Knowledge Transfer Partnerships

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CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Tackling Alcohol Misuse Through Screening and Brief Interventions

A Knowledge Transfer Partnership

Final Report

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1. Executive summary

1.1 Introduction

This report sets out the work undertaken through a Knowledge Transfer Partnership (KTP) between Cardiff University and the Welsh Government (WG) in collaboration with Public Health Wales to develop and deliver an alcohol screening and brief intervention (ABI) programme in Wales. The recommendations in this report are for the WG, Public Health Wales, Cardiff University and other universities, and for other groups outside Wales wishing to establish a screening and ABI programme. They are based on a review of this partnership and formal evaluation of the programme delivered.

1.1.2 The burden of alcohol misuse in Wales

Alcohol misuse is a major preventable threat to public health. In Wales in 2009 there were nearly 13,000 alcohol-related hospital admissions and one in 30 deaths was alcohol attributable. Alcohol misuse cost the NHS in Wales £85 million in 2009.

1.1.3 Tackling the burden of alcohol misuse in Wales

Screening and ABIs (ABI) have been proven to be both effective and cost-effective in reducing alcohol misuse. A brief intervention is a short, evidence-based, structured conversation about alcohol consumption with a person to motivate them to reduce their drinking to safer levels.

1.2 Knowledge Transfer Partnerships (KTP)

Following a series of clinical trials carried out by Cardiff University's Violence and Society Research Group (VSRG), Cardiff University won a KTP with the WG to implement screening and ABI across Wales.

Public Health Wales joined this KTP after signing a Programme Level Agreement (PLA) with the Welsh Government to design and deliver a bespoke ABI training package for practitioners across a range of health and community settings. The work carried out through this collaboration was significantly greater than necessary to achieve the original objectives of the KTP work plans.

1.2.1 Knowledge Transfer Partnership: Key outputs

A Steering Group was set up for this KTP which included representatives from the WG, Public Health Wales and, Cardiff University. Monthly Steering Group meetings were held where key decisions were taken in the development and national implementation of this programme. In addition, Local Management Committee (LMC) meetings; a KTP requirement, were held quarterly to report project progress against KTP aims.

Alongside the KTP Public Health Wales set up a health-based alcohol network. The network consisted of one representative from each of the seven Heath Boards (HB) in Wales, usually the alcohol lead in the local public health team, together with the central Public Health Wales ABI team, the Public Health Wales Substance Misuse lead and the Public Health Wales Observatory analyst with responsibility for alcohol.

Each HB was asked to set up a collaborative working group in their area. Members included the HB alcohol lead, health promotion practitioners, consultants and representatives from Area Planning Boards (APB) throughout Wales. These collaboratives carried out needs assessments to identify practitioner groups which should be prioritised for training. This approach ensured that this national programme had local ownership. To inform prioritisation, HBs

were provided with guidance developed by the KTP Steering Group. To be eligible to receive screening and ABI training, a professional or professional group was required to meet all of the following criteria:

- Contact with patients/clients who misuse alcohol
- Availability of "teachable moments" when interventions can be delivered
- Practical opportunities (time and location) to deliver ABI

In 2010, a Short Knowledge Transfer Partnership (sKTP) between Cardiff University and WG identified a number of barriers and facilitators to implementing ABI in clinical settings. Furthermore, between 2010 and 2012, Public Health Wales delivered ABI training to General Practitioners (GPs) across Wales; full evaluation of this programme was also carried out. The KTP Steering Group used the knowledge from both these programmes to design a blueprint for the development of this programme. The major barrier identified in both projects was the duration of the training course; two days in the sKTP and one day for GPs, which resulted in low attendance rates due to the difficulties of releasing staff for this period.

The KTP associate worked with Public Health Wales to distil and combine the main elements from both previous programmes. This resulted in a two hour course with relevant elements adjusted to meet local and professional needs. This course was piloted in the Cardiff and Vale University HB before being implemented nationally. It was accredited at degree level by the Welsh qualifications body, Agored Cymru, and endorsed by the Royal College of Nursing (RCN).

A 'Train the Trainer' course was also developed for practitioners working in third sector organisations. Both training programmes were based on the FRAMES model for brief intervention delivery (figure 1).

Feedback	giving information to a patient/client which links their alcohol misuse with the physical or other results of this misuse
Responsibility	emphasising that the patient/client is responsible for behaviour change
Advice	tailored to the particular patient/client circumstances
Menu of options	patients have different needs; practitioners need to select a strategy from a menu of effective options, the most suitable in the patient/client context
Empathy	a characteristic of any effective professional relationship
Self-efficacy	the ability of each patient/client to change their behaviour ("You can do it!")

Figure 1: The FRAMES model

1.2.2 Training delivery

The screening and ABI programme developed through this KTP was launched in May 2012. Between 1st June 2012 and 30th May 2013 (the evaluation period) the training team delivered the two hour ABI course to 2486 practitioners across Wales. Training was delivered to a wide variety of both NHS and non-NHS professional groups (table 1)

Table 1: Examples of numbers trained from 1st June 2012-31st May 3013 by role

Nurses (maxillofacial/trauma/primary and secondary care and school nurses)	332
Midwives	71
Health Visitors	150
Youth Workers	145
Pharmacists	97
Dieticians	99
Police (including community support officers and other CJS)	84
Other[1]	1508
Total	2486

1.2.3 Additional KTP outputs: Have a Word

Feedback from trainees demonstrated that some practitioners were not aware of the evidence of efficacy of screening and ABI. Furthermore, ABI language appeared to be technical and alien to the context in which they worked. Therefore the KTP associate, working in collaboration with the KTP Steering Group and a local marketing agency, Stepping Stones, created and developed the social marketing brand, "Have a Word".

The slogan *Brief Interventions Work: Have a Word!* was designed to convey the message to frontline practitioners that screening and ABI is effective in changing health behaviours and that delivery is possible in the very limited time available in clinical settings. The "Have a Word" brand was launched in January 2013 by Lesley Griffiths AM, the then Minister for Health and Social Services and has subsequently been used by Public Health Wales to market screening and ABI training nationally.

Alongside this brand, a strategy was developed to support and sustain the long-term delivery of screening and ABI. As part of this strategy a dedicated website (www.haveaword.org) was developed together with a social media campaign. Materials including posters for staff areas were also developed and distributed. The "Have a Word" brand is an additional KTP output not envisaged in the original project plans. It is generic and accessible and can therefore be applied to any campaign to deliver motivational advice, across all behaviours where brief interventions are known to be effective and in any country or community where colloquial English is understood.

1.3 Programme evaluation

The evaluation of the training delivered through this KTP was undertaken collaboratively by Cardiff University and Public Health Wales. All who attended the training were eligible to participate and were contacted using the information they provided during training. The data presented in this relates to the first 12 months of the programme (1st June 2012 – 30th May 2013).

1.3.1 Evaluation methods

a) 'Quick Eval' forms

Each trainee who received screening and ABI training was asked to complete a short evaluation questionnaire comprising five-questions on training content, impact of training on their understanding of alcohol misuse, practical application/delivery of ABI, and the performance

(Footnotes)

1. "Other" includes health and safety officers, counsellors, doctors, substance misuse workers, support workers, and social workers.

of their trainer.

b) Follow-up telephone interviews

Each professional trained was contacted by telephone by the central team at Public Health Wales at 1, 3, 6 and 12 month intervals after training.

c) Fidelity checks

Clinical observations were undertaken with a sample of maxillofacial and trauma clinic nurses to evaluate screening and ABI fidelity according to FRAMES elements.

d) Semi-structured interviews

Semi-structured interviews were conducted with a range of frontline health and community professionals trained to deliver screening and ABI. Interviews provided detailed feedback on the training programme and the barriers and facilitators to delivering screening and ABI.

1.3.2 Results

Almost all (95%) trainees completed evaluation forms following training; 77% of the trainees who responded felt either confident or very confident that they would be able to deliver ABI. 90% of respondents believed ABI to be an important part of reducing alcohol misuse.

Delivery of screening and ABI varied by professional group. For example, 59% of trained youth workers went on to deliver ABI, compared with just 7% of pharmacists (table 2).

Table 2: Professional groups trained and ABI delivery rates

Professional Group	Response Rate	Delivery Rate
Nurses	45% of total trained	38% of total trained 83% of respondents
Midwives/Health Visitors	55% of total trained	43% of total trained 77% of respondents
Youth Workers	64% of total trained	59% of total trained 93% of respondents
Pharmacists	18% of total trained	7% of total trained 38% of respondents
Dieticians	23% of total trained	15% of total trained 68% of respondents
Police	41% of total trained	32% of total trained 78% of respondents

1.3.3 Conclusions

This KTP has demonstrated the effectiveness of collaboration between university, government and public health sectors at both national and local levels. The two hour course received high approval ratings both from managers and trainees. With training, practitioners were more likely to accept that alcohol misuse is a major public health challenge and that they have a role to play in meeting this. The training programme resulted in increased understanding and confidence in screening and ABI. It was concluded that screening using FAST need not be a paper-based process; verbal screening is effective. Follow-up response rates reflected ABI delivery; practitioner groups with high rates of screening and ABI delivery were more likely to respond. Groups with high screening and ABI delivery rates included nurses, midwives and youth workers. Groups with low delivery rates included pharmacists, dieticians and police

officers. Some practitioners, such as midwives, had been delivering ABI as a result of training but did not recognise this. It was also concluded that on-going support is necessary to maintain delivery.

1.4 Recommendations

The first sets of recommendations (1-19) are specific to this KTP; the second (20-38) are for groups outside Wales who wish to establish a screening and ABI programme. These recommendations are also relevant to the development of a brief intervention programme for health behaviours other than alcohol misuse.

1.4.1 Recommendations for the Welsh Government, Cardiff University and Public Health Wales

1) All three partner organisations should continue to work together to extend the "Have a Word" brand into other, non-traditional areas such as falls prevention and sexual health. *It is recommended* that, during 2014, at least one new programme is developed, and that preliminary trials and evaluation begin.

2) Evaluation of this programme has shown that youth workers in particular are engaged with screening and ABI. *It is recommended* that an efficacy trial is undertaken to develop the evidence base for this professional group. In view of this, a partnership should be established with the Public Health Improvement Research Network (PHIRN).

3) It is recommended that all partners should work to develop an awareness raising programme of the "Have a Word" brand among organisations with a public health remit. This programme should encourage organisations and particularly managers in these organisations, that the "Have a Word" screening and ABI model should be embedded in practice and seen as integral, rather than an additional task. To support this, *it is recommended* that a programme led by the PHW is launched; reminding patients, citizens and their families that NHS care will include discussions about their lifestyles. This will support practitioners in their efforts to deliver screening and ABI.

4) It is recommended that the "Have a Word" brand is adopted for all brief intervention delivery projects in Wales, whether for alcohol or other behaviour change programmes

1.4.2 Recommendations for the Welsh Government

5) The "Have a Word" Alcohol Brief Intervention programme has extended far beyond its original remit, involving both NHS and non-NHS organisations. *It is recommended* that to support the "Have a Word" model in the future, further commitment and WG action is required. This includes population-level policy, arrangements to maintain and extend screening and ABI training delivery, to reduce alcohol related harm across Wales.

6) It is recommended that the WG ensures that tackling alcohol misuse remains a strategic priority for the Minister for Health and Social Services as well as the Chief Medical Officer.

7) The "Have a Word" ABI programme has mainly focussed on adults. Yet evidence from the Public Health Observatory in Wales highlights that underage drinking

remains a problem in Wales. *It is recommended* that WG support Public Health Wales and Cardiff University to develop and evaluate a project to deliver ABI to people under the age of 18.

8) This KTP has demonstrated that practitioners do not find units helpful for measuring consumption. *It is recommended* that WG sets a policy for all organisations working to reduce alcohol harm in Wales to stop using 'units' and to find a more appropriate measurement of consumption.

9) *It is recommended* that the WG should use the screening and ABI blueprint developed through this KTP to market the "Have a Word" model to other UK governments.

1.4.3 Recommendations for Public Health Wales

10) *It is recommended* that any future WG-funded brief intervention training programme should be delivered in a wide range of NHS and non-NHS settings.

11) *It is recommended* that Public Health Wales continues to deliver the "Have a Word" screening and ABI programme, with the support of WG and Cardiff University, in both NHS and non-NHS settings. To do this, the ABI team established through this KTP needs to be retained and adequately resourced.

    a. To support this, *it is recommended* that the on-going evaluation process is used to identify a priority group for national training in each setting (NHS and non-NHS) each year.

    b. Based on the evaluation to date, *it is recommended* that the priority non-NHS group for 2014 is youth workers, along with professionals working with the homeless; and that the priority NHS group is midwives.

    c. Nurses in maxillofacial and trauma clinics should continue to be supported and additional training offered where the need for this is identified.

12) To support the extension of the "Have a Word" programme into other health and lifestyle settings, *it is recommended* that the ABI team develop a half day "Brief Intervention Basics" programme to provide training for those seeking to deliver brief intervention training in those settings.

1.4.4 Recommendations for Cardiff University

13) *It is recommended* that Cardiff University seeks to disseminate the partnership model used in this project as an illustration of translational research in public health and behaviour change.

14) *It is recommended* that the results of this project are used to develop at least one Research Excellence Framework (REF) impact statement for the next REF assessment.

1.4.5 Recommendations for Public Health Wales and Cardiff University

15) *It is recommended* that Public Health Wales and Cardiff University continue to disseminate the products of this KTP including the "Have a Word" brand and seek to explore opportunities to licence

the training courses for users outside Wales.

16) *It is recommended* that both Public Health Wales and Cardiff University continue to seek to identify more robust and effective approaches to evaluation.

a. Information on referrals to specialist services should be sought to determine whether there is any correlation between screening and ABI training delivery and referral patterns.

b. The collection of ABI delivery data using SMS or tweets should be explored using the "Have a Word" brand.

1.4.6 Recommendations for other universities

17) Universities could use this KTP model for achieving impact of public health research.

18) KTP projects, on the basis of this example, provide specific and unforeseen opportunities for research in the area of implementation science and impact.

1.4.7 Recommendations for organisations outside Wales seeking to develop and deliver a screening and alcohol brief intervention training programme

Programme structure

19) *It is recommended* that to make best use of scarce resources and enable sharing of experiences and ideas across localities, programmes are established at a national or regional level, led by a central team with expertise in training and alcohol related harm.

20) *It is recommended* that Programme Level Agreements (PLA) between strategic partners including Health Boards and NHS Trusts are the basis of commitment to the delivery and sustainability of programmes at both a national and regional level.

21) *It is recommended* that central (national or regional) teams take responsibility for the development, delivery and evaluation of training.

22) *It is recommended* that the central team encourages local professionals participating in the programme to form collaborative working groups and that a single point of contact is established between the central team and each local collaborative. *It is recommended* that the membership of local collaborative groups should include public health practitioners/ consultants and representatives of local area planning boards.

23) *It is recommended* that the central team establishes a network consisting of the central team and representatives of local collaborative working groups to support the exchange of ideas and experiences.

24) *It is recommended* that local collaboratives carry out training needs assessments to identify priority professional groups for training in their areas. This process should be supported by the central team.

a. *It is recommended* that central and local teams adopt the criteria set out by the Steering Group for this KTP, or a similar approach, to support the identification of target professional groups. In the first instance, criteria should be applied flexibly and inclusively but,

a. over time, these may be refined to exclude professional groups if evaluation deems this appropriate.

b. *It is recommended* that training should be delivered to both NHS and non-NHS professionals.

25) *It is recommended* that the central team delivers training in localities arranged by local collaboratives, at venues convenient for the professionals to be trained.

26) *It is recommended* that where possible, professional groups targeted for training are not "mixed" (that is, include participants from a number of different professions) to ensure that the training has the highest possible impact and relevance for each practitioner.

27) *It is recommended* that the central team establishes a list of professional groups to be trained in all localities. Arrangements for the delivery of this training should be led by the central team.

Programme branding

28) *It is recommended* that permission is sought from Cardiff University and Public Health Wales to use the "Have a Word" brand.

29) In the event that the organisation does not wish to use the "Have a Word" brand, *it is recommended* that a distinct brand is developed, with the involvement of local stakeholders.

a. This branding exercise should build on the six attributes of a successful brand as outlined in the "Have a Word" section in of this report; simple, unique, safe, aspirational, value based and credible.

30) *It is recommended* that the programme brand is used to support efforts to market the project, identify new training opportunities and motivate practitioners that have received training to deliver screening and ABI. This may include a website and online presence in other social media settings.

The training programme

31) *It is recommended* that permission is sought from Cardiff University and Public Health Wales to deliver the "Have a Word" screening and ABI training courses. However, in the event that a new programme is to be delivered, *it is recommended that*

a. The training is based on an ethos of reduced alcohol consumption, not abstinence. Evaluation of this KTP shows that this approach supports engagement of professionals both in attending training courses and their future delivery of screening and ABI.

b. The training is evidence-based.

c. The training course is centred on the FRAMES model.

d. The importance of the 'teachable moment' is emphasised in terms of both training and delivery.

e. Screening is presented as a key element of ABI training and delivery but that the actual screening

process should be adapted to the delivery context concerned and not be a solely paper-based process.

f. Each training course is tailored to the specific needs of the professional group being trained, in terms of the data presented and with regard to the identification of teachable moments.

g. Each training course should include a vignette; an example of a brief intervention either delivered by the trainer(s) or in the form of a video.

h. Each training course should last for a maximum of two hours to enable professional groups to utilise the training within the constraints of their professional duties.

i. An extended four hour training course should be made available for specialists working in substance misuse.

j. An on-line refresher course should be made available to all trainees.

32) *It is recommended* that appropriate accreditation is sought for any new training programme.

33) *It is recommended* that a 'train the trainer' course is developed. Such a programme is available under licence from Public Health Wales. *It is recommended* that permission and licensing is sought from Public Health Wales to deliver the "Have a Word" screening and ABI train the trainer programmes. However, in the event that a new programme is to be delivered, *it is recommended that*

a. The training course is held over two days, ideally with trainees in residence, in accordance with feedback from the pilot model used in this KTP.

b. The course includes detailed information on the efficacy of screening and ABI and how it can be implemented into existing workload models.

c. The course includes information about screening tools and practical exercises allowing trainees to use these tools.

d. The course includes coaching on motivational interviewing.

e. Trainees are given opportunities to deliver screening and ABI courses within the confines of the training course.

f. An end of course assessment should be implemented where trainees are given feedback on their delivery of screening and ABI.

g. Those who pass the train the trainer course are observed and supervised in delivering two ABI training courses before being released to train alone.

Evaluation

25) *It is recommended* that each screening and ABI training session ends with evaluation of the session. The results of these evaluations should be used to maintain fidelity.

26) *It is recommended* that a follow-up process is established. Trainees should be asked to provide contact email and telephone numbers and made aware that they will be contacted at intervals after their training to check progress.

27) *It is recommended* that trainees are asked to update other trainees on their experiences of delivering ABI using social media. The "Have a Word" social media pages on Facebook and Twitter provide a blueprint.

28) *It is recommended* that focus group sessions are arranged with different professional groups on a six monthly basis to identify any emerging barriers to delivery.

29) *It is recommended* that the central training team regularly reviews follow up data to refine training priorities of the central team and local collaboratives. This process may also be used to exclude some professional groups from the list of training priorities. *It is recommended* that to support this approach evidence of poor uptake or delivery by a professional group should be available from at least two localities.

2. Glossary of Terms

ABI	Alcohol Brief Intervention
APB	Area Planning Board
DH	Department of Health
FAST	Fast Alcohol Screening Test
HB	Health Board
INEBRIA	International Network on Brief Interventions for Alcohol and Other Drugs
KTP	Knowledge Transfer Partnership
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
sKTP	Short Knowledge Transfer Partnership
VSRG	Violence Research Group

3. Introduction

Alcohol has played a key role in the social, cultural and economic life in the UK, including Wales, for over 4000 years. Alcohol misuse, however, in the first decade of the 21st century, was responsible for 2.3 million early deaths annually across the world (World Health Organisation 2011). EU citizens drink twice the amount of alcohol compared with the global average; it has been estimated that, in the EU in 2004, almost 95,000 men and more than 25,000 women (aged between 15 - 64 years) died prematurely of alcohol-attributable causes (Anderson et al 2012).

In the 1950s the UK had one of the lowest drinking levels in Europe and many people continue to drink at safe levels. However in recent decades a culture of misuse has developed and the UK is now one of the few states in Europe where consumption has increased overall (Home Office 2012). In 2010/11 there were over 1.2 million alcohol-related hospital admissions in the UK (figure 2) and alcohol-related harm was estimated to cost society as a whole £21 billion annually (Home Office 2012). Between 2001 and 2009 there was a 25% increase in alcohol related liver disease, which in 2009, accounted for 37% of all deaths from liver disease (Home Office 2012). In Wales alone, by 2008, 1 in 30 deaths were alcohol-related and alcohol misuse cost NHS Wales approximately £85 million per year (Gartner 2009).

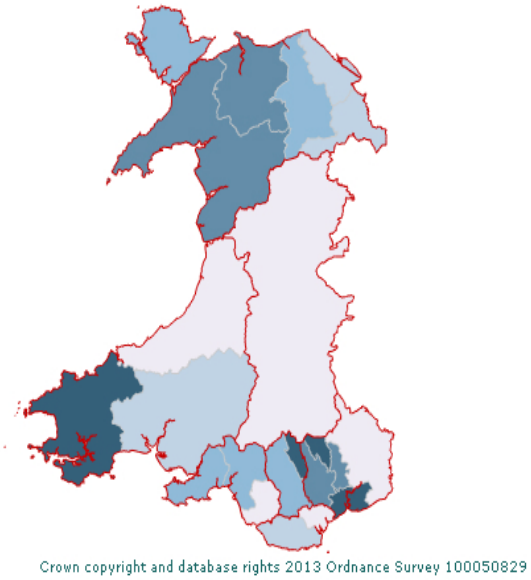


Figure 2: Age-standardised alcohol specific hospital admissions rate for 2011/12 (Health Maps Wales 2012

3.1: Alcohol misuse: a major public health challenge

Alcohol is engrained in British culture and is commonly associated with pleasure and recreation. There is evidence that moderate alcohol consumption can bring positive health benefits such as reducing cardiovascular problems (Ronksley 2011), but regular, excessive drinking poses a serious public health challenge. Whilst there is evidence that consumption is starting to fall (Office for National Statistics, 2011), overall levels remain high. The social costs of alcohol misuse are underestimated, since they do not take fully into account the costs to people other than the drinker, such as children, partners and colleagues. Alcohol misuse is a serious public health challenge and is linked to over sixty conditions (Alcohol Concern 2010).

3.2: Maximum consumption guidelines

Consistent consumption guidelines that are presented in a meaningful way are lacking. Sensible drinking has been defined as "drinking in a way that it unlikely to cause yourself or others significant risk of harm" (Department of Health (DH) 2007). DH recommends that men should not regularly exceed 3-4 units of alcohol per day and women 2-3 units. DH guidelines also state that there should be at least two alcohol-free days per week.

DH defines hazardous drinking as a pattern of consumption which increases the risk of harm in both the long and short-term. Harmful drinking is "a pattern of psychoactive substance use that is causing damage to health" (World Health Organisation 2011). Binge drinking is defined by the DH as consumption of more than six units in one sitting by a woman and eight units by a man. Heavy episodic drinking, or binge drinking, accounts for over half of all alcohol consumed in the UK (Department of Health 2013) and is one of the most significant causes of accident and injury globally (World Health Organisation 2011).

A close related relationship between binge drinking and injury has been demonstrated by two case-control studies and a study of links between amount of alcohol consumed and injury severity: consumption of eight units or more has been shown to differentiate between the injured and non-injured (Shepherd, et al 1990). In the UK, 83% of people who regularly drink above the recommended guidelines do not think that their drinking is putting them at long-term risk (Department of Health 2013).

3.3: Alcohol brief interventions

Alcohol brief interventions (ABI) have been shown to be effective across a wide range of healthcare settings. However, there is little evidence of efficacy amongst dependent drinkers (Raistrick 2006). Gentilello et al (1999) found that ABI led to a reduction in injury as well as harmful drinking.

An ABI has been defined as a "short, evidence-based, structured conversation about alcohol consumption with a patient/ service user that seeks in a non-confrontational way to motivate and support the individual to think about and/ or plan a change in their drinking behaviours in order to reduce their consumption and/ or their risk of harm" (NHS 2009), (see section five).

3.4 Policy context

Welsh Government (WG) and UK policies to address the issue of alcohol misuse and its impact on local services and communities have been developed. In 2010, the Chief Medical Officer for Wales described alcohol misuse as "one of the most serious public health challenges in Wales". The 2012 UK government's alcohol strategy, which applies to England, with aspects which are relevant to Wales and Scotland, includes a range of actions to tackle harms associated with alcohol misuse.

In 2008 the WG launched a ten-year Substance Misuse Strategy, Working Together to Reduce Harm, which placed greater focus on reducing alcohol-related harm. As part of this strategy Cardiff University's Violence Research Group (VSRG) collaborated with the WG in a Short Knowledge Transfer Partnership (sKTP). The sKTP translated the results of trials of screening and brief interventions into practice in NHS trauma and maxillofacial clinics. The aim of the sKTP project, with the collaboration of the University of Wales Institute Cardiff, which was awarded the contract for delivering ABI training, was to train nurses in eight NHS hospitals to identify alcohol misuse and deliver ABI to reduce risky drinking. Whilst progress was made in terms of training

and the delivery of ABI, the pragmatic reality of working in a clinical setting meant that many nurses could not be released for training and, ultimately, for this reason, consistent delivery was not sustained.

3.5 Collaboration

In 2010/11 the WG funded Public Health Wales to deliver an ABI programme including training for primary care professionals (delivered on behalf of the Royal College of General Practitioners (RCGP). As part of this agreement a professional network for tackling alcohol misuse was established and guidance produced for local Health Boards (HBs) across Wales. In 2011/12 a Programme Level Agreement (PLA) was expanded to continue the ABI programme in primary care but also to extend training to include NHS secondary care and other health and community professionals.

In 2011 Cardiff University and the WG successfully applied to the Technology Strategy Board to commission a 24-month Knowledge Transfer Partnership (KTP) to build upon the work from the sKTP. Public Health Wales, under the terms of the five-year PLA with the WG became part of this KTP and worked in collaboration with the KTP Associate and KTP steering group to develop and deliver a robust ABI programme for Wales. The Public Health Wales ABI team comprised a Consultant in Public Health, a Senior Public Health Practitioner and two Public Health Practitioners which specific remits to deliver screening and ABI training.

The specific objectives of this KTP were:

- To work in collaboration with Public Health Wales to develop a robust and sustainable screening and ABI programme for alcohol misuse that will become part of routine clinical practice in hospital trauma and maxillofacial clinics in Wales.
- To increase access to screening and ABI training using a range of formats and approaches to meet local needs
- To establish a mini-collaborative approach similar to the 1000 lives model with participation from each HB area
- To develop agreed monitoring and performance measures to enable local and clinical audit and national monitoring of implementation
- To develop a model that the WG and Public Health Wales could apply to future initiatives in the areas of primary and secondary care, the criminal justice system and sexual health.
- To transfer knowledge to relevant areas of the WG leading to more effective implementation of health related programmes on obesity, smoking and physical exercise.
- To contribute to a healthier Wales.

This report summarises the development and processes of the KTP between Cardiff University and the WG. It does not consider clinical outcomes but provides a robust evaluation of the training delivered across a variety of health and other community settings throughout Wales.

4. Screening and brief Interventions

4.1 Elements of a brief intervention

Brief interventions are based on a form of motivational interviewing, a technique used to "examine and resolve ambivalence about behaviour change" (Rollnick, 1996). Brief interventions include some basic key therapeutic skills, usually following the FRAMES agenda (Miller & Rollnick 1991), (figure 3).

Feedback: helping the patient make the link between their current situation and their alcohol misuse

Responsibility: encouraging the patient to take responsibility for their own drinking

Advice: providing the patient with individually tailored advice on issues such as keeping consumption within safe limits.

Menu: providing the patient with options to enable them to reduce their drinking, for example choosing a small glass of wine instead of a large one, avoiding drinking in "rounds" and not relying on alcohol drinks alone to quench thirst.

Empathy: using an empathetic approach rather than lecturing the drinker, for example, saying "w*e all like a drink but being in A&E on Saturday night can't have been much fun".*

Self-efficacy: emphasising for patients that they can change their drinking habits, in the same way, for example, that patients can and often do give up smoking.

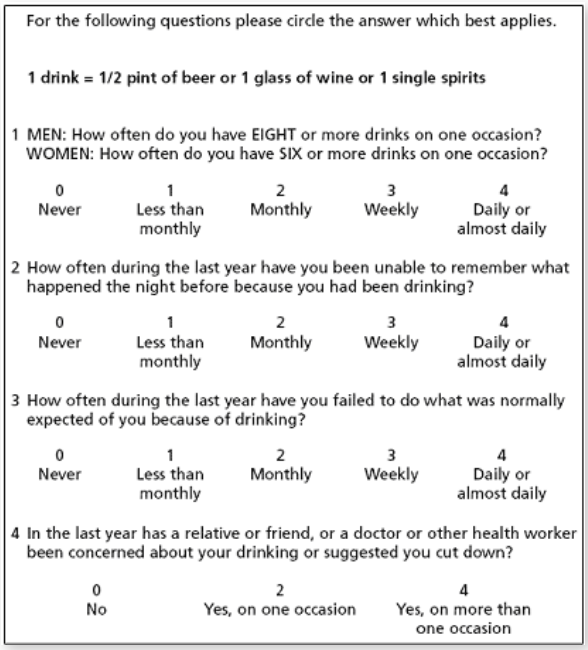
Figure 3: The FRAMES agenda

The FRAMES agenda recognises an individual's concerns about behaviour change and provides professionals with a basic framework in which to approach the issue of alcohol misuse (Miller & Rollnick 1991). The approach used by the professional will vary according to context including the relationship or rapport with the individual and other situational elements such as where a person is in the stages of change process. Interventions are designed specifically to meet this challenge. The whole approach can be summarised as one of partnership rather than one dependant on an expert-patient relationship. By selecting the appropriate strategies, the intervention can be tailored to fit each individual patient.

4.2 Screening for alcohol misuse

According to the National Institute for Clinical Excellence (NICE) brief interventions should be delivered after screening has taken place (NICE 2010). There are a range of different screening tools which have been tested and found to accurately identify hazardous and harmful levels of drinking (Mably and Jones 2010).

One of the most widely used tools is the Alcohol Use Disorders Identification Test (AUDIT) which is a ten item questionnaire which has also been adapted to a shorter three question version, AUDIT-C. Both have been validated as effective (Bush et al 1998) maintaining 80% sensitivity, 96% specificity and an overall accuracy of 92%. In accordance with NICE guidelines the screening measure chosen for this KTP was the Fast Alcohol Screening Questionnaire (FAST) which was developed by Hodgson et al (2002) and is an adaptation of AUDIT. The FAST was designed for use in busy clinical settings, has been shown to be valid and can be used for a range of medical services (NICE 2010) and has a sensitivity of 94%, a specificity of 89% and an overall accuracy of 97% (Jones 2011). It takes approximately 15 minutes to complete and can be easily scored. The FAST questionnaire comprises of four questions (figure 4)



For the following questions please circle the answer which best applies.

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

1 MEN: How often do you have EIGHT or more drinks on one occasion?
WOMEN: How often do you have SIX or more drinks on one occasion?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

2 How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

3 How often during the last year have you failed to do what was normally expected of you because of drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

4 In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

0	2	4
No	Yes, on one occasion	Yes, on more than one occasion

Figure 4: The Fast Alcohol Screening Test (FAST)

The FAST can be completed by patients in a clinical waiting room or with a practitioner. A positive score, highlighting alcohol misuse, is three or more (Hodgson et al 2002). ABI are opportunistic and can take place at the same time as routine clinical practice, such as during wound care for example, to guide the patient or service user to make a positive change in their drinking behaviour (Smith et al 2003).

4.3 The evidence base for screening and brief interventions

Trials indicate that on average, for every eight people drinking at hazardous levels who receive an ABI, at 12 months, one will have reduced their drinking to within safer limits. The VSRG at Cardiff University has found in clinical trials that ABI delivered by nurses are particularly effective in trauma and maxillofacial clinics, capitalising on the high receptivity of patients in these settings (Smith et al 2003). Since ABI can be opportunistic and incorporated into routine clinical work without the need for additional clinical resources, they are cost effective (Tariq et al 2009). Timing is crucial; ABI work best when there is a *"teachable moment"* (Longabaugh et al 1995).

4.4 Teachable moments

A teachable moment can be defined as a naturally occurring life transition or health event that motivates or activates individuals to spontaneously adopt risk-reducing health behaviours (Williams et al, 2005). It is that moment in time when a person is faced with the consequences of their actions and therefore more receptive to the suggestion of behaviour change (Shepherd et al, 2012). Timing ABI to take advantage of these events increases the effectiveness of that behaviour change (Longabaugh et al 1995).

5. Barriers and facilitators to implementing ABI in Wales: Learnings from the sKTP

As highlighted in the introduction, this project builds upon the previous work which was undertaken as part of a Short Knowledge Transfer Partnership (sKTP) between Cardiff University and the WG in 2010, which identified a number of barriers and facilitators to implementing screening and ABI in clinical settings. Between 2010 and 2012, Public Health Wales delivered screening and ABI training to General Practitioners (GPs) across Wales; full evaluation of this programme was also carried out. The KTP Steering Group used the knowledge from both of these programmes to design a blueprint for the development of this programme. This section provides reviews the barriers and facilitators to implementing screening and ABI in Wales.

5.1 Barriers to implementing screening and ABI

- **Low levels of attendance at training events**
  The sKTP associate worked in collaboration with colleagues in the University of Wales Institute, Cardiff (UWIC) to deliver ABI training to staff from eight hospitals across Wales. The two-day training model covered both how to distribute and score the FAST screening measure and how to deliver ABI using a Motivational Interviewing (MI) approach. Whilst initial uncertainly about who would manage the training was resolved by clinical management, there were also substantial difficulties in releasing staff to attend the training. Head nurses in each clinic were responsible for release of nurses to attend training. However, due to the pragmatic nature of the clinical environment many nurses were unable to attend the training events. General staffing issues such as sickness, annual leave and staff shortages further impacted upon availability for training. Release of nursing staff for two days was a particular challenge (Zabel and Shepherd 2010).

- **Unsuitable trainees**
  On occasions staff attending training events were not suitable since they worked in mental health and midwifery; the training was designed specifically for a trauma clinic setting (Zabel and Shepherd 2010).

- **Uncertainty about screening in a clinical setting**
  Some nurses expressed uncertainty about how the ABI process could be implemented in relevant clinics. The head nurse in each

clinic identified the optimal way to distribute the screening tool. In some cases this involved either a receptionist distributing the questionnaire to patients when they first attended clinic or by a nurse in the treatment room. In some cases the lack of clarity concerning the recording of patient data and the accompanying issues of patient confidentiality meant that some staff felt uncomfortable delivering screening and brief interventions. In some clinics there were no private treatment rooms for wound care; nurses here felt that this compromised patient confidentiality. In other cases, patients questioned nurses why their alcohol use was being investigated. There was also uncertainty about what to do with completed questionnaires; many were kept by patients or returned to reception.

- **Difficulty in monitoring continuous delivery of ABI in a clinical setting**
  There was uncertainty in some clinics about how to monitor the delivery of ABI. The sKTP associate proposed a solution in the form of an audit book in which staff recorded their delivery of screening and brief interventions. However in many cases these log books were not completed due to other priorities.

- **Lack of opportunity to access additional training or supervision**
  The two-day training model meant that of the nurses who originally attended, few, if any, were able to access further support. At the time, the UWIC model was the only training available and whilst nurses had opportunities for continuous professional development, there was little available in relation to ABI at the time.

The sKTP also highlighted a number of facilitators to delivering screening and brief interventions in a clinical setting. In particular it found that nursing staff at all levels were supportive, enthusiastic and understood the importance of addressing issues relating to alcohol misuse. The sKTP project provided a valuable foundation on which to build. The barriers highlighted during the sKTP informed both the KTP associate and colleagues in Public Health Wales as they worked in collaboration to develop a screening and ABI model.

6. Knowledge Transfer Partnership: Objectives, Outputs and Products

The main objectives of this KTP are set out in the introduction of this report. This section provides a detailed commentary on the developments and milestones which have been achieved as a result of joint work by the KTP associate and Public Health Wales under the terms of the PLA with the WG.

Objective I

- Review the training activity undertaken in secondary care under the sKTP and to consider the barriers to implementation of the training with a view to the provision of an alternative training model.

The KTP associate worked in collaboration with Public Health Wales to review the training activity delivered as part of the sKTP including measures to overcome the barriers that the sKTP highlighted. The KTP associate carried out a series of clinical observations of the delivery of ABI by nurses working in the maxillofacial clinic of University Hospital of Wales (UHW) in Cardiff.

Product: The Associate produced a summary of evidence and key findings in relation to screening and brief interventions across a range of health settings including secondary care and presented this to the WG (see appendix I)

Output: Knowledge about the clinical context and how ABI can be delivered in busy medical settings.

Output: The evidence base for screening and ABI was distilled and refined in to a document highlighting the studies which have taken place across different settings.

Output: Professor Jonathan Shepherd presented the KTP work schedule and relevant research to the Directors of Public Health and the Chief Medical Officer at one of their regular meetings to gain national support for this KTP programme.

Output: The KTP associate worked in collaboration with Public Health Wales to distil and combine the main elements from both the sKTP training course and the RCGP course. This resulted in a two hour course with relevant elements adjusted to meet local and professional needs.

Output: Public Health Wales successfully applied for accreditation for the training package through Agored Cymru at Level 4 (degree level). The KTP training model was also endorsed by the Royal College of Nursing (RCN).

Knowledge transfer: The KTP associate undertook a series of clinical observations which highlighted barriers and facilitators to implementing ABI in a clinical setting. This included discussions with Professor Jonathan Shepherd from Cardiff University and Nurse Manager Kathryn Bridgeman on releasing nursing staff for training. The KTP associate drafted a report based on these observations along with potential solutions to the barriers observed. These findings were then discussed and shared with Public Health Wales.

Objective II

- To establish a mini-collaborative approach similar to the 1000 lives model with

1000 Lives Plus is a national improvement programme supporting organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales. One of the ways in which this works is through the formation of mini-collaborative groups in each of the seven HBs in Wales. This involves bringing together key decision makers and practitioners around a topic to ensure that training programme implementation, for example, results in the greatest possible improvements in service to the public. The mini-collaborative, in its purest form, is driven by the Breakthrough Series Model (figure 5).

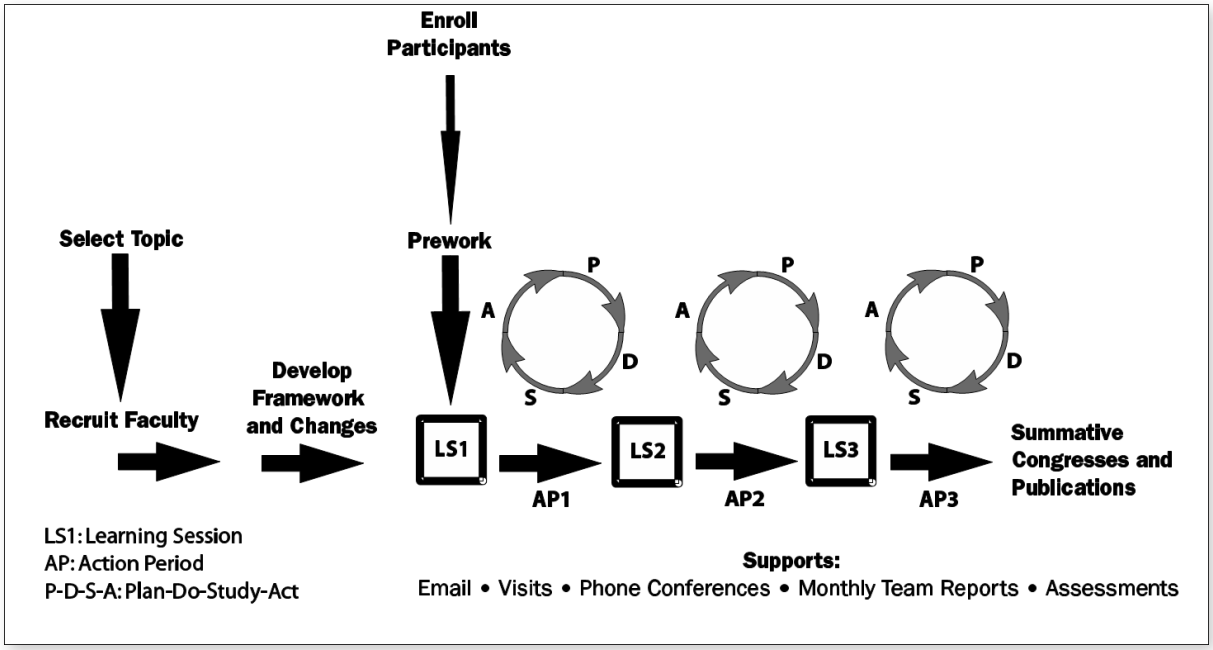


Figure 5: The Breakthrough Series Model

Alcohol collaborative working groups were set up by Public Health Wales in each HBs in early 2012. The Plan-Do-Study-Act (PDSA) cycle, described above which is the model used in the 1000 Lives campaign and in this KTP, allows changes to be made in each locality, ensuring that the wider national ABI programme responds to local needs. Membership of the collaborative groups included a combination of the national and local Public Health Wales staff (e. g. Senior Public Health Practitioner (Alcohol) and local Public Health Team alcohol leads), relevant members of the local HB, practitioners participating in ABI training and subsequent roll out and any other interested parties or those considered experts in the field.

Product: A briefing paper was published by Public Health Wales outlining the plans for developing collaborative working groups in each HB to take forward a programme of ABI training.

Outputs: Public Health Wales and the KTP associate worked together to identify potential members of each HB collaborative group. These collaboratives then carried out a training needs assessment. Key groups eligible for training were identified through the collaboratives together with venues and information to facilitate further recruitment.

Objective III

To increase access to ABI training using a range of formats and approaches to meet local needs.

The training model was reduced in duration from two days as used in the sKTP, and one day as used by the RCGP, to a two hour model. This allowed far greater take-up by managers and attendees. Public Health Wales delivered training locally, minimising the need for trainees to travel or take prolonged periods away from clinical duties. There were also criticisms that the sKTP course was irrelevant for some trainees, midwives for example.

Product: Briefing papers were developed by the KTP associate and Public Health Wales to raise awareness of training model and generate support in each locality.

Output: A training model was developed using the two hour course as a foundation, with appropriate elements altered to meet local and professional needs. As it now stands, the model includes:

- A bespoke two hour course delivered locally ensuring the training is more accessible to staff. The content of each course is tailored to the specific professional group concerned.
- A four hour extended course is available for specialist substance misuse workers
- A 'train the trainer' course enables HBs to have ownership of the training in specific localities.
- All courses are accredited by Agored Cymru at Level 4 (degree level) and are certified by the RCN.

Output: The collaboratives and the KTP Steering Group identified evidence-based criteria for training eligibility. Those who attend training should have:

- Contact with a person who misuses alcohol
- Availability of a teachable moment
- Practical opportunity to deliver screening and ABI

Output: A national launch event was organised in May 2012 by the KTP associate and Public Health Wales in which the training package was presented to representatives from each HB.

Collaborative groups identified the following health and community professionals as eligible for screening and ABI training:

- Nurses (maxillofacial/trauma/primary care)
- Midwives
- Youth Workers
- Health Visitors
- Community Pharmacists
- Dieticians
- Police officers

Facilitator: The collaborative approach meant that the training was responsive to local needs and barriers could be overcome. For example nurses in the Glan Clwyd hospital (Betsi Cadwaladr University HB), highlighted that many patients attended their local GP surgeries to have sutures removed; thus there was potential in training primary care nurses so that opportunities to deliver ABI would be realised.

Managers across all health and community settings were supportive of training and reported that the two hour model made it easier to incorporate into schedules allowing staff release for training. Managers highlighted that having training delivered locally by Public Health Wales was beneficial.

> ***"Having them come to us made it much easier to release staff and generate support for the training"***
> Nurse Manager, Aneurin Bevan Health Board.

Objective IV

- To develop and agree monitoring and performance measures to enable local clinical audit and national monitoring of implementation.

Collaborative leads asked training attendees for feedback via telephone and email at the end of each training course. This was supported by follow-up telephone calls from the central team in Public Health Wales which were completed at 1 month, 3 month, 6 month and 12 months to monitor the delivery of screening and ABI amongst those who had received training.

Product: Each trainee who received screening and ABI training was asked to complete a short evaluation questionnaire comprising five-questions on training content, impact of training on understanding of alcohol misuse, practical application/delivery of ABI as well as the performance of their trainer (appendix II).

Output: Public Health Wales collated information from collaborative groups and from course evaluation forms and entered it into a central database. This information was shared regularly with both the KTP associate and the KTP steering group.

Output: Development of a method to record screening and brief intervention activity. To evaluate the success of implementation, a clinical audit protocol was developed by the authors of this report.

Product: A clinical audit protocol was produced for maxillofacial clinic staff which facilitated monitoring of the implementation of screening and ABI (chapter nine).

Objective V

- To oversee the screening and ABI programme

The KTP associate worked with the central team in Public Health Wales to refine and provide materials for training days. This included managing production of the ABI and screening manuals and collating all the attendance lists and evaluation forms.

Knowledge transfer: The associate worked with Public Health Wales to deliver screening and ABI training. The KTP associate prepared a PowerPoint presentation for the WG on the evidence base for ABI including the clinical trials undertaken by Cardiff University's VSRG (appendix I).

Output: Materials compiled for each of the training events.

Product: The KTP associate, Nurse Manager Kathryn Bridgeman, Professor Shepherd and Craig Jones from Public Health Wales wrote an article on screening and ABI which was peer reviewed and published in the Nursing Times (appendix III).

Product: A database with the contact details for each of the trainees was created.

Objective VI

- To transfer knowledge to relevant personnel in the WG to support more effective implementation of health related programmes on obesity, smoking and physical exercise.

Product: A PowerPoint presentation prepared by the KTP associate on the evidence base for brief interventions across a range of settings was delivered to WG leads with a remit for delivering interventions for smoking cessation, obesity, exercise and sexual health.

Output: The KTP associate wrote a briefing paper in collaboration with Public Health Wales detailing knowledge transfer methods and practice developed from this KTP programme, which are relevant to other health and lifestyle areas.

Knowledge Transfer: The KTP Associate attended Wales-wide meetings (such as the Making Every Contact Count national meeting in Wales) alongside personnel from the WG and Public Health Wales. The KTP associate and the central team at Public Health Wales provided information on the evidence base for screening and ABI to the Consultant in Public Health, Sarah Jones for use in presentations at these national meetings.

Knowledge Transfer: The KTP Associate worked with the central team at Public Health Wales to develop a 'train the trainer' ABI course to ensure that it was evidence based. The KTP Associate attended the piloting of the training course and presented the ABI evidence base.

Output: The 'train the trainer' course was developed and piloted in the Aneurin Bevan Health Board.

Objective VII

- To contribute towards a healthier Wales

Public Health Wales supported the KTP associate in establishing contacts with relevant service delivery leads in the NHS and WG to ensure that there were regular knowledge transfer opportunities throughout the project.

Output: The KTP Associate and central team at Public Health Wales used collaborative groups in each HB to disseminate information, provide support for professional briefings and seminars and oversaw training delivery to ensure that it remained evidence-based.

Output: Development of an accessible, evidence-based training programme for allied health and community professionals under the terms of the PLA between the WG and Public Health Wales.

Output: By the end of May 2013, 2486 health and community professionals had attended the training courses (see chapter 7).

Product: Using KTP funds and drawing upon the branding expertise of the associate, a social marketing brand was developed to capitalise on the extensive training delivered. The resulting "Have a Word" brand aims to encourage those health and community professionals who have received ABI training to deliver interventions when appropriate and to raise the issue of alcohol misuse with their patients/clients. This product was not originally envisaged in the KTP work plan and therefore serves as a tangible and valuable product out-with the original KTP remit (see chapter 8).

Output: The associate worked with Professor Shepherd to produce a factsheet about the "Have a Word" brand.

Knowledge Transfer: The factsheet was sent to the Chief Medical Officer for Wales who then distributed it to her counterparts across the United Kingdom.

Objective VIII

- **To sustain the delivery of screening and ABI**

The literature on programme implementation indicates that education outreach visits, reminders, computerised decision support and patient-mediated interventions are effective (Grol and Grimshaw 2003).

Output: A sustainability strategy was developed which incorporates these elements – including recommendations for a dedicated website, social media feeds and timetable email communication with trainees.

Products:

- The Have a Word website (www.haveaword.org).
- Have a Word Twitter account (@haveaworduk).
- Dedicated Facebook page (https://www.facebook.com/pages/Have-A-Word-Campaign/296619243799823)
- Timetabled email strategy.
- Formal launch of the Have a Word campaign by the government health minister.

Objective IX

- **To disseminate knowledge and expertise**

Products:

- Book chapter: *Alcohol, maxillofacial trauma and the prevention of personal violence* in the ABC of Alcohol (forthcoming)
- Article: *Brief interventions for alcohol misuse* in the Nursing Times (December 2012)
- Article: *Having a word can help cut the dangers of alcohol* in the Western Mail (January 2013)
- Poster: *The role of the NHS in the prevention of violence and the reduction of alcohol misuse: The Cardiff Model* presented at the Cardiff and Vale UHB Inaugural Research and Development conference (June 2013).
- Poster: *Have a Word: The Welsh Model of Best Practice* presented at the 2012 INEBRIA conference (September 2012).
- Oral presentation: *The Evaluation of the Have a Word Alcohol Brief Intervention Programme* at the 2013 INEBRIA conference (September 2013).

7. Training delivery

The training programme was formally launched on 30th May 2012. Between 1st June 2012 and 30th May 2013 (the evaluation period) the training team at Public Health Wales delivered the two hour screening and ABI course to 2486 practitioners across Wales (table 1). However since delivery is on-going, over 3500 practitioners have now been trained since the programme was launched. The main groups relevant to this KTP are listed below (table 1) and figure 6).

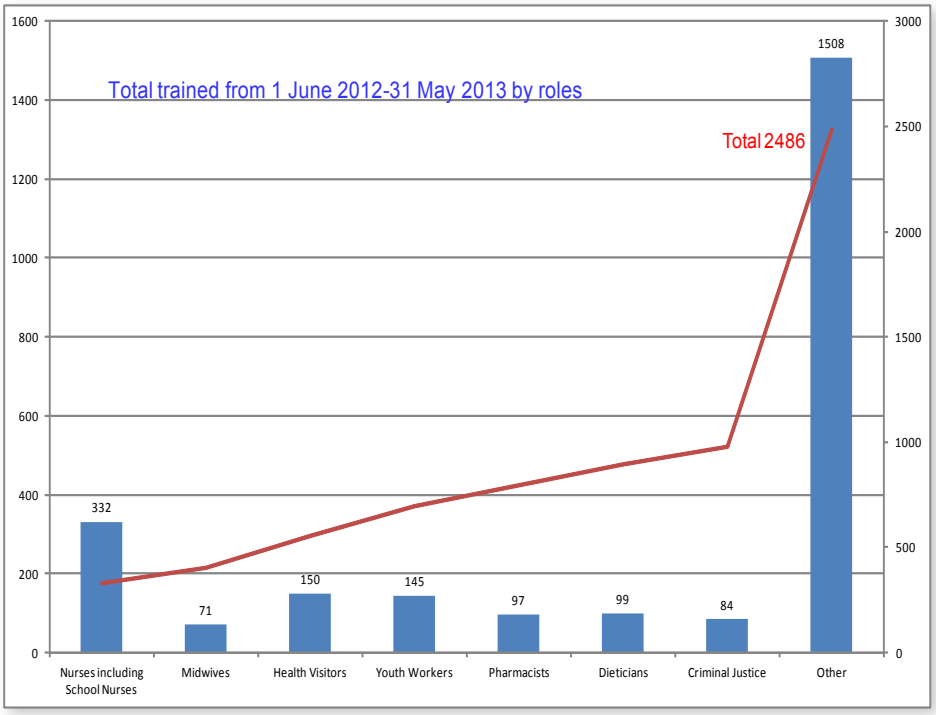


Figure 6: Total trained from 1 June 2012- 31 May 2013 by professional group

Each HB set up a collaborative group which carried out needs assessments to identify professional groups to be prioritised for training. This ensured that the national programme had local ownership. It also resulted in targeted training which meant that delivery across each HB was unique to the local context. For example midwives were prioritised in the Aneurin Bevan Health Board (table 4 and figure 7).

Health Board	Numbers Trained	Population	Numbers Trained Per Head of Population
Cardiff & Vale University Health Board	682	472,000	1 per 692
Betsi Cadwaladr University Health Board	489	688,000	1 per 1406
Hywel Dda Health Board	334	382,000	1 per 1143
Aneurin Bevan University Health Board	207	577,000	1 per 2787
Cwm Taf Health Board	280	293,000	1 per 1046
Abertawe Bro Morgannwg University Health Board	270	518,000	1 per 1918
Powys Teaching Health Board	99	133,000	I per 1343
No HB information provided	25	N/A	N/A

Table 3: Summary of training delivered by Health Board (June 2012- May 2013)

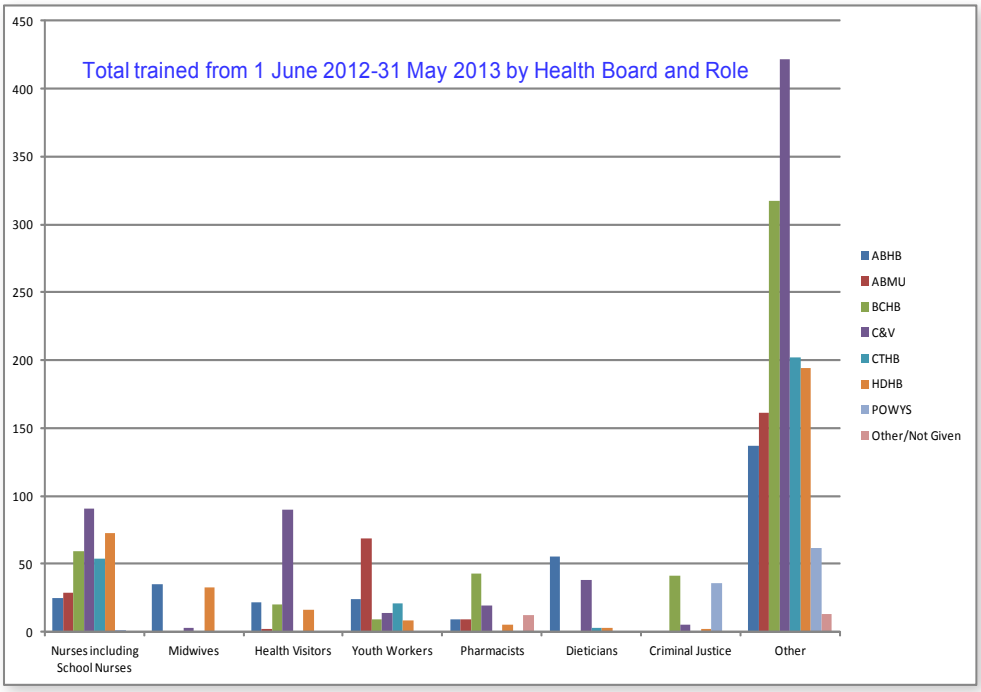


Figure 7: Total trained from 1 June 2013 – 31 May 2013 by Health Board & professional group

The delivery of training, at a national level, to over 2400 practitioners, by a team of three people, is a testament to the effectiveness of collaborative working. However, feedback from some trainees demonstrated that some practitioners did not believe the evidence of efficacy of screening and ABI. Furthermore, ABI language appeared to be technical and alien to the context in which they worked. The KTP associate, working in collaboration with the KTP Steering Group developed a social marketing brand, “Have a Word”, to overcome these barriers (see chapter 8).

8. The Have a Word Brand

The "Have a Word" brand is a unique social marketing product designed to increase the delivery of screening and ABI to people consuming alcohol at hazardous and harmful levels in order to effect health behaviour change. It was developed to overcome three specific barriers to delivery. Firstly, some professionals viewed the screening tool as additional to already busy workloads. Secondly, there was a resistance to raising the issue of alcohol misuse with patients/service users with some professionals either seeing it as none of their business or feeling hypocritical if they themselves consumed alcohol. Thirdly, the language of MI, brief interventions, cognitive behavioural approaches and other psychological terms was impenetrable and foreign to many trainees.

> ***"I want to deliver brief interventions but sometimes I don't think it is any of my business".***
> *Maxillofacial nurse, Cardiff and Vale University Health Board.*
>
> ***"I should probably remember it's just a chat isn't it? It's not rocket science".***
> *Maxillofacial nurse, Aneurin Bevan Health Board.*

It was in this context that the "Have a Word" social marketing brand was developed to manage the image of screening and ABI so that it was not seen as an added burden and also to motivate practitioners who have received training to include ABI in ordinary conversation with people identified as drinking at hazardous and harmful levels. The "Have a Word" brand aims to ensure that the delivery of the ABI is sustained over time.

"Have a Word" was launched in January 2013. The campaign, with the slogan, *Brief Interventions Work: Have a Word!* reminds health and other professionals that ABI are effective therefore provide motivation for delivery. The campaign therefore acts as a further catalyst to increase the delivery of ABI across a variety of health and community settings.

8.1 Brand development

Branding can be used as a social marketing tool to engender behaviour change (Mitchell 2002). Healey (2008) argues that anything can have a brand whether it is products, services, countries or even people. A brand is a product or service or organisation, considered in combination with its name, its identity and its reputation (Anholt 2007). A brand name identifies the product and services of a seller and serves to differentiate them from that of their competitors (Evans 1982). The brand essence of the Have a Word campaign aims to convey simplicity; ABI are simply a short conversation. Needham (2005) identifies six attributes of a successful brand:

- **Simple** – Effective campaigns present "a few high quality pieces of information". Therefore those who have received brief intervention training should not be bombarded with large amounts of information when their time is increasingly limited.
- **Unique** – the personality and attributes of the brand, the way it is conveyed. In a healthcare context there are few if any campaigns which are as succinct as "Have a Word".

- **Safe** – an effective brand is reassuring and is a guarantee of standardisation and replication. "Have a Word" can be applied to a range of different settings and highlights that brief interventions are not daunting, and that there is little new learning or additional resources required. It is simply a case of "having a word".
- **Aspirational** – evoking a particular vision of the "good life" and holding out the promise of personal enhancement based on a set of values. In this context "the good life" will mean an increase in the number of brief interventions delivered and a decrease in the number of alcohol-related injuries or other harms. This may take years to materialise. Any sustainability work should therefore highlight that brief interventions can and do make a difference in people's lives; ABI has the potential to save lives.
- **Value based** – brands symbolise the internal values of the product or company (i.e. in the NHS the values are based on patient care, harm reduction)
- **Credible** – it has to be something believable in order for people to buy into it. In order for people to alter their health habits they need to believe in their own efficacy to change these habits (Bandura 2004). Similarly those delivering ABI need to believe that the process works. Hence the campaign slogan, *Brief Interventions Work: Have a Word!*

> ***"I didn't really believe it worked when I was first involved in the trials, now having done it and seen the difference it makes, I believe in it".***
> *Nurse Manager, Aneurin Bevan Health Board.*

In order for a product or service to be successful it needs to have the belief and support of the staff involved (Mitchell 2002). Healey (2008) outlines some of the outputs from having a robust branding campaign:

- **Branding can reinforce a good reputation** – If the "Have a Word" campaign helps to increase the delivery of ABI then this will in turn have a positive impact upon the image of the campaign itself; a successful initiative which has engendered change.
- **Encourage loyalty** – If those who have received ABI training believe in the model and the essence of what "Have a Word" means they will remain loyal to it. ABI is therefore far more likely to become embedded into routine clinical practice.
- **Grant the buyer a sense of affirmation** – In this case the professionals who have the capacity to deliver ABI, to use the famous quote, "we are all in this together". Sustainability efforts should reflect this, being part of "Have a Word" means being part of an exclusive club.
- **Create a sense of (imagined) community** – Sustainability initiatives should help people to work together, share stories to inspire, examples of best practice and essentially create a peer support network.

- **Convey a perception of greater worth** – By delivering ABI professionals are not only ensuring that their work is counted but that their duty of care is extended. Have a Word can convey this sense of a greater worth; it allows for a formal recognition of their work and can provide rewards as and when appropriate.

The KTP associate worked with a marketing agency, Stepping Stones, to develop the "Have a Word" brand in order to market the Welsh ABI model as well as overcome existing barriers as outlined in this report. Focus groups were held with NHS nurses to develop the brand essence of the campaign and to ensure that slogans and images resonated with the core target audience (figure 8).

Figure 8: The Have a Word brand logo

Cardiff and Vale University HB supplemented existing KTP funds for the development of resources for the Have a Word campaign. Promotional items included branded pens, notepads, enamel badges and bi-lingual posters for use in staff areas (see appendices for poster). A formal launch in the presence of national media was held in Cardiff on 10 January 2013.

Pictured above: Professor Jonathan Shepherd, Lesley Griffiths AM and nurse manager Kathryn Bridgeman

Lesley Griffiths AM, Minister for Health and Social Services provided a keynote speech in which she voiced her support for the "Have a Word" campaign:

"Have a Word is the branding campaign for our alcohol brief intervention programme in Wales. This links with our Champions for Health project, which encourages NHS staff to become more effective role models and advocates of public health actions. We at the Welsh Government want to see the delivery of alcohol brief interventions go from strength to strength. I hope today's launch of the Have a Word Campaign will act as a springboard to further success in the delivery of alcohol brief interventions in Wales. As the slogan for this campaign states, brief interventions work, so please do have a word".

Lesley Griffiths AM, former Minister for Health and Social Services, Welsh Government.

9. Service Evaluation

Aims of the evaluation

- To examine how knowledge, attitudes and behaviour of professionals have been affected by participation in the KTP ABI training programme.
- To examine the extent to which ABI has been implemented across a variety of health and community settings in Wales.
- To gain professional views on the training programme delivered.
- To identify barriers encountered in either delivery or implementation of ABI across a variety of settings.
- To obtain insights into the perception of the Have a Word brand.
- To examine the fidelity of interventions delivered.
- To gain an understanding from professionals about how receptive patients/service users have been to the intervention.
- To make recommendations for the future development, delivery and sustainability of the ABI programme in Wales.

9.1 Protocol, methods and recruitment

A protocol was developed by the KTP associate and Professor Simon Moore at Cardiff University. In line with MRC guidelines (Craig et al. 2008), this process evaluation was designed to provide information on opportunities for programme refinement by identifying barriers to implementing ABI across a variety of settings. It also identifies key processes, impacts and outcomes. It is important to note that this evaluation is not a follow-up of patients who have received an ABI; this is an evaluation of the training delivered. Following the framework proposed by Steckler (Steckler & Linnan, 2004) and adopting a critical realistic approach (Pawson & Tilley, 1997), respondents were asked for their views on the training programme and the implementation of ABI in their specific setting.

All participants who attended the training were eligible to participate in this evaluation. Participants were sent an information sheet detailing the purpose of the evaluation, information about the KTP project and how the data provided would be used (appendix IV). Consent forms were also completed. Participating respondents were interviewed via telephone, face-to-face or in groups. Where consent was given, interviews were recorded, transcribed and thematically analysed. Sampling continued until data saturation was achieved.

Eligible participants were selected from settings where at least one person who attended training had indicated an interest in taking part in the evaluation. Participants were sampled according to the following stratification model (figure 9)

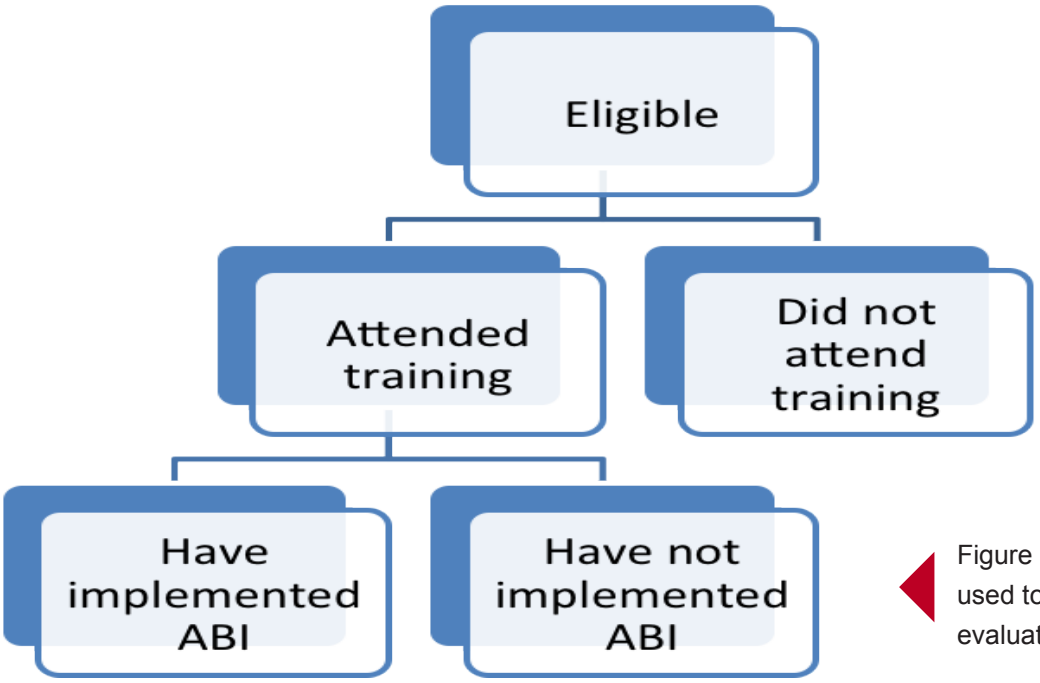


Figure 9: Sampling strategy used to identify participants for evaluation

Participants were sampled by HB and occupational group. Since the specific remit of the KTP places emphasis on trauma and maxillofacial nurses, qualitative interviews were focussed in this area. However under the PLA to which Public Health Wales and the KTP associate have been working, interviews were also conducted with professionals in other health and community settings.

9.2 Ethical considerations

This project was considered by the KTP steering committee to be low-risk. There was the possibility that participants risked revealing personal information about patients; however, during the evaluation process this did not happen once. In the case that such an issue had arisen the associate would have reminded participants that the focus of the evaluation was their professional opinion and not on patients or service users. There was also the possibility that respondents might reveal that they would like support with their own alcohol consumption. Again, this did not happen. However, if it had done the appropriate signposts to access services would have been provided. Respondents were only identified by their profession and locality and are not named.

9.3 Data collection methods

9.3.1 'Quick Eval' forms

Each professional who attended ABI training was asked to complete a short, five-question evaluation form. Themes covered included training content, the impact of training upon the individuals' understanding of alcohol misuse issues, the practical application/delivery of ABI, and the performance of the trainer (appendix II)

9.3.2 Follow-up telephone interviews

Ewles and Simnett (2005) assert that changes in behaviour and practice can be assessed by maintaining regular records. Those who had received ABI training were followed up by the central team in Public Health Wales at 1,3,6 and 12 month intervals. To achieve high response rates, up to three attempts to contact each trainee at each time point were made. In the event of a missed call, where possible a voicemail message was left informing the participant of the reason for the telephone call. The timescales used allowed comparisons to be made and also to allow for a pragmatic approach to delivery since not all professionals will have had the same opportunities to deliver ABI in the immediate phase following training.

9.3.3 Audits

A retrospective audit was conducted to assess the implementation of screening and ABI in a maxillofacial/trauma clinic setting. Data were collected for a five month period. Numbers of patients screened using FAST and the numbers of patients who received an ABI were calculated. This audit highlighted barriers and facilitators to delivery and implementation of screening and ABI in a clinical setting.

9.3.4 Fidelity checks

Clinical observations were carried out by the KTP associate in maxillofacial clinics in all seven HBs to ensure that ABI delivered by nurses included the FRAMES elements (feedback, advice, menu of options for reducing consumption, empathy and self-efficacy). In addition, the strategies used were recorded; exploring concerns, highlighting positive and negative aspects of excessive alcohol consumption, using stories to motivate patients to adopt lower risk drinking patterns and providing feedback about the injury.

9.3.5 Qualitative interviews

Qualitative research is appropriate when investigating experiences and exploring attitudes (Morse and Field, 1995) and it therefore a suitable method for examining attitudes to screening and ABI. It can also provide an overview of implementation. Kvale (1996) defines qualitative research as “attempts to understand the world from the subjects’ point of view, to unfold the meaning of peoples’ experiences”. Qualitative methods therefore provide an opportunity to explore the intangible in a way in which quantitative methods would be unable to do. Interviews are a powerful tool in research due to “expressive power of language” which can help to describe, explain and evaluate (Ritchie 2003). The interviews were designed to allow the respondent to give their full opinions as possible to allow some flexibility and scope to bring in new ideas and angles. This has worked well for researchers such as Lupton et al (1992) who wrote “interviewees themselves raised additional or complimentary issues, and these form an integral part of the study’s findings” (cited in Bryman 2004). However the key themes relating to screening and ABI were central to this evaluation so some guidance and structure was necessary in order to keep the interview focussed.

36 semi-structured interviews were conducted with both frontline professionals with an opportunity to deliver ABI and key informants from the WG and Public Health Wales who held national roles relating to ABI. Respondents therefore represented a range of both ABI strategy and operational delivery of ABI across a number of sectors. All seven HBs in Wales were represented. The qualitative methods used for this evaluation captured the views of practitioners in relation to the training received and the barriers and facilitators to delivering ABI.

9.4 Results

9.4.1 'Quick Eval' forms

Data from evaluation forms completed by trainees immediately after attending training were collated by the central team in Public Health Wales. They were organised as monthly data sets which were aggregated to provide summaries for each question. Of the 2486 people who attended training between 1 June 2012 and 31 May 2013, 2351 completed the evaluation forms (95% response rate); 135 abstained. Of the trainees, 84% felt that their understanding of ABI and its application had increased (figure 10) and 77% felt either confident or very confident that they would be able to deliver ABI (figure 11). Almost all (90%) of trainees believed ABI to be an important part of reducing alcohol misuse at a population level (figure 12) and 84% believed that ABI would be utilised within their respective profession (figure 13).

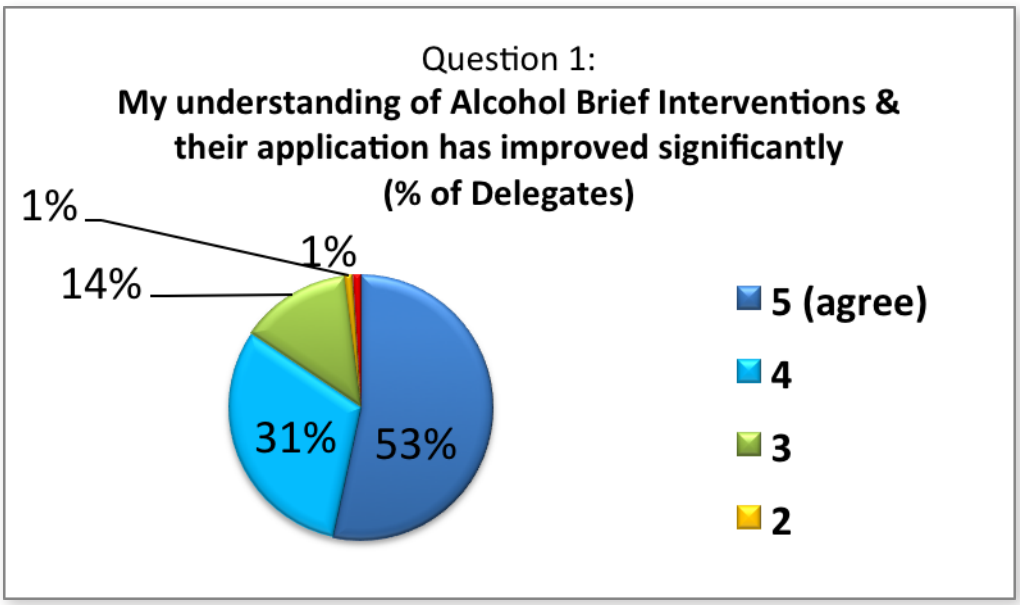


Figure 10: Responses for question one on the evaluation form

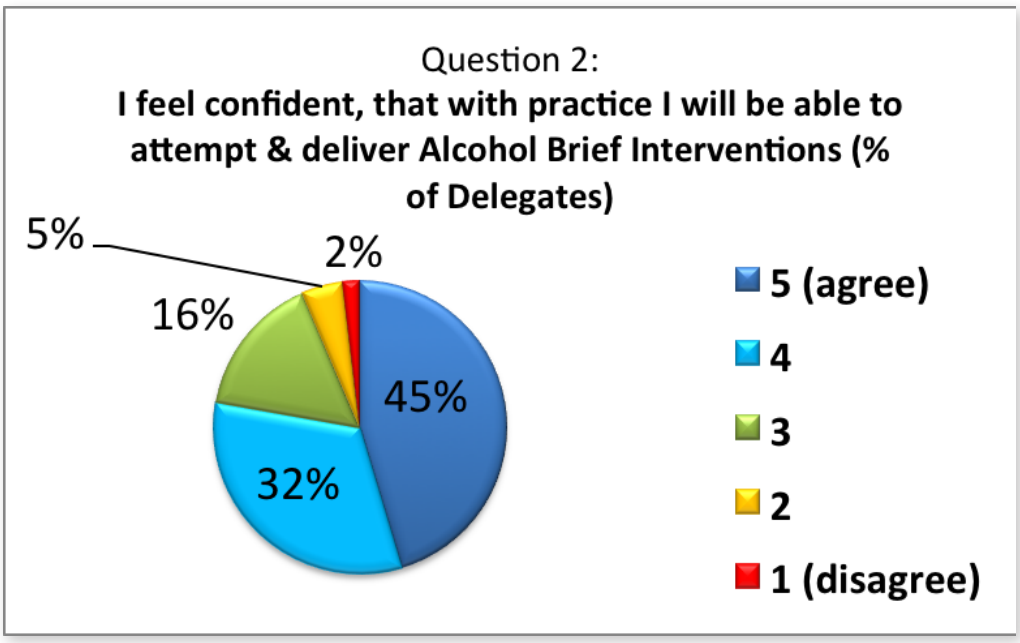


Figure 11: Responses for question two on the evaluation form

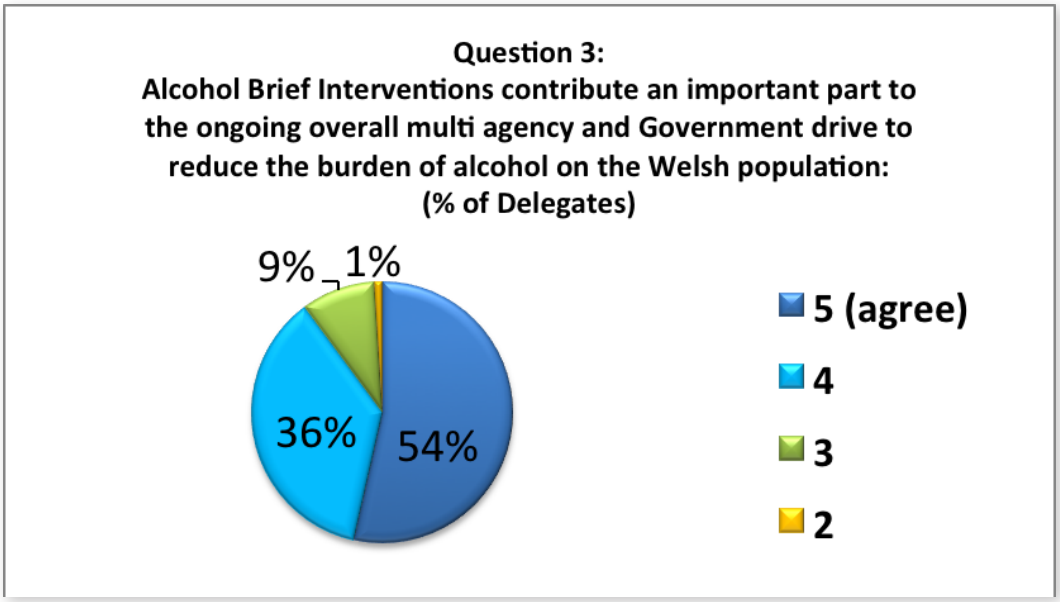


Figure 12: Responses for question three on the evaluation form

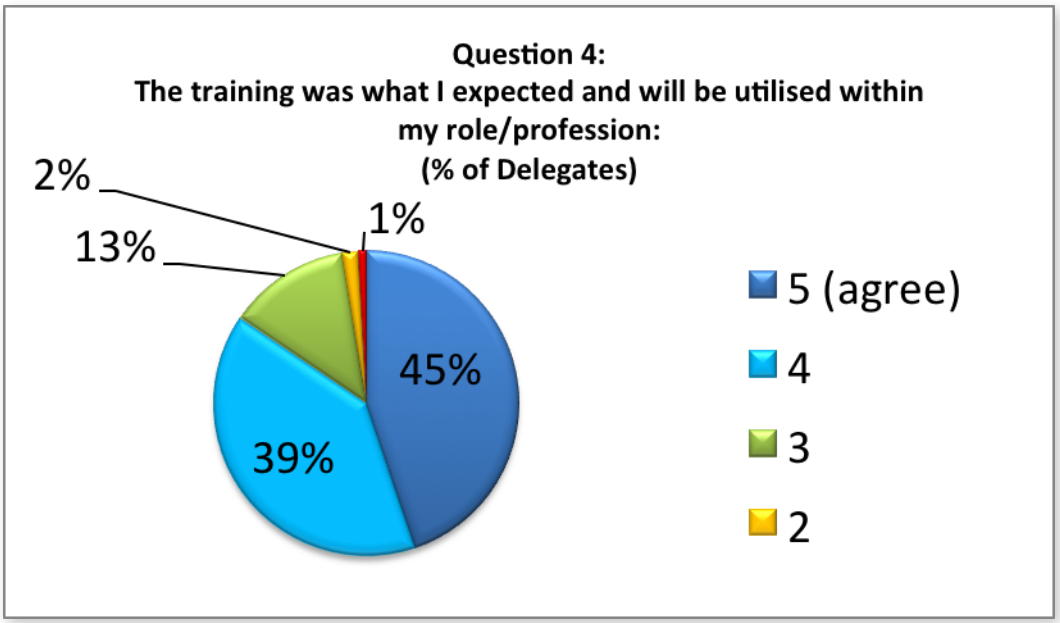


Figure 13: Responses for question three on the evaluation form

Attendees were also asked to describe the ABI course and trainer in one word each. These words were then put into tag or word cloud which is a visualization of word frequency in a given text as a weighted list. Tags are usually single words, and the importance of each tag is shown with font size or colour. The majority of the words used to describe the training course included “informative”, “good”, “useful”, “interesting” and “excellent” (figure 14). Trainers were described as “knowledgeable”, “enthusiastic”, “excellent”, “good”, “interesting” and “informative” (figure 15).

Figure 14: Word cloud to describe the training course

Figure 15: Word cloud to describe the trainer(s)

9.4.2 Follow-up telephone interviews

Evaluating ABI delivery was an area that presented significant challenges. Options considered by the KTP steering committee included asking each practitioner to log delivery of ABI. However this was impractical since it relied on self-reported data and busy workloads meant recording was either missed or forgotten as the sKTP demonstrated. The KTP steering committee therefore adopted a more pragmatic evaluation protocol whereby instead of measuring how many ABIs a practitioner had delivered, a simple question asking if ABIs had been delivered at all was used instead. In the KTP work plan, there was no target for numbers of ABIs delivered and whilst these data would have been useful, it was not possible to robustly collect them in the range of settings and professional groups that they were being used.

Respondents were contacted three times in total by the central team in Public Health Wales. Response rates varied by professional group, as did the delivery of ABI (table 5). It appears that low response rates are linked to low ABI delivery. Youth workers had a high response rate, of which 59% went on to deliver screening and ABI, whereas this was true of just 7% of pharmacists who had one of the lowest response rates (table 5).

PROFESSIONAL GROUP	NO. TRAINED	RESPONSE RATE	ACTUAL NO. RESPONDING	% DELIVERING ABI
Youth Worker	145	64%	93	59% of total **93% of responders**
Midwife/ Health Visitor	221	55%	122	43% of total **77% of responders**
Dietician	99	23%	22	15% of total **68% of responders**
Pharmacy	97	18%	17	7% of total **38% of responders**
Criminal Justice	84	41%	34	32% of total **78% of responders**
Nurses (including Maxillofacial)	332	45%	149	38% of total **83% of responders**

Table 5: Delivery of ABI by professional group

9.4.3 Audits

The implementation of screening and ABI in the maxillofacial trauma clinic in the University Dental Hospital of Wales over five months (01/08/12-31/12/12) was audited. 148 patients met inclusion criteria, of whom 68.9% (n=102) were screened using FAST when they attended for suture removal. Of those who scored positive for alcohol misuse on the FAST (a score of 3 or higher) 94.9% (n=75) received ABI. (table 6).

Month	% Screened with FAST	% Screened not screened
August	67.9%	32.1%
September	52.0%	48.0%
October	93.1%	6.9%
November	86.7%	13.3%
December	47.8%	52.2%
Total	**68.9%**	**31.1%**

Table 6: Table to show percentages of patients screened with FAST for each month

The following information was gathered from each clinic

1. The number of patients attending each clinic
2. The number of patients screened using the FAST tool in each clinic
3. The number of patients who scored positive on FAST (>3)
4. The number of patients who received brief intervention
5. The name of the nurse who delivered the brief intervention
6. Reason for FAST screen or brief interventions not being delivered

Information was taken from audit forms completed by the nurse on duty. 12 clinics were not included in the study, 5 because no data were available and seven because no patients attended for suture removal. A total of 170 patients were seen, 148 of which met the inclusion criteria. In total 68.9% of patients attending clinics were screened using FAST (table 6).

9.4.5 Fidelity check findings

The KTP associate observed nurses whilst they delivered screening and ABI to ensure that the strategies used complied with FRAMES. The results of these clinical observations are outlined below (tables 7-9).

FRAMES	Observed
Feedback	“You scored 8 on the FAST, that’s pretty high”
Responsibility	“I keep telling my son, you only get one face”
Advice	“Think of how many drinks it takes you to get tipsy, when you reach that point have a break”
Menu of options	“Rounds are the worst, they’re expensive and you drink twice as much, twice as fast”
Empathy	“We’ve all be in a state at one time or another”
Self-efficacy	“You’re lucky, the scar will heal nicely, we don’t want to see you back here”

Table 7: Clinical observation at University Dental Hospital of Wales, Cardiff

FRAMES	Observed
Feedback	"You've got a nasty gash there, what happened?"
Responsibility	"When you're drunk people forget that they're much more likely to be a victim"
Advice	"When I see trouble I try and steer clear"
Menu of options	"When it's your round buy a soft drink, people won't notice that you're not on the vodka"
Empathy	"The scar is in your eyebrow so by the time Christmas comes your mum won't notice, you've had a lucky escape"
Self-efficacy	"You're a good-looking lad, you don't want to end up looking like a boxer!"

Table 8: Clinical observation at the Royal Gwent Hospital, Newport

FRAMES	Observed
Feedback	"That's a lot of alcohol all in one go"
Responsibility	"Do you think the argument would have happened without the booze?"
Advice	"If you cut down on drinking you'll have more money"
Menu of options	"Try going for a single instead of a double"
Empathy	"There are lots of good things about alcohol as well as bad"
Self-efficacy	"Give it a try and see how you get on"

Table 9: Clinical observation at the Prince Charles Hospital, Merthyr Tydfil

9.4.6 Semi-structured interviews

- **Views on access to and utility of the ABI training programme**

Practitioners were overwhelmingly positive about the two hour course. This reflected the opportunity this gave them to attend. Managers commented that whilst previous training programmes had been useful, there were many wasted opportunities due to staff being unable to attend at late notice.

participation from each HB area

"A two hour course is far more practical from a clinical perspective; we can't have nurses going off all day. With this shorter course they [nurses] can get the basics and be back on the clinic before lunch."

Nurse Manager, Aneurin Bevan Health Board.

"I attended the course in the piloting stage when it was 90 minutes. That was too short, it felt rushed. Two hours is a nice time and it means that you can learn the main points without losing concentration".

Maxillofacial nurse, Cardiff and Vale University Health Board.

"The training was great, I found the more relaxed approach easier. I really didn't like role play. What might be good in future is if you showed us a video of what a brief intervention looks like. I knew because I had been on the previous training but others might not know as much as me".

- **Views on implementing ABI in a clinical setting**

Practitioners were generally positive about implementing ABI in a clinical setting. In many cases, nurses, in particular, expressed the view that one of their roles was health promotion and that raising the issue of alcohol misuse was therefore part of their role. Time continues to be seen as a pressing factor relating to the implementation of ABI.

"Since the training I have been delivering ABI when and where appropriate. I do try to speak to everyone about alcohol misuse but it depends on the context. For example someone might be coming in to the clinic after being treated for oral cancer, I don't think I should then raise the issue of drinking"

Maxillofacial nurse, Aneurin Bevan Health Board

"Initially there was some grumbling that it was yet another demand on existing workloads but when it was explained in training that a brief intervention was an opportunistic chat the nurses seemed to be more receptive to the idea. I certainly encourage my staff to have that discussion with patients"

Nurse Manager, Abertawe Bro Morgannwg University Health Board

"I don't feel comfortable talking about alcohol to be honest. I don't drink myself and when I've raised the issue of alcohol in the past patients think I am judging them. My priority is wound care"

Maxillofacial nurse, Cardiff and Vale University Health Board.

"It takes time for a cultural shift to happen but we really shouldn't see this as additional work. I don't see taking someone's blood pressure as additional, it's part of my job, it needs to be done. I think alcohol interventions should be seen the same way really"

Maxillofacial nurse, Aneurin Bevan Health Board

- **Barriers to effective ABI delivery**

During interviews practitioners identified barriers to delivery of ABI. Saturation point was reached very early on, within the first six interviews the same themes emerged; difficulty engaging with the FAST, time constraints and a lack of certainty that ABI delivery actually worked since there was no opportunity to discuss this with the patient at some later time.

"The FAST tool is burdensome, there was confusion about who should get it, who takes charge, even a five year old boy was given one once. People also know when they're being scored, they go on the defensive and most of the time

I think they lie, knock off a few drinks, I know I would if someone asked me how much I drank"

Nurse manager, Aneurin Bevan Health Board

"Definitely the screening tool is a problem, faffing around with paperwork, we have enough of that already. Anyway people aren't stupid, they can tell when they're being scored at a higher level and will adapt their answers accordingly"

Maxillofacial nurse, Betsi Cadwaladr University Health Board

"I find it disheartening to be honest, that you can't measure the impact. That's the frustrating thing for me as a nurse, you can't measure how effective you've been as you don't follow the patient when they've gone".

Maxillofacial nurse, Aneurin Bevan Health Board

"I saw one guy more than once, it made me feel like a failure as my intervention hadn't worked the first time. I still did one though, second time lucky"

Maxillofacial nurse, Abertawe Bro Morgannwg University Health Board

"Talking in units doesn't help, people don't understand it. I try to talk in terms of drinks, pints, glasses and so on. When I quickly calculate how many units this is and feed it back the patients are shocked, they didn't realise how much they are drinking. People have heard of units but they don't know how this translates into reality. To be honest I didn't until I went to your training"

Maxillofacial nurse, Aneurin Bevan Health Board

"I don't find the FAST too much trouble really since alcohol is an expected question, I slip it into my booking-in forms. It's not usually the pregnant women drinking but their partners. If I can reach them too then that's only a good thing"

Midwife, Aneurin Bevan Health Board

"Health promotion is of course important but we are also a business, delivering interventions puts us in a bit of an awkward position especially if there isn't any private areas to have that conversation".

Pharmacist, Powys Teaching Health Board

- **Fidelity of the intervention**

The KTP associate found that the vast majority of ABI deliveries followed the FRAMES format. In interviews practitioners were asked about this and shared the technique they used as well as their feelings about their own self-efficacy and belief that ABI has an impact.

"You have to rely on the evidence and have faith that it works, it's a leap of faith really"

Maxillofacial nurse, Aneurin Bevan Health Board

"When I first became involved in brief interventions I was completely cynical. I didn't see how a chat could lower a person's alcohol consumption. Then I saw it with my own eyes, the person reflects on their behaviour. In order to deliver nurses need to believe it works, that's why I reinforce this idea with my staff"

Nurse Manager, Cardiff and Vale University Health Board

"When they're in denial about how much you drink, that's when you hit a bit of a wall, that's when you decide how to play it. You could play on the town being a dangerous place, advise them to keep their wits about them, generalise around it. I make up stories about friends of friends. This means that I can deliver the intervention but in a non-personal way so that they don't feel judged"

Maxillofacial nurse, Aneurin Bevan Health Board

"I use whatever strategy works, vanity is one option. People are so fashion conscious and vain now. I play on the impact that their injury has had on their image, that seems to work"

Maxillofacial nurse, Cardiff and Vale University Health Board

"The use of humour lightens the atmosphere, it doesn't make them feel judged. I tell them that I drink myself, I try to bring in a bit of personality into it. I make jokes like 'Too much water was it? I find it puts them at ease and then they have more chance of taking in what you're saying"

Nurse Manager, Abertawe Bro Morgannwg University Health Board

"I try to keep FRAMES in mind, it helps me to remember that you need to relate the injury to the alcohol and give them advice in a friendly way. It depends very much on the context, if the patient isn't up for talking then I don't force it. The specific hook I go for depends on the person, vanity and calories is one perhaps for the younger people and long-term health for older. It's a generalisation I know but seems to work".

Maxillofacial nurse, Aneurin Bevan Health Board

- **Patient receptivity to ABI**

The sKTP report highlighted that some practitioners were hesitant to raise the issue of alcohol consumption due to the perception that patients will react negatively. This was discussed with respondents and remains an issue which impacts on delivery of ABI. However the vast majority of interviewees stated that they attempt to approach the subject and use an exit strategy if appropriate, as advised on the training course.

"Only once someone took offence. I didn't pursue it since I felt quite threatened to be honest"

Maxillofacial nurse, Aneurin Bevan Health Board

"I think they do take it on board if they're embarrassed, you have to play it down though so that they don't feel lectured. You'll always get the ones that don't care, they're even proud of it. I find the most difficult ones are when the parents are there, it's so difficult to talk about alcohol in front of them"

Maxillofacial nurse, Cardiff and Vale University Health Board

"Patients often ask me about scarring and if it's permanent. I use that as my in-road to talk about alcohol. One girl got into a fight at a taxi rank, I turned the situation around and asked her if she would have been in that position if she was sober. It made her realise that it was the drink that contributed to that situation"

Maxillofacial nurse, Aneurin Bevan Health Board

"Nurses need to get over this fear about patient reactions. They can ask practically any question about the body whether it's erectile dysfunction or bowel movements and yet they won't ask about alcohol. I think the tide is turning, look at the way smoking was viewed – it used to be personal choice and now it's seen as a health issue. Alcohol will hopefully go the same way, but it will take time"

Substance Misuse Liaison Nurse, Cardiff and Vale University Health Board

"Would we be saying this about smoking though? It's a cultural issue, one which we need to get used to discussing. Cot death is an example. We never used to talk about it. This will change as alcohol moves up the agenda"

Health Visitor, Cardiff and Vale University Health Board

9.5 Discussion

From the findings, the training delivered has had a positive impact on attitudes and knowledge of practitioners with regards to ABI. Data from course evaluation forms suggests that knowledge and awareness of alcohol misuse improved along with understanding that ABI has an important role in reducing alcohol related harm. 77% of trainees felt either confident or very confident that they would be able to deliver ABI; only 7% expressed a lack of confidence. Almost all (90%) of trainees believed ABI to be an important part of reducing alcohol misuse. There is also strong evidence that practitioners continue to develop their ABI skills after attending the training course as further opportunities to deliver ABI arise.

Delivery rates varied according to professional group and the picture is arguably distorted due to the varying response rate. Of the professional groups trained, nurses, youth workers and midwives were the most responsive and had the highest rates of ABI delivery. Those with the lowest response rates, pharmacists for example, had the lowest levels of delivery. Non-respondents were classified as not delivering ABI. However, this may not necessarily tell the full story. Recent anecdotal evidence presented by collaborative groups to the central training team at Public Health Wales suggests that some practitioners who received training have not yet been presented with an opportunity to deliver ABI but are willing to do so should the opportunity arise. There appears to be a social norming effect in that those who responded appeared to be far more likely to state that they had delivered ABI. With regards to midwives and health visitors, there was a much higher response rate in Cardiff and Vale and Aneurin Bevan HBs where the collaboratives prioritised the training of these professionals. This indicates that local management has an important impact on the sustainability of delivery of ABI. Dieticians already deliver motivational behavioural change interventions in which alcohol use is included. This might explain the low delivery rates of ABI by dieticians in this evaluation. Resistance to delivery of ABI on the part of pharmacists seems to reflect concerns that this might harm their business. However, the recent focus on drug reviews may be a new opportunity to provide lifestyle advice.

The maxillofacial clinic audit found that 94.9% (n=75) of patients that scored 3 or higher on the FAST received an ABI. No patients arrived for suture removal at six clinics. This reflects that their GP surgery delivered suture removal rather than the maxillofacial clinic. This emphasises the importance of targeting ABI training and delivery to suit local circumstances. In the Betsi Cadwaladr HB, practice nurses have been trained in ABI therefore minimising the risk that

hazardous and harmful drinkers will not be identified and advised on their alcohol misuse. The audits showed that when the usual administrative support and clinical nurse are not available screening and ABI are not delivered as regularly. This suggests that further on-going support is required from the central team in Public Health Wales to ensure that screening and ABI delivery is sustained.

This evaluation shows that practitioners have developed personal methods/techniques when delivering screening and ABI. The main barriers to delivery reported by respondents included time, screening tools and patient interaction. There was a widely held belief amongst respondents that a culture change was needed amongst practitioners so that discussions concerning alcohol consumption were not seen as intrusive or additional work. In this context it is interesting to note the responses from some nurses equating blood pressure measurements with "additional work". It was generally accepted by respondents that alcohol misuse is a risk to health and that ABI should no longer be seen as an additional, optional measure for combatting alcohol misuse. Rather, it should be seen as core work.

The FAST posed the most significant challenges for practitioners. The vast majority of respondents reported that it was burdensome and that patients were not wholly truthful when completing FAST forms. They also viewed it as prompting patients to be defensive when nurses raised the topic of alcohol consumption. In place of the formalised FAST, nurses sometimes reported screening patients verbally, using FAST questions, as part of a routine conversation. This approach has led to more sustainable delivery since nurses felt more comfortable and, in addition, reduced their paperwork.

"I do not feel comfortable using the FAST tool. I can deliver brief interventions without it and find patients more responsive without using the FAST tool"

Maxillofacial nurse, Aneurin Bevan Health Board.

On the other hand some professional groups used the screening tool as a way to raise the issue of alcohol consumption with patients and service users. Midwives reported that the form has been incorporated into the routine paperwork for new patients and that since alcohol is an expected question, there is less reluctance to raise the issue. Overall this evaluation suggests that as long as conversations with patients include FAST questions and that action is taken if the threshold for alcohol misuse is reached, then there is no need for a paper-based FAST.

Since ABI training has been delivered in the two hour course format, there has been a high demand to attend. This is partly due to the local HBs playing a leading role as part of collaborative groups but also due to the nature of the course itself. The high numbers of trained, over 3500 at the time of writing, representing one person for every 1000 people in Wales, highlights the continuing demand for ABI training across the country. There is also anecdotal evidence that providers of specialist treatment for alcohol dependency are experiencing an increase in demand in their locality in the immediate period after training has been delivered. This suggests that those who attended the training are delivering and where appropriate referring clients and service users to appropriate support.

Public Health Wales are currently investigating this with third sector organisations with a view to developing a more robust evidence base for the future.

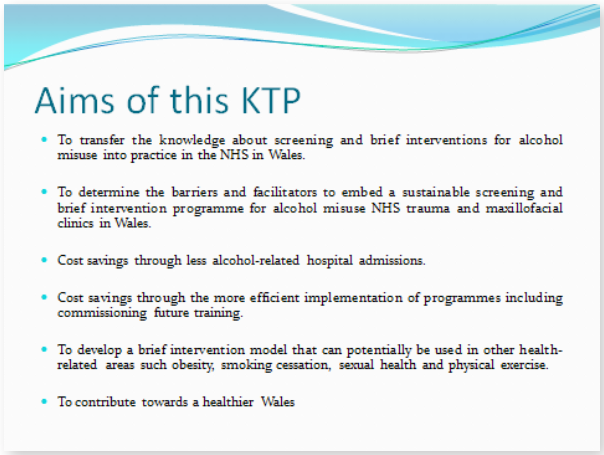
9.6 Strengths and limitations of this evaluation

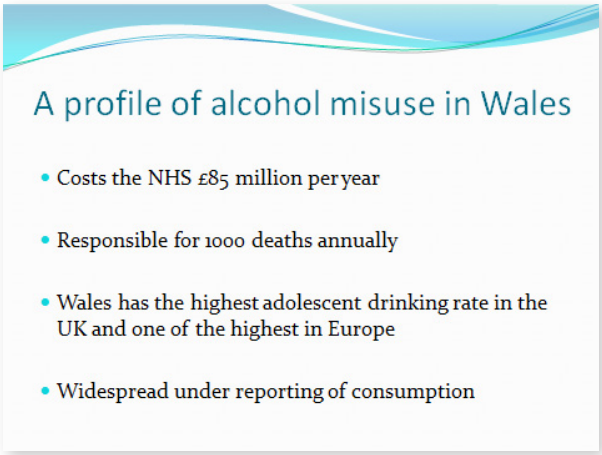
This evaluation focusses on ABI delivery rather than efficacy of screening and ABI. Readers wishing to understand effectiveness are referred to published reports of clinical trials (RCTs). Major strengths of this evaluation are the very high post-course questionnaire completion and the rich qualitative data obtained from semi-structured interviews. However, there are also some limitations to this evaluation. Many of the practitioners who attended the training had received previous ABI training as part of the sKTP and RCGP programmes. Therefore, their responses may reflect the success or otherwise of this prior experience rather than provide a measure of impact of this ABI programme. The varied response rates concerning follow-up telephone interviews impacted upon qualitative data collected but since the data saturation point was reached, this does not constitute a serious limitation. Overall, this evaluation provides a unique insight into the realities of implementing health promotion interventions across a range of health and other settings.

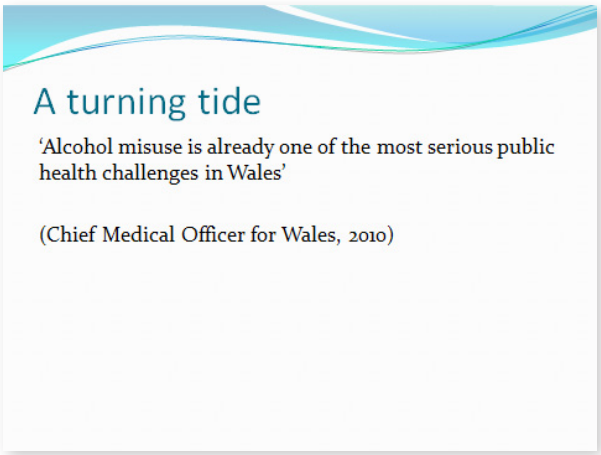
10. Appendices

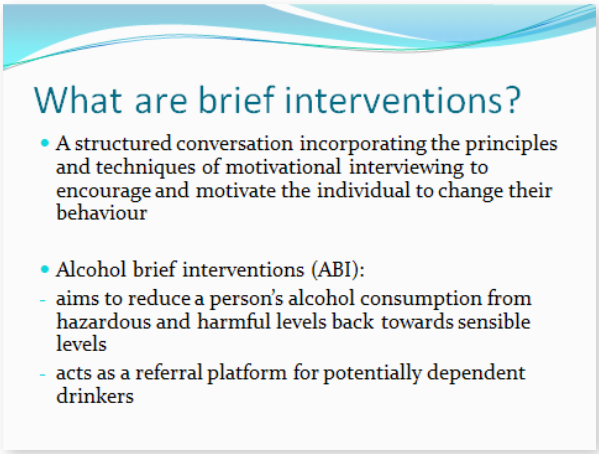
Appendix I

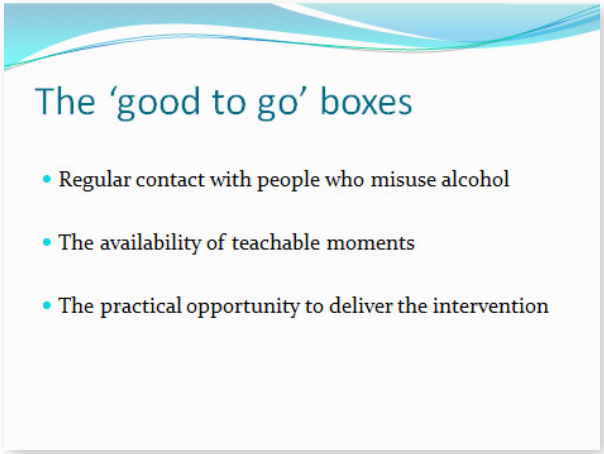
Presentation on evidence base for ABI across a range of settings











The 'teachable moment'

- The moment in time when a person is faced with the consequences of their actions
- The critical time when a person is most likely to be open to the idea of change

Motivational Interviewing

F	R	A	M	E	S
Feedback -Tell the person what they scored -Link their drinking to the situation - Be realistic! Cut Down not Cut Out	**Responsibility** -It's the individuals' own responsibility to change their habits - You're responsible for info and advice	**Advice** -Set a daily (& weekly) limit -avoid the strongest drinks - Reduce daily drinks + alcohol free days	**Menu** -Give them a range of options	**Empathy** -Empathic -Non Judgmental	**Self-Efficacy** -Positive message -Boost their self confidence - " you can do it"

Bien, T. H., Miller, W. R. and Tonigan, J. (1993) Brief interventions for alcohol problems: a review. Addiction 88, 315–336.

Brief interventions work!

56 controlled trials indicate that for every **eight people** who receive simple alcohol advice, **one** will reduce their drinking to within lower risk levels

Brief interventions can be undertaken as part of routine clinical practice and are therefore both effective and cost effective

The Welsh ABI programme

- Launched in May 2012
- Over 1700 healthcare and community workers trained by a small team of three
- Condensed, manageable two hour training course as a result of KTP collaboration
- Holds a formal qualification (Agored Cymru Level 4, Royal College of Nursing Certified)
- Currently being evaluated

Can we Have A Word elsewhere?

- Evidence base for brief interventions in other health and lifestyle settings is not as strong compared to alcohol misuse intervention trials
- Smoking cessation: 31 out of 42 studies demonstrated that interventions increased the likelihood of quitting (Cochrane Review 2009) 40-60% of people who received BI attempted to quit smoking (Aveyard et al 2011)

  NNT for smoking cessation is 1 in 20 but is cost-effective (Law et al 1995)
- BI/MI effective in HIV risk reduction and safer sex (Carey et al 1997, Belcher et al 1998)

Can we Have A Word elsewhere?

- Physical activity: MI and BI approaches can facilitate the uptake of exercise (Butterworth et al 2006) however other studies have shown that it is an ineffective approach (Hillsdon et al 2002)
- Healthy eating: BI resulted in increased readiness to change for binge eating compared with the self-help-only (Dunn et al 2006). Motivational interviewing interventions increase adherence to weight-loss programmes (Smith et al 1997)

Moving forward

- Can we adapt the Have A Word model to work in your specific area?

- Teachable moment
- Regular contact
- Practical opportunity

- FRAMES

Thank you

For further details about Knowledge Transfer Partnerships please contact:

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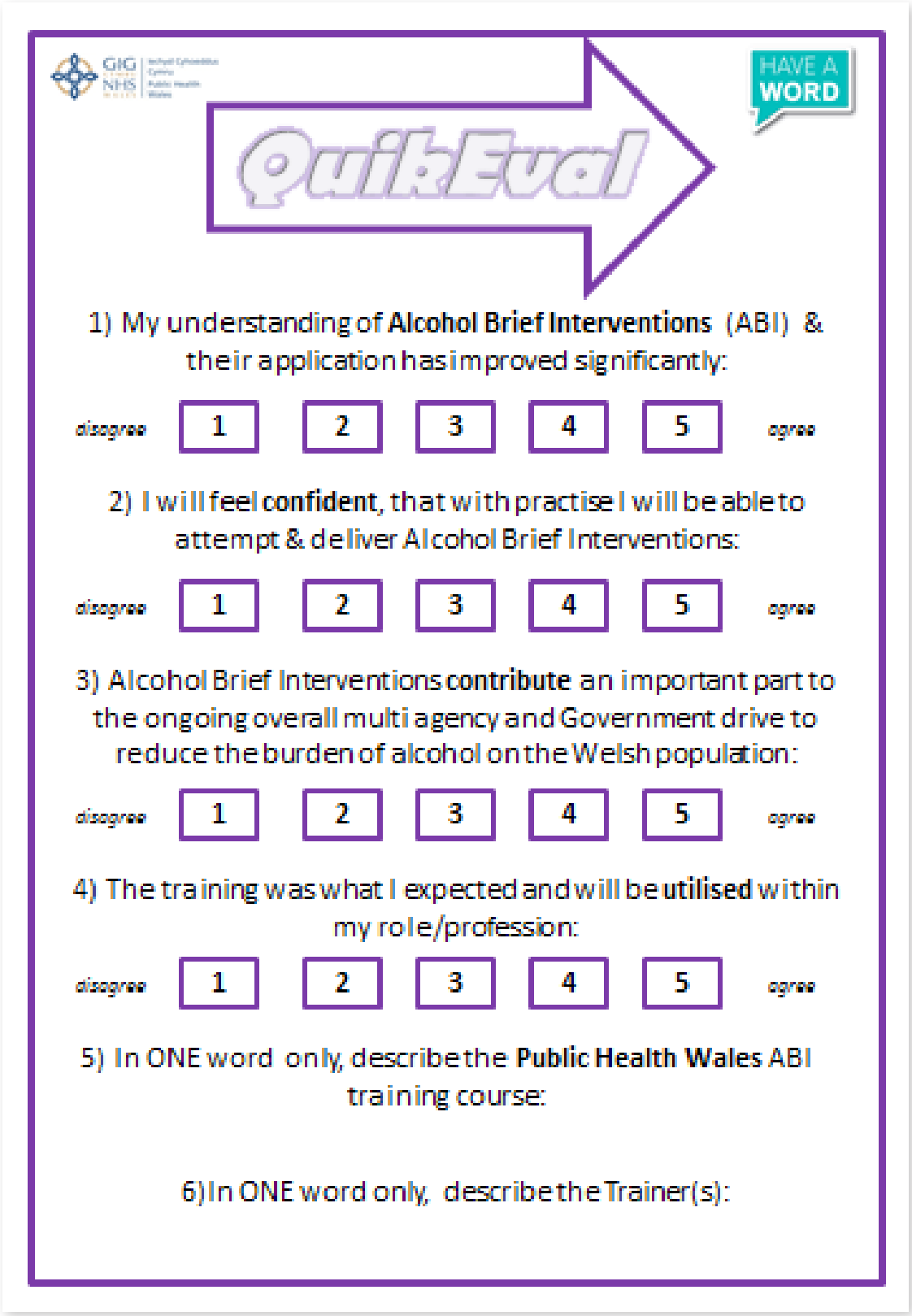
Appendix II

Course evaluation form



QuikEval

HAVE A WORD

1) My understanding of **Alcohol Brief Interventions** (ABI) & their application has improved significantly:

disagree 1 2 3 4 5 *agree*

2) I will feel **confident**, that with practise I will be able to attempt & deliver Alcohol Brief Interventions:

disagree 1 2 3 4 5 *agree*

3) Alcohol Brief Interventions **contribute** an important part to the ongoing overall multi agency and Government drive to reduce the burden of alcohol on the Welsh population:

disagree 1 2 3 4 5 *agree*

4) The training was what I expected and will be **utilised** within my role/profession:

disagree 1 2 3 4 5 *agree*

5) In ONE word only, describe the **Public Health Wales** ABI training course:

6) In ONE word only, describe the Trainer(s):

Appendix III

Nursing Times article

Nursing Practice
Innovation
Substance misuse

Keywords: Alcohol misuse/Drinking/Maxillofacial/Brief intervention/FAST/FRAMES
•This article has been double-blind peer reviewed

Brief interventions – "having a word" at the right time – can be effective in making people reconsider their drinking behaviour and cut their alcohol intake significantly

Brief intervention for alcohol misuse

In this article...

- Alcohol misuse and its growing impact on the NHS
- Why brief intervention by nurses works
- How best to "have a word" with patients about alcohol

Author Kathryn Bridgeman is nurse manager at Cardiff University Health Board; Jonathan Shepherd is professor of oral and maxillofacial surgery and director of the Violence Research Group at Cardiff University; Paul Jordan is knowledge transfer associate at Cardiff University; Craig Jones is senior health promotion practitioner at Public Health Wales.

Abstract Bridgeman K et al (2012) Brief intervention for alcohol misuse. *Nursing Times;* 108; online issue.

Alcohol consumption has increased by over 19% in the UK over the last 30 years and alcohol-related conditions now cost the NHS over £2.7bn annually.

A randomised controlled trial undertaken in maxillofacial clinics has shown that brief interventions delivered by nurses result in significant reductions in alcohol consumption in the long term. The Royal College of Surgeons, endorsed by the Royal College of Nursing, recommends that screening and brief interventions for alcohol misuse should be adopted as a routine part of clinical practice.

Brief interventions – "having a word" in a structured format – are cost effective and could save health and social service providers £124.3m in England alone over the next 30 years. This article describes how a programme of nurse-led screening and brief interventions is being rolled out in maxillofacial and trauma clinics across Wales.

Alcohol consumption has risen by 19% since 1980, and a quarter of England's adult population now drink at hazardous levels. Alcohol-related conditions cost the NHS £2.7bn annually (Department of Health, 2008). Alcohol misuse has been identified as the third most important risk factor for ill health in Europe after tobacco use and high blood pressure (Gartner, 2009).

Over the past 10 years there has been a steady rise in alcohol-related hospital admissions in the UK. For example, in Wales between 1999 and 2009, the rate of hospital admissions directly attributable to alcohol misuse rose from 327 to 449 per 100,000 in men and from 172 to 236 per 100,000 in women, while alcohol-related health problems cost the NHS in Wales £70m-£85m per year.

Sensible drinking guidelines

Current recommendations are that women should not regularly (most days or every day) drink more than 2-3 units of alcohol a day; that equates to no more than a standard 175ml glass of wine a day, with two days per week without alcohol. Men should not regularly drink more than 3-4 units of alcohol a day, equating to not much more than a pint of strong lager, beer or cider, with two alcohol-free days per week (Change 4 Life, 2012).

Hazardous drinking levels are defined as drinking more than 22 units per week for men and 15 units for women. Drinking at these excessive levels contributes to a range of medical conditions including cancers, cardiovascular diseases, diabetes, gastrointestinal diseases and neuropsychiatric disorders, as well as accidental injury and violence (British Medical Association, 2008).

Screening and brief interventions

Guidance from the National Institute for Health and Clinical Excellence (2010) recommends that health professionals should routinely carry out alcohol screening as an

5 key points

1. Alcohol-related conditions cost the NHS over £2.7bn annually
2. In one study, one in four patients receiving brief intervention reduced their drinking significantly
3. Brief intervention works best at a "teachable moment" in a drinker's life
4. Nurses are well placed to deliver brief intervention because of their rapport with patients
5. A simple framework can help nurses to structure interventions

integral part of their practice. A position statement from the Royal College of Surgeons of England (2010), endorsed by the Royal College of Nursing, recommends brief, cognitive advice delivered by nursing staff as part of care for conditions resulting from alcohol misuse.

Along with evidence from numerous clinical trials and systematic reviews in a range of healthcare settings, trials conducted by the Violence Research Group at Cardiff University demonstrate the effectiveness of brief interventions. One trial found that opportunistic brief interventions delivered by nurses while removing sutures in patients with alcohol-related facial injury resulted in significant long-term reductions in drinking in one in four young men consuming alcohol at hazardous levels (Smith et al, 2003).

These findings regarding the effectiveness of brief interventions for alcohol misuse have changed nursing practice in the Cardiff maxillofacial service. Brief intervention delivery has now been standard practice in Cardiff for 10 years without additional resources.

This nurse-led approach is now being rolled out in all trauma and maxillofacial clinics across the country with funding from the Welsh Government and the Technology Strategy Board (a non-departmental public body).

The FAST test

Although the elements of screening and brief interventions for alcohol misuse are well understood, implementation requires nurse leadership and determined management in specific clinical settings.

In Wales, patients complete the Fast Alcohol Screening Test (FAST) questionnaire before receiving wound care in the outpatient clinic (Fig 1). The questionnaire comprises four questions, asking patients how often they drink heavily, how often drinking has affected their memory, how often it has affected their ability to function, and whether anyone has expressed concern about their drinking or suggested they cut down (Hodgson et al, 2002).

This screening, which is designed to identify patients who drink excessively, takes less than 20 seconds to complete and can be completed by patients either in the waiting room or with the nurse. A combined score greater than two indicates hazardous drinking and should prompt a brief intervention. It should be noted that brief interventions are not designed for drinkers who are dependent on (that is, addicted to) alcohol, for example those who drink excessively on a daily basis. Such patients should be referred to specialist addiction services.

FIG 1. FAST ALCOHOL SCREENING TEST

For the following questions, please circle the answer that best applies

1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit

1. MEN: How often do you have EIGHT or more drinks on one occasion?

WOMEN. How often do you have SIX or more drinks on one occasion?

0	1	2	3	4
Never	Less then monthly	Monthly	Weekly	Daily or almost daily

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0	1	2	3	4
Never	Less then monthly	Monthly	Weekly	Daily or almost daily

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

0	1	2	3	4
Never	Less then monthly	Monthly	Weekly	Daily or almost daily

4. In the last year, has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

0	2	4
No	Yes, on one occasion	Yes, on more than one occasion

Source: Hodgson et al (2002)
NB: Questionnaire refers to drinks and not units

Brief intervention

A brief intervention in this context is a structured conversation between patient and nurse; they are designed to motivate patients to change their drinking behaviour. The intention is to prompt patients to recognise the harm their drinking has caused, especially the wound being treated; review their drinking; set themselves drinking limits; and make and act on decisions to reduce their hazardous drinking. These interventions will prompt some who have relapsed in their drinking behaviour to adopt sensible drinking once more.

Brief interventions should be personalised and offered in a supportive, non-judgemental manner using the FRAMES approach (Miller and Rollnick, 1991). This provides a simple outline and structure for the brief intervention conversation (Box 1). The conversation will comprise a combination of feedback and structured advice delivered in an empathetic matter. This will not be alien to nurses.

Brief interventions do work

Controlled trials indicate that on average, for every eight people drinking at hazardous levels who receive an alcohol brief intervention, one will reduce their drinking to within safe drinking limits.

Effectiveness seems to be even greater if the intervention is delivered at a particularly teachable moment (see below) in patients' lives, for example while they are having their sutures removed five days after sustaining a weekend face laceration.

Since brief interventions can be opportunistic and incorporated into routine clinical work without the need for additional clinical resources, they represent a worthwhile use of nurses' time and are therefore cost effective (Tariq et al, 2009). There is no need to label brief intervention as such in clinical settings; it should be incorporated into usual conversation during clinical contact, as described below by a nurse manager whose service uses this approach.

"The intervention starts as a normal conversation and it is only when it develops and the patient engages with you, they realise that there is a structure to the conversation and an agenda. At the point of realisation, it is important for the nurse to re-evaluate the engagement of the patient. It may be necessary to regroup and assure the patient that you're not being judgemental about their drinking habits. It is often at this point that full realisation dawns on the patient and the process of intervention can truly begin" (nurse manager).

Timing is crucial. Brief interventions work best in "teachable moments". These are when individuals are faced with the consequences of their actions and are more receptive to the suggestion of behaviour change.

Why nurses?

Nurses are best placed to deliver brief interventions for a variety of reasons. They often have a natural rapport with patients that doctors sometimes do not. Patients are known to respond to nurses because they see them as "non-threatening and approachable" (Mistral and Velleman, 1999), and providing a brief intervention is simply an extension of this role.

Some nurses might feel hypocritical delivering interventions if they themselves drink above the guidelines but, clearly, a professional approach to health risks for patients should include helping them to reduce these risks. Nevertheless, the screening and brief intervention process may perhaps be helpful to the health professionals themselves as a challenge to their own health behaviour.

QUICK FACT

Over £2.7bn
The amount that alcohol-related conditions cost the health service

Putting research findings into practice

In Wales, a knowledge transfer partnership between Cardiff University, the Welsh Government and Public Health Wales has been set up to deliver the alcohol brief intervention programme in all maxillofacial and trauma clinics.

Following feedback from nurses and recognising the need for effective and efficient training arrangements, rather than the overly time-consuming and impractical training sometimes recommended, a dedicated two-hour brief intervention course has been developed and is accredited by the RCN and Agored Cymru. Public Health Wales is also delivering an alcohol brief-intervention training programme aimed at professionals across primary and social care, including GPs and youth workers.

Conclusion

Nurses can make a positive difference to the lives of their patients by leading and delivering screening and brief interventions for alcohol misuse during the provision of routine nursing care. In the great tradition of nursing, this "have a word" approach reaps great benefits for patients, their families and the community. **NT**

BOX 1. THE FRAMES APPROACH

Feedback: helping patients to make the link between their injury and their alcohol misuse
Responsibility: encouraging patients to take responsibility for their own drinking
Advice: providing patients with individually tailored advice on issues such as keeping consumption within safe limits
Menu: providing patients with options to enable them to reduce their drinking, for example choosing a small glass of wine instead of a large one, avoiding drinking in rounds and not relying on alcoholic drinks alone to quench thirst
Empathy: using an empathetic approach rather than lecturing, for example, saying: "We all like a drink but being in A&E on Saturday night can't have been much fun"
Self-efficacy: emphasising to patients that they can change their drinking habits, in the same way, for example, that patients can and often do give up smoking

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Appendix IV

Patient information sheet

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Alcohol Brief Intervention Training Evaluation

Information Sheet for Health and Community Professionals

18 April 2013
Version: ABI 1.1

You are being invited to take part in the evaluation of the Welsh alcohol brief intervention training programme which you have attended. Before you decide if you would like to take part, it is important for you to understand why the evaluation is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

Introduction

Cardiff University is conducting an evaluation of the Welsh alcohol brief intervention training programme. This evaluation seeks to establish if alcohol brief interventions are being delivered in your professional area and to understand some of the barriers preventing delivery. It also seeks to establish how the training programme can be improved in future.

In order to comprehensively evaluate the training programme, it is essential that we conduct a robust evaluation. The main purpose of this evaluation is to identify areas for improvement in the training that was delivered to you and to identify the factors contributing to and inhibiting successful implementation of the alcohol brief intervention model. Part of this involves conducting interviews with people who have attended this training course, we would therefore like to invite you to contribute towards this evaluation.

How will I be involved?

We have identified a sample health and community professionals across Wales eligible to be involved in this evaluation. A number of health and community professionals are invited to participate in this evaluation. As an attendee of the training , you will be asked to take part in a telephone interview. We are interested primarily in what you thought of the training course, whether you have delivered alcohol brief interventions since attending and what barriers (if any) are preventing this delivery. We do not require any personal information from you, we are only interested in your professional opinions as someone who has attended alcohol brief intervention training.

Do I have to take part?

Contribution to this evaluation is entirely voluntary. If you do not wish to take part there will be no negative consequences

What will happen to the data?

As the data is reviewed and stored, all names and identifying information will be removed. By doing this we can ensure to a very high degree that what you say during interviews and observations will not be linked to you as an individual. Please note that in very rare circumstances we may need to break confidentiality. This occurs when researchers are told information about highly illegal activities that are due to take place. In these situations it falls within our ethical and moral duty to inform someone outside of the research team.

We will allocate each participant a unique ID number which will be used on all transcripts and files instead of real names. All data will be kept in a locked office within Cardiff University, either in locked filing cabinets or on a password-protected computer.

Once the results have been analysed, we may publish them at conferences and in academic journals. If you would like to receive information about the results of the study this will be available towards the end of the project (October 2013).

Who is organising the project?

The project is led by a research team at Cardiff University. Dr Simon Moore is leading the evaluation along with Dr Paul Jordan who will conduct the interviews.

Who has reviewed the project?

This project is funded by the Welsh Government and has been reviewed by Cardiff University Research Ethics Committee.

Contact for further information

For further information about the alcohol brief intervention programme and the evaluation please contact Paul Jordan on JordanPT@cardiff.ac.uk or 02920 746553.

For further information about the wider study, please contact Dr Simon Moore on MooreSC2@Cardiff.ac.uk or 0754 0825513

and this remains your choice. If you decide you would like to retract anything you have said during interview, this will be done immediately and without question.

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