be embraced where workers can see value in doing so, and where they perceive ABIs to be compatible with existing goals and ways of working; conversely, where ABIs are seen as having poor coherence with a project's way of working and its objectives, they are less likely to be adopted. Various drivers of alcohol work were identified in the study, including a desire to address alcohol's negative impact on young people's lives (for example, the consequences of unprotected sex), a desire to engage with vulnerable young people around crime and anti-social behaviour issues, and a desire to provide alternative activities, such as sport.

Central to much of the work with young people which was examined in the study was a commitment to focusing on the individual young person in a non-judgemental way and equipping them with knowledge and skills to help improve their lives. These principles of youth work - starting with the young person's view of the world and seeking to develop skills and attitudes rather than remedy problem behaviours - informed all decisions and activity including ABIs. ABIs as adapted by the projects were generally seen to be compatible with this approach, and tended to be seen by project staff as an early intervention health promotion strategy that would benefit young people later in life, particularly against a backdrop of Scotland's culture of normalised alcohol use. ABIs were seen as one component of the work needed to address alcohol issues in their service or setting, rather than the only approach.

The work with young people examined in this study placed a strong emphasis on the relationship between the worker and the young person: developing the trust on which a relationship can be built, maintaining the relationship, and avoiding or minimising any actions or events which might jeopardise the relationship. It was important to staff to work intuitively to build up rapport and make the contact fun and relaxed for the young person. For some staff, there were concerns that doing ABI work might threaten this relationship by bringing in an unwanted power inequality because of the fear that ABIs, if not adapted to some degree, were too 'clinical'. Some, too, expressed some discomfort about talking about alcohol with young people because of their own drinking, or because they were near in age to the young people.

The study suggests that ABIs will be seen as feasible and acceptable to workers to the extent that they can be incorporated in such a way as not to threaten working relationships with young people. This concern for preserving the client relationship when delivering ABIs is of course not unique to youth work; for example, studies have found that both antenatal (Doi, 2012) and primary health care settings (Kaner *et al*, 2001; Lock and Kaner, 2004), place importance on nurturing and maintaining the relationship with clients when considering ABI delivery. However, the emphasis placed on the quality of the relationship is perhaps greater in young people settings, particularly in outreach work, and it is likely that judgements about how ABIs might affect the relationship will always be a primary concern shaping whether and how ABIs are used. This makes it unlikely that any standardised, routine approach to ABI delivery would be seen as appropriate or adopted uncritically in young people settings. Rather, ABIs will be more likely both to be valued as an approach and to be adopted if there is flexibility in how they are defined and if they are viewed as part of the repertoire of approaches that workers can draw on as and when needed and circumstances allow. The ability to 'dip in and out' of different approaches to communicating with clients is an important skill for proficient use of the motivational style inherent in ABIs as defined in Scotland (NHS Education for Scotland/NHS Health Scotland, 2010).

Training has a clear contribution to make here. Training which recognises the values and methods of youth work, and which demonstrates how ABIs can fit with and complement this work, is important. The perception here in some cases was that an inflexible model of ABI delivery designed for adult and health care settings was sometimes being inappropriately expected of youth services. Future effort to implement screening and ABIs should be based on detailed consideration of current practice in each team or setting targeted, and a clear model or models of delivery should be developed with sufficient flexibility to allow staff to exercise professional judgement, while still with clearly defined content. This would include adaptations to any existing assessments, documentation and recording procedures. The activities delivered in training could then focus on enabling staff to implement changes in practice to deliver ABIs in ways that had already been agreed. Such an approach is likely to be better appreciated by workers in these settings and to encourage the development of ABI activity (Aarons *et al*, 2011; Damschroder *et al*, 2009; Feldstein and Glasgow, 2008; Greenhalgh *et al*, 2004; McCambridge and Strang, 2004).

7.2.2 Acceptability to young people

The study also examined the acceptability of ABIs from the perspectives of young people (section 5 of the report). In discussing the acceptability of ABIs to young people, it should be noted that not all the young people interviewed had experienced an ABI *per se*, although they might recall conversations about alcohol, and some were unsure whether they had had an ABI or not. Where young people had not experienced an ABI, the study explored their feelings about the concept of alcohol conversations and ABIs being offered by the particular project they attended. Young people's acceptance of ABIs was strongly bound up with their wider feelings about the projects and workers. The young people interviewed were mostly very positive about the projects, perceiving them as welcoming and safe places. Their views of the staff were generally similarly positive, and indicated that they trusted the staff. Young people also felt valued by staff, and felt that staff were credible sources of advice and support. In this context young people were largely amenable to conversations about alcohol, or to the concept of conversations about alcohol, and felt that these fitted with the perceived concern that youth workers had for their wellbeing. They did not always respond positively to form-filling and appreciated efforts to make conversations about alcohol more engaging and less formal. Some who had experienced ABIs or similar interactions welcomed the one-to-one format and felt that it enabled them to be more honest about their alcohol use.

It is worth noting that the concerns expressed by some staff about potentially jeopardising relationships with young people by introducing the topic of alcohol did not appear to be borne out by the interviews with young people themselves, who appeared largely open to the concept of talking about their alcohol use with staff. A similar apparent mismatch in perceptions has been found in primary care, whereby practitioner concerns about potential offence to patients if alcohol is discussed are not always shared by patients themselves (Hutchings *et al*, 2006; Richmond *et al*, 1996; Rush *et al*, 2003; Wallace and Haines, 1984). However, it should be emphasised that, in this study, young people's apparent comfort with the concept of alcohol discussions reflected the very positive relationships which they reported having with the project workers, and the time and effort put in by these workers to build trust. In other words, it should not be assumed that young people would be equally accepting of ABIs delivered in other contexts or by other workers where these positive foundations were not in place.

7.2.3 Organisational factors

A number of organisational factors affect the feasibility of ABIs in young people's settings. Staffing was an important factor in several projects. Consistency and continuity of staff were important because much work involved follow-up after the first contact, and having the same member of staff involved helped to build trust and relationships. Lack of consistency of staff tended to be a problem in police and diversionary sports projects.

The skill mix in staff teams was also important. Having health staff integral to ABI teams was thought to be of benefit because of their expertise on alcohol and its relationship to other health issues, and their knowledge of specialist services. While it was not always seen by staff interviewees as appropriate for some project workers (for example, police in certain roles) to deliver ABIs, they were seen as having a role in engaging with young people and in signposting and referral for ABIs, and it was

seen as valuable to draw on the different strengths of team members within multi-agency, multi-disciplinary teams. This relates to the earlier discussion about the goals of ABI delivery and relevant screening tools. Where goals are health related it is easier to see why health staff are seen as having a more legitimate role in ABI delivery. However if goals are about reducing crime/public disorder, it is possible that, with an appropriate screening tool, police personnel could legitimately take on the role, albeit with suitable support and referral options.

Organisational funding arrangements and stability are also important factors in terms of longer term feasibility of ABIs in these settings. The projects examined in this study varied widely in terms of their financial security, with some having been in operation for thirty years or so and others operating on a more precarious basis (one project came to an end during the study because of a lack of future funding). These funding issues affect ABI delivery in several ways: limited resources and insecure funding may affect the priority given to ABI work, particularly if ABIs are seen as an add-on to core activity; training for ABI delivery may not be seen as a worthwhile investment where project continuation is uncertain; and longer term follow-up of those who receive ABIs is less viable if a project is dependent on short-term funding contracts. On the other hand, where ABI work might be seen as a means of securing additional funding, this could be a driver of ABI activity. Involvement in a fully funded trial or study of ABI efficacy could also be a source of funding for projects.

7.2.4 Client and community factors

The feasibility and acceptability of ABIs should also be considered in relation to the perceived needs of local communities and individual clients. Each of the projects in the study had identified alcohol as an issue for young people in their local area, although in some it was seen to affect some youth sub-populations and ethnic groups more than others. Some staff emphasised that local drinking patterns were not fixed but could change – for example, in some areas, there was perceived to be less drinking in the street compared with a few years earlier. The location, timing and targeting of ABI delivery, along with other services relating to alcohol, needed to acknowledge and adapt to these changing patterns where necessary and to adopt a tailored approach to different sub-populations where appropriate.

Related to the need for tailoring, a clear need was identified in the study for screening tools and resources which would be suitable for ABIs with young people. The lack of appropriate tools and resources reflects the still developing nature of ABI work in these settings. This is an area where future research and development should be directed.

7.3 The feasibility of an outcome evaluation and recommendations for future evaluation of ABIs in young people settings

A number of issues and barriers to evaluating impact of these types of projects in the future were identified (see Table 6 below). These issues and barriers affected the projects in the current study to varying degrees, with some projects facing considerably more challenges in terms of potential outcome evaluation than others.

Table 6: Issues and barriers affecting the feasibility of an outcome evaluation

Issue	Barriers to overcome
Client access	Barriers to accessing young people who have received an ABI. E.g. in outreach projects where young people may only attend the project once
Sample size	Insufficient numbers/positive screens coming through the system; could be related to local changes in drinking patterns and different drinking norms between ethnic sub-populations
Recording	Absence of a robust system or culture of recording; inconsistencies in recording practice
Screening	Limited or no use of screening tools; lack of appropriate screening tools; doubts about efficacy of screening tools
Follow-up	Limited ability to follow up young people who have received an ABI
Attribution	Difficulties isolating the impact of ABIs from a broader package of intervention measures
Fidelity	Difficulties in establishing when or how ABIs have been delivered

Undertaking effective outcome evaluation of complex interventions can be a lengthy process involving a series of sequenced preparatory phases (e.g. Medical Research Council Guidance (Craig *et al*, 2008)). Results from this study indicate diversity in readiness for outcome evaluation, with most participating projects still at a relatively early developmental stage. Few projects demonstrated a coherent theoretical basis for the delivery and use of ABI and were in a position to describe the intervention in sufficient detail to support implementation for the purposes of outcome evaluation. In view of this, further developmental work is required to establish what ABIs are expected to achieve within the context of the projects' wider work, how they will be delivered and how fidelity will be ensured. Consistent and robust implementation of ABI delivery in adult health services has also been shown to be difficult to achieve both in large research trials (Kaner *et al*, 2013; van Beurden *et al*, 2012) and in other national programmes (Mäkelä *et al*, 2011; Nilsen *et al*, 2011), and is not a problem unique to youth settings.

These findings indicate that training and research support are likely to be vital to achieving the kinds of consistency necessary for conducting a meaningful outcome evaluation.

The study also raises some important questions about the value of outcome evaluation in wider settings. Findings indicate that projects delivering ABIs in this area represent quite different or multiple settings. Consequently, this is likely to create problems with generalisability where implementing a trial in one project setting may not necessarily inform efficacy in another. In view of this, recognising the characteristics that explain such differences is important to determining the value of outcome evaluation.

Conducting an outcome evaluation presents a number of challenges in this new and developing area. A controlled study would be most desirable for assessing outcome.

This would be dependent upon being able to disentangle the key elements of the intervention (the ABI 'core') from wider intervention elements and on being able to establish appropriate comparison groups. It would be particularly challenging, both logistically and ethically, to conduct a study involving randomisation within any of the projects examined in this study. Only if projects were considering expanding into a new geographical area or were delivering the same level of service without ABI in another area would this be likely to be possible. No such opportunities emerged from the current study.

Observational study approaches using a before and after design are less robust than studies using a control group because they cannot control for the potential confounding effects of policy changes and naturally occurring changes in the cohort. However, they would be more achievable in the contexts examined in this study but would still require considerable efforts around follow-up. As indicated the readiness and suitability of the projects which participated in the study with regard to an outcome evaluation varied considerably. A couple of projects were identified as being well positioned to undertake such an evaluation, although detailed negotiations would be required to inform, support and gain access to the data collection process.

The complex nature of much of the activity examined, particularly some of the more innovative work, may be more suited to realist evaluation, which seeks to identify the mechanism by which an intervention works, than to outcome evaluation. This type of evaluation would typically involve a mixed methods approach using a combination of observation, survey and in-depth interviewing techniques to examine intervention process and effects across time to better understand the factors that contribute to effective delivery. The findings from this study may provide some early insights into the mechanisms for and factors likely to effect change.

7.4 Strengths and limitations of the study

The study has several strengths. To the authors' knowledge, this is the first time that ABIs with young people have been examined outside of the context of a research trial. The ABI activity examined in this study was not set up for the purposes of this study but had evolved naturally in various settings in Scotland and had in part been driven by the growing profile of ABI in adult and health care settings. Consequently, the study provides detailed insight into the realities and challenges of ABIs in these real world settings, and into the perceived acceptability, feasibility and value of ABIs for young people.

A particular strength of the study lies in its bringing together of multiple perspectives and data sources on ABI delivery. The study involved interviews with project managers and trainers, frontline workers delivering or thinking about delivering ABIs, and young people who had received or might in the future receive ABIs. The study also examined project documentation, screening tools and data collection forms. This triangulated approach helps build a detailed and rich picture of ABI delivery and potential value. It is relatively rare to hear the voices of those on the receiving end of ABIs in ABI research, particularly young people. The fact that nearly all of the young people involved were able to be interviewed face to face, rather than by phone as had originally been proposed, meant that more meaningful interviews could be conducted and that the local communities and conditions in which the projects operated could be observed first hand.

The study also had several limitations. It did not include every project in Scotland doing ABIs with young people at the time, but only those projects known to the study commissioners and the research team which consented to and were able to take part in the research. Only one social work criminal justice project was included in the study, and this project was only included in Phase 1 of the study. This limits what can be said about the delivery and potential value of ABIs in criminal justice settings and in social work settings more widely.

Another potential limitation of the project is that the young people interviewed were sometimes selected by project staff themselves or were self-selecting, and could have been those more likely to be engaged with and positively disposed towards the projects, which might have coloured their response to ABI delivery. However, many of the young people participating in Phase 2 did not appear to have been pre-selected by projects, and sometimes the young people who participated in interviews were simply those who happened to be present at the project when the researchers visited. For some young people interviewed, ABIs had little relevance because they did not drink; this is not a weakness of the study, but rather provides insight into the importance of considering where ABIs might most usefully be targeted and delivered.

Finally, it is worth re-stating: the study was not set up to evaluate the impact of ABIs in this setting, something that would not have been possible without further work to develop record-keeping and follow up systems in the settings examined. However, it was one of the objectives of the study to explore the feasibility of conducting such a study in the future, and this was achieved.

7.5 The perceived value and benefit of ABIs in young people settings

This study has shown that ABIs are currently being used in various youth settings across Scotland to reach and engage with a group towards which little ABI activity has been directed in the past.

ABIs were seen to have value for young people because of alcohol's role in many of the health and social issues affecting them. However, the study also found that, in a few projects, some of the young people accessing the projects did not drink, or that few young people were identified as drinking at levels which merited further intervention; these variations would need to be considered in deciding on appropriate communities and services in which to situate future ABI work with young people.

Although ABIs in young people settings involve challenges, it was clear from the interviews both with project staff and young people that there was perceived to be value and benefit in speaking with young people about alcohol in ways that fitted with a broad definition of ABI. For staff, ABI was sometimes described as a *way of working* with young people, rather than as a one-off discrete intervention, and as part of a process over several sessions to engage, build up trust and encourage young people to a stage of readiness for more extended work such as motivational interviewing. This is in keeping with examples of ABI delivery in the wider literature in which longer or multi-session ABIs are relatively common (Curry *et al*, 2003; Aalto, 2001; Altisent *et al*, 1997).

The structured framework of ABIs was seen to have some benefits because it could help to involve the young people and to structure their thinking about their drinking behaviour; at the same time, the ability to adapt the ABI and to make it less formal was also important, particularly in terms of preserving the important worker-client relationship. These adaptations provide some new and potentially valuable insights into the role and contribution that ABIs can make to addressing drinking behaviour and presents some challenging questions about how ABIs are defined.

Issues and challenges around how ABIs are defined, the diversity in delivery and the tension between structure and flexibility are particular features of ABI delivery in young people settings but are not unique to these settings. It is important to recognise that in the wider research literature, ABIs are heterogeneous and vary in ways including length, content, delivery, deliverer and target group, that are not always clearly described (Heather, 1995; Shaw *et al*, 1978). The need for further study and understanding of the content of ABIs has been noted (McCambridge, 2013), as well as a need to be clearer about core and adaptable components in this kind of intervention (Damschroder and Hagedorn, 2011). Avoiding an overly rigid conceptualisation of ABI seems particularly important in the context of this study. Practitioners see the need for different varieties of intervention that can meet young people's needs; however, the literature has been slow to develop to support decisions on ABI design in settings such as these where alcohol problems frequently present (McCambridge, 2011; Shaw *et al*, 1978).

7.6 Implications for policy, practice and research

Policy & practice

- The finding that ABIs in youth settings were perceived to be feasible and acceptable supports the government policy of having up to 10% of the HEAT standard to be derived from non-priority (wider) settings
- Organisational factors including staff consistency, staff skill mix and funding can affect the feasibility of ABIs in youth settings and should be considered by current and planned activities in this field
- Training and support for ABIs in youth settings need to avoid a one-size-fits all model and to recognise the very different contexts in which these kinds of projects work
- Training for ABI delivery in youth settings needs to recognise the values and methods of youth work and to demonstrate how ABIs can fit with and complement this approach
- ABIs in this setting should be sufficiently flexible to allow staff to exercise professional judgement, while still having defined content. This would include adaptations to any existing assessments, documentation and recording procedures.
- There is a need to develop ABI screening tools which will be feasible and acceptable for use with young people in the types of diverse settings

examined in this study. Project workers who have expertise in working with young people should be involved in the development of such tools.

- Projects working in these settings should be encouraged and supported to build in routine monitoring and systems, where appropriate, for recording ABI and ABI-related activity
- More support could be provided for projects in these settings to set in place more robust systems for collecting follow-up data on clients' alcohol consumption where appropriate.

Research

- Given that ABIs are relatively undeveloped in this setting, further developmental work could be carried out to identify the mechanisms by which the interventions work
- Collaborative research with young people could be carried out to identify innovative ways of collecting data in these settings which are acceptable to young people
- Research could be carried out to identify and validate a screening tool for use in young people and social work settings

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