Getting the Measure: An evaluation of Alcohol Intervention(AI) training and resources for frontline staff working in the homelessness sector

A report for
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1.0 INTRODUCTION

1.1 BACKGROUND

For many people the term 'homelessness' is closely associated with rough sleeping and those who access services such as hostels, night shelters and day centres. However the term covers a considerably broader range of circumstances as described by Shelter Scotland:

> "Homelessness means not having a home. You don't have to be living on the street to be homeless - even if you have a roof over your head you can still be without a home. This may be because you don't have any rights to stay where you live or your home is unsuitable for you." (Shelter Scotland 2010).

Young people who are living in supported housing or their own accommodation with planned support would also be covered by this description (Wincup et al 2003).

Homeless people are a diverse group with wide-ranging socio-economic and health needs; as a result the research literature views homelessness as more than just a housing problem. Recognisable and common problems experienced by homeless people of all ages are acknowledged to include health problems, unemployment, poverty and social exclusion (Fitzpatrick et al 2000, Wincup et al 2003).

> "It is often the visible sign of much deeper problems such as poverty, mental ill health, drug abuse, poor family relationships, inadequate education and lack of skills." (Blake et al 2008).

In response to the background of homelessness and related problems, legislation in Scotland has made it a requirement for housing authorities to assist those who are or are under threat of homelessness. Additionally it requires local authorities to make inquiries to judge whether the applicant is homeless or potentially homeless. The statistics and information taken during these enquiries give a good picture of the extent and variety of homelessness in Scotland. The figures, which were presented by Scottish Government (2010), show that:

- Over 50,000 applications were made to local authorities under the Homeless Persons legislation in 2009-10. The majority of these applications were from single males or females.
- On 31 March 2010 there were 10,815 households in temporary accommodation who had been placed there under the Homeless Persons legislation, an increase of 8% from the same date in the previous year.
- Of the applications made in 2009 and 2010, 4% reported that they had slept rough the night before the application was made.

The broad based approach to homelessness that is adopted by Cyrenians and its services reflects these needs and broad definitions on homelessness. This is evident in the range of prevention, education, residential and social care services and programmes that Cyrenians

provide to support adults and young people who are at risk of or who are experiencing homelessness.

Through these services, Cyrenians staff are directly involved in supporting people with a wide range of health and social problems. This includes a significant focus on addressing substance misuse, particularly in relation to alcohol.

1.2 CYRENIANS SERVICES

Edinburgh Cyrenians is a charity that aims to make a real difference in the lives of people who are at risk from poverty and homelessness. They offer practical help and support for people trying to improve their lives. The work of Cyrenians started in 1968 and now directly benefits over 1300 people a year in Edinburgh, Falkirk and East & West Lothian.

Their mission is to reduce the causes of disadvantage by raising awareness, lobbying for better laws and policies and demonstrating in practice the social advantages of inclusion. Their main services are summarised by three distinct but interlinked strands of work:

People and Change – enabling people to overcome deep seated problems and move forward in their lives. This includes;

- Drug and Alcohol Service – providing recovery orientated support to around 75 people a year who are looking to build a life away from problematic dug and alcohol use (age 16+)
- Cyrenians Communities – providing accommodation for about 30 young people a year whose lives have been in a downward spiral. (16-30yrs)
- People with Potential (16-25yrs) and Learning and Work(16+) – supporting over 300 people a year to move into or towards employment

Prevention – effective interventions to prevent escalation of problems into spiraling crises. This includes;

- Cyrenians SmartMove – providing access to private rented tenancies for around 300 people who would otherwise be excluded because of being on benefits (16+)
- Amber mediation – supporting nearly 100 families to improve relationships and avoid youth homelessness (16 -21rs)
- Homelessness Prevention Service – supporting in the region of 350 people a year to make their life more secure by avoiding homelessness (16+)

Social Enterprise – opportunities for people to move in through meaningful engagement in Cyrenians enterprises

- Good Food - health improvement & promotion, including a large surplus food distribution & food education service.
- Farm Enterprise –bringing people together from all walks of life to work and manage a small organic farm.
- CORE - organic recycling enterprise, providing opportunities for people to get involved with food waste recycling initiative

Cyrenians have a range of staff working across these services. This includes those working on a 1:1 basis with clients. Cyrenians has adopted the generic term 'key worker' which describes staff who primarily work with an allocated case load of service users whom they support on an ongoing basis. This includes "Support Workers"; "Personal Advisors" and "Coaches". These staff are trained to work to a particular model of practice known as the Key worker Practice Model (KWPM). The model is based on a professionally recognised

approach to working and links to the core Cyrenians values of acceptance, respect and tolerance with practical, day to day ways of working with people facing challenges in their lives.

Prior to the start of the evaluation Cyrenians introduced the Key Worker Light approach. This follows the same principles as the KWPM but is aimed at staff who do not have an allocated case of service users or predominately work with clients on a one off basis. It also includes staff working within the Social Enterprises who have other priorities (such as running a business). This means that all staff within Cyrenians work to a key worker model with some to a greater or lesser extent than others.

The services and projects offered by Cyrenians make a significant contribution to addressing the problems associated with homelessness in Scotland. See appendix A for key statistics relating to Cyrenians services.

The most common reasons cited for making homeless presentations in Scotland are those related to relationship breakdown, being unable to pay the rent/mortgage, and being asked to leave the property (Scottish Government, 2010). This reflects the client group Cyrenians are working with. Alcohol can play a part in these presentations too and can be seen to prevent people from making improvements to their lives. In 2008, Cyrenians worked with 1000 people, 200 of which were young people aged 16-25. In a scoping exercise undertaken internally by Cyrenians it was found around half of these young people felt their progress was inhibited by alcohol related problems.

Many people who have contact with Cyrenians are considered to struggle in recognising the direct impact of their alcohol use on their health and everyday lives, as well as the impact on significant others such as family and friends. This poses particular challenges for Cyrenians workers in being able to effectively engage with and support individuals with their alcohol use and related problems. In addition, the experience of Cyrenians is that many specialist alcohol services are often oversubscribed and not geared towards working with vulnerable people.

In response to these issues, Cyrenians identified a need to build internal capacity to enable staff to more effectively address problematic alcohol use amongst its service users. Cyrenians therefore identified a need to develop particular alcohol expertise, skills and resources, and an effective model of early intervention that could be integrated throughout the existing services that Cyrenians offers to homeless people.

1.3 ALCOHOL USE IN SCOTLAND

When considering the work carried out by Cyrenians it is important to place this into the context of alcohol use among the general population in Scotland.

In recent years the Scottish Government has placed an increased focus on tackling the misuse of alcohol in our society. This is in recognition of the damage caused by alcohol across all sections of the population. Key statistics on alcohol include:

- Alcohol related problems have been estimated to cost the Scottish economy £3.56billion per year. More than half of this is incurred by the economic and human

cost to society. This includes people being absent from work, being less productive when they are working, or dying at a younger age from illnesses caused by alcohol consumption (University of York 2010).

- While the most highly dependent drinkers experience the greatest harm as individuals, overall most harm comes from the much bigger population of non-dependent, harmful drinkers, who are the key target group for alcohol brief interventions (Scottish Government 2008).
- The most recent Scottish Health Survey estimates that in 2008/09 50% of men and 39% of women exceeded either the daily or the weekly guidelines on alcohol consumption, or both. In addition, that 14% of men and 10% of women indicated possible problem drinking and 11% of men and 6% of women possible physical dependency on alcohol (Scottish Government 2010b).
- Alcohol is a contributory factor in a wide range of physical and mental health problems, including many cancers, gastric problems, accidents, depression and anxiety among numerous others (SIGN 2003).

In response to the evidence, the Scottish Government set a target for the delivery of alcohol brief interventions by doctors and nurses within primary care, accident and emergency and antenatal settings for the period April 2008 to March 2011 (Scottish Government 2007).

Since the rollout of brief interventions in Scotland and elsewhere there has been a growing interest in the applicability of this approach to non health service community settings.

1.4 GETTING THE MEASURE PROJECT

In 2008 Cyrenians were awarded alcohol funding from Comic Relief UK grants programme. This funding was granted to enable them to respond to the need that they had identified for building individual and organisational capacity to more effectively address alcohol problems amongst service users and in particular young people. Funding was awarded to Cyrenians to:

- Enable more effective interventions and specialist help in each of the 3 years and beyond, for young people who are involved in Cyrenians programmes, whose problematic use of alcohol is inhibiting progress to their chosen goals.
- Up-grade in-house knowledge, practice skills and general capacity so that these effective approaches continue beyond the end of funding. Develop a pioneering approach which incorporates the identification and addressing of alcohol problems as a constant strand in Cyrenians everyday services for young homeless people.
- Research, monitor and evaluate the alcohol intervention approach to produce a tool which allows Cyrenians to be better equipped and effective in an ongoing way. Produce and disseminate evaluation, making learning available to others - and produce a model which can be adapted into the work of Cyrenians partner organisations at a local and national level.

The Comic Relief funded - ***Getting the Measure*****:** alcohol intervention project has been in operation since October 2008.

Getting the Measure project included an initial review of literature and existing approaches to help inform the development of staff training and support materials. The training programme was developed in conjunction with Scottish Training on Drugs and Alcohol (STRADA).

STRADA is a partnership between the University of Glasgow's Centre for Drug Misuse Research, the Department of Adult and Continuing Education, and DrugScope. As the leading national workforce development organisation they support organisations and individuals working with and affected by drug and alcohol misuse.

It was identified that an inability to discuss alcohol openly and objectively was a key contributor to staff not raising the issue of alcohol with clients particularly where consumption was less excessive but risky and problematic drinking behaviours were apparent. Due to this the following principles were embedded into the training;

- An 'its everyone's job' approach – i.e. regardless of why an individual has approached services, Cyrenians have an obligation to explore whether there is underlying and problematic alcohol use which will untimely inhibit the success of our intervention
- A simple, and non-judgemental tool to draw out accurate information in relation to alcohol use – where most screening tools focus on establishing whether consumption is within, or exceeds drinking guidelines, Cyrenians require a more conversational approach which helps the service user conclude for themselves the negative impact and risks

The training consisted of a one day course, co-delivered with STRADA, which engaged all Key Worker staff within Cyrenians. The aim of the training was to:

- Help develop Key Workers' awareness and knowledge surrounding Scotland's unhealthy relationship with alcohol.
- Equip Key Workers with the tools to be able to talk about alcohol with service users including motivational interviewing.
- Understand what units are and what the government recommends as safe limits for men and women.
- Understand and use motivational interviewing techniques and Prochaska and DiClemente's stages of change model to motivate clients' to change their drinking behaviour.
- Explore harm reduction strategies.

Alongside the training a number of resources were developed to aid Key Workers to put into practice what they have learned. This includes a 'Getting the Measure' website which Key Workers could use to revisit the ideas behind motivational interviewing, download resources to support behaviour change, and an up to date list of services which offer more professional help to those who are abusing alcohol.

4 training courses were delivered to 52 staff members in May, August, October and November 2010. Although the training was focused on Key Worker staff courses also

included wider staffing groups within Cyrenians. This was in keeping with the principle of 'it's everyone's job'.

The design of the Getting the Measure alcohol intervention project was informed by available evidence in relation to alcohol early interventions, and good practice in the homelessness field. In addition, it is based upon many of the underlying principles and elements which are common to an alcohol brief intervention approach.

The Getting the Measure project had much in common with a brief intervention on alcohol approach but had also been designed with particular differences in mind in an attempt to respond to the complex circumstances and needs of Cyrenians service users. The project set out to develop a practical working model which could be integrated across Cyrenians services and case work, and which reflects the context and relationships that key workers have with service users.

The adaptations which Cyrenians have made to the widely practiced model of screening and brief interventions on alcohol can be summarised as follows:

- Not to focus on the brief intervention as a 'brief' time-limited and one off intervention and instead to incorporate it into Cyrenians key-work as part of ongoing case management support to service users.
- An emphasis upon supporting people throughout the change process. Whilst staff would set out to build clients motivation to change and equip them with the necessary knowledge and skills to make a change- there would be less of an emphasis upon 'self-help' as individuals would be supported throughout their case management contact with Cyrenians as appropriate.
- A decision not to use a formal and validated screening tool such as FAST or AUDIT. This decision was based upon questions that Cyrenians had about the appropriateness of a formal screening tool and the possible negative impact that its use would have upon the relationship between client and key-worker.
- Cyrenians are however interested in the question '*Is a validated alcohol screening tool essential to an alcohol intervention being effective?* Whilst it is outwith the scope of this study to fully examine this question, the research evidence and literature has been explored in an attempt to try and provide some insight and guidance in this area.
- The introduction of assessment, monitoring and planning tools in which to plan and monitor changes in alcohol use and related problems on an ongoing case management basis.

The Cyrenians alcohol intervention model (Getting the Measure) has drawn upon and incorporated some of the key principles and elements of a brief intervention on alcohol approach. These consist of:

- A focus upon 'raising the issue' of alcohol. To equip staff with the necessary knowledge and skills in which to raise the issue in a natural and non-threatening way with individuals as appropriate;

- Raising the issue is recognised as relating to staff attitudes and the role of alcohol in society. Training is designed to explore these issues with staff as a way of challenging attitudes and promoting discussions about alcohol as part of routine practice with service users.
- Exploring alcohol consumption, assessing risk and problems, and providing information and feedback. This is an integral part of an alcohol brief intervention approach. Whilst Cyrenians do not use a formal validated alcohol screening tool such as FAST or AUDIT, staff are encouraged to ask service users a series of questions which are designed to explore alcohol consumption and assist with the process of identifying alcohol health risk in relation to recommended alcohol limits as well as the identification of other alcohol related social problems. Staff are also encouraged to provide personalised feedback and guidance on alcohol use and risks, particularly in relation to the recommended limits.
- Motivational Interviewing (MI) techniques. Brief Interventions on Alcohol utilise tried and tested MI techniques with the aim of building motivation and confidence to enable individuals to think about and/or plan alcohol behaviour change. Cyrenians staff are trained in the use of similar techniques to help support individuals via discussions on alcohol use and alcohol problems.
- Harm reduction advice. The provision of harm reduction information and advice within the context of a brief intervention is promoted by various good practice alcohol brief intervention models. Cyrenians staff are encouraged to provide similar advice when supporting service users within the context of the Getting the Measure project.
- Supporting readiness to change. Brief interventions set out to assess an individual's motivation or readiness to change and to provide guidance and support with the planning of change accordingly. Although a brief intervention would set out to support individuals via a short one-off conversation, Cyrenians staff are encouraged to support clients in this process albeit as part of an ongoing relationship with them. As highlighted above, various assessment, monitoring and planning tools have been developed to support this process.

The review of the literature in this report sets out to provide some commentary relating to the Cyrenians alcohol intervention model and the adaptations which have been made to a traditional brief intervention on alcohol approach.

1.5 GETTING THE MEASURE EVALUATION: AIMS AND OBJECTIVES

In April 2010 Cyrenians commissioned Create Consultancy Ltd. to evaluate 'Getting the Measure' and the effectiveness of its alcohol interventions training and resources.

The evaluation set out to:

1. Assess the effectiveness of the training and resources in encouraging frontline workers to discuss alcohol use with their service users.
2. Draw conclusions as to the effectiveness of the alcohol intervention model for wider use.

3. Assess whether the interventions are effective in changing levels of alcohol consumption amongst service users.

On development of the evaluation methodology it was decided that the focus of the evaluation should be on the engagement of staff. Thus this report is concerned with the reporting of key findings and discussion which sets out to answer the first two of the evaluation questions. Any discussion relating to the third evaluation question is indicative. Further research would be required to answer this question authoritively.

2.0 METHODOLOGY

2.1 APPROACHES USED

'Getting the Measure' was evaluated using a multi-method approach which incorporated quantitative and qualitative methodology. This included:

- **A review of literature**

A summary of relevant literature and evidence in relation to alcohol and homelessness is presented. Also presented is research evidence relating to alcohol early interventions and in particular alcohol brief interventions which the Cyrenians Getting the Measure alcohol intervention project is founded upon.

- **A pre-course questionnaire**

This provided baseline information on perceived levels of knowledge about alcohol related issues, how alcohol issues can be addressed, the level of importance placed on Cyrenians being able to address client's drinking behaviour and levels of confidence in using alcohol interventions in practice. It also collated information about participant job role and client group, previous training and current practice in dealing with alcohol issues

- **A post course questionnaire**

This repeated the questions about knowledge, how alcohol issues can be addressed, level of importance and confidence in using alcohol interventions in practice. In addition it included questions on intention to implement alcohol interventions into practice and any further support needs as well as general questions relating to the training course delivery i.e. usefulness, style and competence of trainers etc.

- **Follow up questionnaire at 3 and 6 month intervals.**

These repeated the questions about knowledge, how alcohol issues can be addressed, level of importance and their confidence in using alcohol interventions in practice. In addition they include questions exploring the implementation of brief interventions and on-going support needs.

- **Qualitative interviews**

Thirteen interviews were carried out with randomly selected staff from a range of services provided by Cyrenians.

- **Case file analysis**

Twenty two case files were analysed. This included case files from before and after the training so that the potential impact of the training on client discussions and monitoring of these discussions could be explored.

- **Validation groups**

Two validation groups were carried out with 12 staff members representing the different services provided by Cyrenians. This was an opportunity to present initial findings to staff and explore their views on whether these were reflective of their own experience.

2.2 ANALYSIS

Survey

Respondents were asked to provide the first four digits of their birth date (dd/mm) and the last part of their home postcode this allowed questionnaires to be 'matched' and comparisons to be made on the information provided by individual respondents. A total of 39 positive matches were made across each stage of the evaluation.

All data was collated and inputted into Excel where descriptive analysis, filtering and cross referencing was undertaken. Further statistical analysis (t-tests) was carried out on the time sequenced data that was collated across each stage of the evaluation.

Qualitative approaches

Each interview was recorded with detailed notes taken during the interview. Immediately following the interview the notes were written up. The recording was used for reference purposes i.e. for clarity on the notes and/or where direct quotes were used.

Each interview write up was read in its entirety and themes that emerged were identified and became the basis for an analysis framework. Using the framework each interview was re-read with issues relating to the identified theme being selected and categorised under the theme heading.

The theme headings then became the basis of the final report.

2.3 IMPLICATIONS OF METHODOLOGY

The range of approaches, including a balance between qualitative and quantitative methods, has enabled different perspectives to be included in the evaluation. However, it should be noted that It was agreed with the commissioners that at this stage the evaluation methods would focus on the engagement of staff. This means that the focus of this report is on the impact of 'Getting the Measure' on staff skills, knowledge and attitudes. Although this provides some indicative measure about the potential impact on clients no conclusions about this impact can be drawn. Other limitations of the evaluation methods include:

Literature review

The literature relating to alcohol and homelessness is limited, particularly in relation to studies exploring the effectiveness of alcohol (early) interventions within the homeless setting. Brief intervention on alcohol approaches have been primarily designed for health settings which is reflected by the available research in this area. We were unable to find any significant research literature relating to brief intervention approaches that was wholly relevant to the homeless setting. These limitations are highlighted in the literature review where relevant.

Survey

Numerous attempts were made to maximise the involvement of staff at each stage of the evaluation. This included e-mail reminders and information updates at staff meetings. Of the 52 staff members that participated in the training 39 were included in the evaluation

(75%). A large number of staff removed from the evaluation was due to staff changing roles i.e. into managerial positions or moving on from Cyrenians within the 6 months time period following training.

Staff were informed that a condition of them attending the training was their participation in the evaluation and that this involved a pre and post course survey as well as 3 month and 6 month follow ups. Despite this there was some indication of 'evaluation fatigue' particularly at the follow up stages. This was seen in the drop off in respondents providing written responses within the evaluation and also a tendency in some of the surveys for respondents to tick the highest rating for each statement across all questions.

It is important to note that the survey data represents self perceptions of knowledge, skills and attitudes. There was no process built into the evaluation to observe or test these areas externally. However, some balance was provided through the case file analysis and the interviews and validation groups with staff.

Case file analysis

There were a number of factors that impinged upon the analysis of case files.

Just over half of Cyrenians key workers had full case loads before and after training. However, some individuals had started work a few weeks before training and it was therefore not possible to analyse their case file records pre & post.

At the time of the analysis, Cyrenians had recently introduced new paperwork for assessing, planning and reviewing the support needs of clients. This also included a distance travelled monitoring tool i.e. matrix. At the time of the evaluation some key workers were still working to the old paper work system and had not fully transferred to the new system.

The transition from the old to the new paperwork system may have been partly responsible for some case file records being incomplete and not always reflecting client contact pre and post training. It was therefore not possible to conduct a complete and comprehensive pre and post training analysis of all case files. To do this effectively we would have had to observe staff client practice alongside the analysis of case files to determine whether recorded information accurately reflected practice.

Although it is important to acknowledge the above limitations we feel that the mixed method approach has provided us with a useful insight into the impact of the training on staff practice. Issues that have arisen from each stage of the evaluation are discussed in full within the final section of this report and accompany recommendations which we hope will strengthen the ongoing development and implementation of the Cyrenians approach.

3.0 LITERATURE REVIEW

3.1 METHODOLOGY

Key literature identified by Cyrenians was reviewed by the researcher. In particular, Pleace (2008) literature review on services for substance misuse and homelessness in Scotland provided a starting point. The researcher then examined any UK based literature from the last 10 years which was specific to alcohol and homelessness. This was widened to include literature on substance misuse and homelessness, including alcohol use. Additional searches were performed on NHS Health Scotland's Knowledge Network Portal and Google for any additional literature written from 2008. The search terms used were alcohol and homeless(ness), alcohol use and deprivation, alcohol use and housing.

3.2 HOMELESSNESS AND ALCOHOL

The links between homelessness and alcohol have been well established (Fitzpatrick et al 2000, Morrison 2008). The literature relating to alcohol and homelessness is however limited. Pleace (2008), in his review of literature relating to substance misuse and homelessness, highlighted that literature specific to alcohol and homelessness is sparse from the early 1980's, after which the focus moved to drug use or substance misuse in general.

Available research indicates that levels of alcohol usage differs amongst different homeless groups, with alcohol use being shown to increase with age (Kershaw et al 2003, Schertler 2010) and being more common amongst older men (Kershaw et al 2003). Research also indicates that levels of alcohol use and related social and economic problems amongst this group are much higher than those who do not experience homelessness. Furthermore, a study of youth homelessness in England and Wales revealed diverse patterns of alcohol use amongst young homeless, including risky and problem drinking (Wincup et al 2003).

Alcohol use among homeless people is also commonly associated with wider drug use (Fountain et al 2003). It is also common for homeless people to present with multiple support needs, which in many cases are related to alcohol and other substance misuse (Griffiths 2005, Scottish Executive 2003, Kershaw et al 2003, Gilchrist and Morrison 2005). Large proportions of homeless people have indicated that their alcohol or drug use was one of the reasons that they became homeless (Fountain et al 2003, Scottish Government 2010). Other studies support this link but argue that the relationship between alcohol and homelessness is far more complex, and often involves a range of additional factors and socio-economic conditions (Owen and Hendry 2001, Fountain et al 2003, Kershaw et al 2003, Gilchrist and Morrison 2005, Lamont et al 1997).

Individuals who have contact with Cyrenians homelessness services are therefore likely to experience a broad range of issues and problems that are influenced by wider social-economic structural factors such as poverty, housing and unemployment and which are likely to impact on health behaviours such as alcohol use. It is therefore important that any work that Cyrenians undertakes to tackle alcohol problems amongst its service users is able

to take a broad based holistic approach to supporting individuals that reflects their socio-economic circumstances and conditions.

It is now commonly accepted that a broad approach to promoting population health requires a combination of both downstream and upstream actions (McDaid et al 2008).

Downstream interventions set out to address poor health behaviours and lifestyles through health promotion, education and preventative actions through programmes such as smoking cessation and brief interventions on alcohol, whereas upstream interventions are directed at the wider determinants that bring about adverse health behaviours such as poor housing, homelessness, unemployment and poverty (Kelly 2005, Marmot and Wilkinson 2006).

This relationship is discussed by Kelly et al (2005) who conclude that whilst *"upstream interventions to improve the circumstances in which people live may not be a **sufficient** condition to produce health improvements, they may be a **necessary** precondition for other downstream interventions to be effective"* (2005:1).

This broad based approach to dealing with the causes and effects of particular social problems is often described as a 'wrap-around' service approach where the emphasis is placed upon providing continuous and comprehensive support relating to all aspects of a situation and where complex multi-dimensional problems are present (Goldman 1999, Walker and Shuttle 2004). Wrap around support would normally be provided by multiple service providers, such as those services provided by Cyrenians, working together to provide a co-ordinated response to the needs of high-risk individuals (Walker and Burns 2006).

Berglund, Thelander and Jonsson's (2003) review of eleven randomised treatment studies of homeless people highlight positive effects for behavioural interventions where wrap-around services were provided. The importance of co-ordinated actions and services which set out to improve socio-economic conditions alongside reductions in alcohol use, particularly among clients with complex needs is broadly supported by available research (Cox et al 1998, Raistrick 2006).

We can therefore conclude from the evidence that the integrated multiple service approach to dealing with alcohol issues, that is promoted by the Cyrenians Getting the Measure programme, is likely to be more successful than a narrow based approach that does not take into account the complex circumstances and multi-dimensional socio-economic problems that Cyrenians service users are likely to be presenting with.

3.3 ALCOHOL BRIEF INTERVENTIONS

Alcohol brief interventions originated in Europe in the early 1980s, when, inspired by the work of Kristenson and colleagues (1983), Heather (1987), developed the DRAMS programme for use in general practice. DRAMS (Drinking Responsibly and Moderately with Self-control) was evaluated in Dundee, Scotland by Heather and colleagues (1987). At the same time as the first trial was taking place in general practice in Dundee, Chick and colleagues (1985) were conducting the first trial of BIs in a general hospital setting in Edinburgh.

As described by Heather (2011), the context at that time was a heated debate about whether it was possible for individuals who had suffered from 'alcoholism' to return to normal or controlled drinking. At that time, the disease theory of Glatt (1982) and others, insisted that the existence of any type of alcohol problem was evidence of a 'slippery slope' to chronic alcoholism and that any intervention should be based on the goal of total abstinence. It is no longer controversial to suggest that there are many people who may drink more than is healthy who may never become dependent on alcohol and who can benefit from reducing or moderating their consumption. These 'hazardous' or 'harmful' drinkers are the primary target group for brief interventions.

Hazardous drinking includes people who regularly drink more than the recommended limits and is used to describe 'an individual whose level of alcohol consumption or pattern of drinking will increase their risk of harm if their current drinking habits continue' (NHS Health Scotland 2009:5). Unlike hazardous drinkers, harmful drinking would consist of individuals who already display clear evidence of alcohol-related harm to their health.

Brief interventions on alcohol are considered to be an effective public health strategy in reducing consumption amongst hazardous and harmful drinkers if implemented widely in routine general health practice (Moyers et al 2002, Bertholet et al 2005). While brief interventions are described in many studies, few provide formal definitions. Create Consultancy have defined a brief intervention on alcohol as

'*a short, structured conversation that seeks in a non-confrontational way to motivate and enable an individual to think about or plan a change in their drinking behaviour in order to reduce their alcohol consumption and/or their risk of harm'* (Create Consultancy, 2010).

The research literature provides a solid and substantial evidence base that supports the efficacy and effectiveness of brief interventions in healthcare settings (Kaner et al 2007, Raistrick et al 2006, SIGN74 2003). A World Health Organisation review (2009) of a wide range of alcohol interventions found brief interventions to be among the most effective. Evidence supporting brief interventions (in primary care) includes at least 56 controlled trials (Moyer et al 2002) and 15 systematic reviews and meta-analysis that have been conducted over the last seventeen years, the most recent being a Cochrane review by Kaner et al (2007).

Evidence suggests that people who receive a brief intervention are twice as likely to moderate their drinking compared to drinkers that receive no intervention (Wilk et al 1997). Other evidence suggests that positive effects can be sustained up to and beyond a year and can last for as long as 48 months (Bertholet et al 2005). Brief interventions on alcohol also compare favourably with other health behaviour interventions such as smoking (Silagy & Stead 2003)

It should be noted that the available research evidence is primarily concerned with the delivery of alcohol brief interventions across health settings with some evidence relating to higher education settings.

The authors of this literature review were unable to identify any research specific to alcohol brief interventions in the homelessness setting. Raistrick, Heather and Godfreys (2010) review of the effectiveness of treatment for alcohol problems, acknowledge that research on brief interventions on alcohol has not been widely replicated in social care and community settings out with primary health care. This review does however acknowledge the important role of the voluntary sector in helping to deliver their recommendations for preventing the

development of hazardous and harmful drinking amongst the general population, particularly amongst services that are likely to have contact with individuals who are not seeking help for alcohol related problems and who are unaware that their alcohol consumption may be compromising their physical or mental wellbeing.

The review concludes that the *"evidence from other areas (such as educational settings) clearly shows that it is worthwhile for healthcare professionals outside primary care – and non-healthcare professionals – to carry out these interventions."* (Raistrick et al 2010:35). This view is further supported by Nilsens (2010) summary of alcohol brief interventions over the last three decades where he argues for broader research to obtain knowledge in which to inform wider implementation and understanding of brief interventions on alcohol in routine care and other community settings.

The work of Cyrenians in relation to Getting the Measure including this evaluation study is therefore considered to be an important contribution to the growing interest in alcohol brief intervention based approaches for non-healthcare community settings.

3.4 MOTIVATIONAL INTERVIEWING

Subsequent to the original work on brief interventions in the 1980s, the concept of motivational interviewing emerged in the early 1990s (Rollnick et al 1992). It has influenced brief interventions in a number of ways, including in giving rise to the use of the FRAMES (see below in this section) and in leading to the testing of brief interventions based on a motivational approach (rather than just simple structured advice).

Motivational interviewing has been described as a person-centred approach that includes behavioural strategies targeted to the individual's stage of change (Prochaska at al 1992). The broad aim of a motivational intervention is to enhance motivation by helping individuals explore and resolve ambivalence to change (Miller and Rollnick 2002).

A systematic review and meta-analysis of seventy-two randomised controlled trials concluded that motivational interviewing outperforms traditional advice giving in the treatment of a broad range of lifestyle problems and diseases (Rubak 2005). Research into the efficacy of motivational interviewing has also provided strong support for this approach in the areas of alcohol and drug treatment (Miller et al 1993, Burke et al 2003).

The most up to date and comprehensive meta-analysis (Lundahl et al 2010) of twenty five years of empirical studies into motivational interviewing provides further support for this approach. The main conclusion of this analysis was that *"motivational interventions exert small though significant positive effects across a wide range of problems as well as deepening engagement in treatment. Their economy of time and widespread applicability suggest services should consider their adoption."* (2010:159).

The links between motivational interviewing processes and outcomes are less well understood and research into the key active ingredients or characteristics of what makes a motivational interviewing intervention effective have only recently begun (Burke et al 2003, Moyers et al 2009). Available literature is however able to provide some useful insights into

what ingredients may be necessary for a motivational intervention approach to be successful.

The acronym FRAMES is often used to describe the key elements of what constitutes 'motivational interviewing' and 'brief interventions' (SIGN74 2003, Bien et al 1993). This is described as-

- **F**eedback: about personal risk or impairment
- **R**esponsibility: emphasis on personal responsibility for change
- **A**dvice: to cut down or abstain if indicated because of severe dependence or harm
- **M**enu: of alternative options for changing drinking pattern and, jointly with the patient, setting a target; intermediate goals of reduction can be a start
- **E**mpathic interviewing: listening reflectively without cajoling or confronting; exploring with patients the reasons for change as they see their situation
- **S**elf-efficacy: an interviewing style which enhances peoples' belief in their ability to change. (SIGN74 2003:7)

As an approach, motivational interviewing when applied to service users with complex and multiple problems may enhance an individual's engagement with the case management and treatment system, but also has the potential as an effective 'brief' intervention for those who drop out and where the opportunity to provide support has been limited (National Treatment Agency for Substance Misuse 2006, Aston 2005).

The emphasis upon motivational interviewing within the Getting the Measure programme is broadly supported by the evidence and is therefore more likely to enhance client treatment outcomes when applied by Cyrenians services and staff as part of their ongoing case management support to individuals.

3.5 DETECTION OF ALCOHOL PROBLEMS AND RISK

The detection of alcohol problems or risk is often described as 'screening' and has been defined as *"the systematic application of a test or inquiry, to identify individuals at sufficient risk of a specific disorder to warrant further investigation or direct preventive action, among persons who have not sought medical attention on account of symptoms of that disorder"* (Department of Health 1998:50). The use of validated alcohol screening measures or tools are intended to provide an 'objective' measure of alcohol consumption and related risk to avoid bias

Available evidence supports screening as part of the process of promoting positive lifestyle changes and outcomes on a range of health related behaviours including substance use and alcohol, and may play an important part in the empowerment and motivation of service users (NHS Health Scotland 2009, Bankhead et al 2003). Some evidence also suggests that screening in itself could be an effective primary prevention strategy (Jepson et al 2000).

Kaner et al (2007) Cochrane review of the effectiveness of brief alcohol interventions suggests that there is some indication that the process of 'screening alone' may result in

reductions in alcohol consumption. The authors do however conclude that this is an area that requires further investigation.

The Cyrenians alcohol intervention projects decision not to use a 'formal' screening tool such as FAST or AUDIT was mainly based upon concerns about the possible negative impact that its use would have upon the relationship between Cyrenians workers and clients.

Barry and Fleming (1990) acknowledge concerns of this nature and highlight the importance of utilising screening tools that are acceptable to both service users and workers alike. The authors conclude that earlier intervention with a problem is more likely when screening tests are acceptable to both service users and practitioners.

Research suggests that individuals are rarely uncooperative and are unlikely to object to being asked about their alcohol consumption (Kaner et al 2007). Screening is considered to engender co-operation by the individual if it is viewed as desirable and in their interests. In general, research indicates that individuals are likely to view alcohol screening and brief interventions as part of the valid role of the health practitioner (Raistrick et all 2006, Babor et al 2001, Richmond et al 1996).

It is however less clear as to whether service users would also perceive this as part of the valid role of non-health practitioners such as those that operate across community services that are similar to those that are delivered by Cyrenians. We were unable to identify any similar research evidence that explored this issue in relation to non health care practitioners within services similar to Cyrenians.

The broad literature supports the use of formal screening tools (such as FAST or AUDIT) over other clinical measures to identify alcohol problems (Fiellin et al 2000, Raistick et al 2006). The use of formal validated questionnaires is the method which is most commonly employed within the context of a brief intervention on alcohol approach. Many validated (tested for sensitivity and specificity) alcohol screening questionnaires are available and include tools such as the 10 question AUDIT and various adapted and shortened versions such as FAST (4 questions) and AUDIT-C (3 questions).

Whilst screening and the identification of risk can be conducted by more informal methods and approaches it should be recognised that many hazardous drinkers are not likely to display obvious signs of alcohol problems and therefore run the risk of not being picked up and identified by informal methods of identifying alcohol risk and problems (Raistrick et al 2006). Kaner et al (1999a) survey of general practitioners went as far to suggest that an over reliance on clinical history and signs could see as many as 98 per cent of hazardous and harmful drinkers not being identified.

It may be immediately clear that someone is 'at risk' from their alcohol use without having to calculate exact consumption and explore related behaviours via a formal screening tool. For example, it may be clear that the presenting problem is alcohol-related if someone acknowledges that there is a link between their consumption of alcohol and their homelessness, and/or particular health and relationship problems. In these cases, the use of formal screening tools in which to identify risk may not be required.

A formal tool may still be useful however in determining if an alcohol intervention is appropriate or if a person might benefit from referral to a service for assessment of possible alcohol dependence.

Not all research is in support of alcohol screening practice and methods. Beich et al (2003) raise questions about the feasibility of alcohol screening in general practice and conclude that screening in this setting does not seem to be an effective precursor to conducting brief interventions.

It should be noted however that the research evidence from Beich et al has been the subject of fierce debate and has been actively contested by a number of eminent research academics and authors on methodological and other grounds (see correspondence on www.bmj.com from 18/10/2002 to 1/12/2002 and from 4/9/2003 to 7/3/2004).

The literature so-far discussed on alcohol screening is primarily related to screening in medical settings particularly primary care. The authors of this literature review were unable to identify any studies that were particular to alcohol screening and the homelessness setting and were therefore unable to reveal any evidence relating to the direct transferability and applicability of formal alcohol screening tools into the homelessness setting or other community settings.

In conclusion, it is beyond the scope of this literature review to fully critique and appraise the transferability and applicability to the homelessness setting of the many standardised alcohol screening tools that are widely available. There are however clearly identified strengths to using a formal validated tool such as a questionnaire over other formal and informal screening methods. There is also some evidence that if used properly the process of alcohol screening in itself can contribute to the process of motivating and supporting individuals to think about or plan alcohol behaviour change.

The work of Warner (2004) is felt to be a useful starting point for the appraisal of screening tests and tools to different settings and services. Warners checklist and guide may provide a useful basis in which Cyrenians can more fully explore and critique the use of standardised screening methods and tools as part of its alcohol intervention project, particularly in relation to the impact that the use of these tools may have upon the relationship between service users and workers. Table 1 highlights Warners (2004:252) critical appraisal questions.

Table 1 Critical Appraisal: Will the results help me in caring for my patient?

Is the test available and easily performed?

Look specifically at how you can perform the test in your setting. Do you require any special equipment?

Is there a sensible estimate of pre-test probability?

Pre-test probability is the probability a patient has an illness determined *before* the test is performed. You may use clinical intuition for a particular patient, or base the pre-test probability on existing prevalence data.

Will the results change how I manage this patient?

This is worth considering. Is it ever necessary to perform a test: (a) if it has such a low likelihood ratio that it has little or no effect on your decision of whether a condition is present; or (b) if the prevalence of a condition is very low?

Will the patient be better off if the test is performed?

Even if the test is valid and reliable, with a high likelihood ratio, if the patient will not benefit from the disease being identified there may be little point in performing it.

3.6 BARRIERS TO IMPLEMENTATION

Cyrenians training is designed to address barriers and promote integration of its alcohol intervention model in practice. The evaluation findings presented in this report are broadly concerned with exploring this area amongst Cyrenians services and staff who have undertaken training.

Barriers to the implementation of brief interventions on alcohol approaches have been explored by research. Kaner et al (1999b) identified a number of barriers to implementation of brief interventions in practice. These barriers included beliefs that individuals will not accept advice to change; fear of offending people by raising the issue of alcohol and negative attitudes towards people with drinking problems as a result of practitioner's experience of individuals with more serious problems. Whilst these attitudes pose real difficulties for the adoption of brief interventions in practice by healthcare and other staff, various studies have set-out to explore these barriers and provide practical solutions (Wallace and Haines 1984, Richmond et al.1996, Rush et al 2003, Hutchings et al 2006).

Raistrick et al (2006) suggest that such barriers could be easily addressed and professional attitudes to putting alcohol brief interventions into practice could be overcome by providing:

- Appropriate training to practitioners
- Evidence to practitioners that brief intervention approaches are effective
- Information between the difference of targets for brief intervention and the management of dependent individuals, and arrangements for referring the latter to specialist treatments
- Evidencing that most individuals expect health professionals to enquire about their drinking in appropriate circumstances and see this as a legitimate part of their practice.

Whilst these solutions relate to overcoming barriers within health settings, as a principal, these approaches may go some way towards addressing perceived barriers within non-healthcare settings. Further investigation and research would however be required to fully explore and test the effectiveness of these approaches for non-healthcare settings and for specific solutions for these settings to be identified and evaluated in practice.

4.0 FINDINGS: SURVEY

PART ONE: RESPONDENT CHARACTERISTICS

From the pre-course questionnaire respondents provided information on their job role and the service they worked within. They also provided information on current practice in dealing with alcohol related issues and previous training they had received that was relevant to alcohol and/or alcohol interventions.

4.1 PROFILE OF SURVEY RESPONDENTS

The 39 survey respondents included staff from each of the services within Cyrenians and a range of job roles within the organisation. The Homelessness Prevention Service and the Substance Misuse Service had the greatest number of staff attending the training. This is reflected in the number of respondents from these services. The three most common job roles were:

- Key worker 35% (n=14)
- Personal advisor 23% (n=9)
- Senior Key worker 15% (n=6)

The average length of time within post for survey respondents was 12 months, however this ranged from less than one month to 72 months (6 years).

Graphs A and B provide an overview of the services and job roles represented by the survey respondents.

Count of responses

Count of responses

4.2 CURRENT PRACTICE

In the pre-course questionnaire respondents were asked how often in their professional practice they discuss different aspects of alcohol with clients. Table A outlines the responses. Key issues highlighted were:

- Prior to the training few practitioners discussed any aspect of alcohol on a weekly basis.

- Alcohol related issues most commonly discussed by respondents were:
    - exploration of how much alcohol is currently drunk by a client
    - providing feedback on how a client's current drinking may affect/be affecting their health

- Prior to the training few respondents included the key components of brief interventions on alcohol on a regular basis i.e. reference to drinking limits, advice or tips on reducing alcohol use etc.

- Over half of the respondents indicated that they had never or a few times in their career had provided written information related to sensible drinking.

Table A: Practice prior to training	Once per week or more	A few times per month	A few times per year	Never	NA*
a. Exploration of how much alcohol is currently drunk by a client	5	21	6	3	1
b. Feedback on how a client's current drinking may affect/be affecting their health	4	20	7	3	2
c. Discussed sensible drinking guidelines	3	9	12	6	4
d. Advice or tips on how to reduce their drinking	2	8	10	8	5
e. Provided written information related to sensible drinking	2	2	9	11	5
f. Advice about or referral to other agencies about alcohol issues	3	5	13	8	4
Count of Responses				*Not Answered	

4.3 PREVIOUS TRAINING

In the pre-course questionnaire just over half of the respondents (n=21) indicated that 'Getting the Measure' was the first training course they had received on alcohol issues. Other respondents had received a range of training from modules incorporated into their degree course to attending general awareness raising sessions on alcohol through current or previous employers.

Four respondents indicated that they had previously attended training on alcohol and brief interventions with a further respondent indicating that they had received training on health behaviour change. Five respondents held a qualification on alcohol/drugs/addiction.

PART TWO: KNOWLEDGE, ATTITUDES & CONFIDENCE RATINGS

39 positive matches were made from which comparisons in perceived knowledge, attitudes and confidence levels could be drawn across the 4 stages of the evaluation i.e. pre, post, 3 month and 6 month follow up.

4.4 KNOWLEDGE OF ALCOHOL RELATED ISSUES

1 = I don't know much about this

2 = I understand a little about this
3 = I understand this well
4 = I understand this very well
Respondents were asked to rate how knowledgeable they felt on alcohol related statements according to the scale shown opposite.

The statements were:

a) What alcohol is and how it affects the body.
b) What a unit of alcohol is, alcohol content of common drinks and recommended drinking limits for adults.
c) The reasons why people use alcohol.
d) The factors which put people at risk of developing drinking problems.
e) The impact of alcohol on individuals (physical, mental and social health).
f) The impact of alcohol use in Scotland.
g) What a motivational behaviour change intervention on alcohol is and how to deliver one.
h) Approaches for assessing level of risk from alcohol consumption.
i) How to deliver brief harm reduction advice with regards to alcohol.
j) When and where to make appropriate referrals to specialist alcohol support services.

To allow easy comparison between knowledge levels before and after the training and at the 3 and 6 month follow ups the above statements have been given a knowledge scoring.

The Knowledge Score is the combined score awarded by the 39 respondents for each statement. Within this system the maximum combined score that could be allocated is 156 i.e. if each participant gave the statement a rating of '4 -I understand this very well'. The minimum combined score that could be allocated is 39 i.e. if each participant gave the statement a rating of '1- I don't know much about this'.

Graph C provides an overview of the knowledge score for each statement at the 4 stages of the evaluation.

Key findings that emerged from the analysis were:

- Participant perceptions of their knowledge for each statement increased after the training with at least 75% of respondents indicating that they understood the issues within each statement well or very well at each stage after the training.
- Prior to the training the highest levels of perceived knowledge levels related to 'the reasons that people use alcohol' (statement c), 'the impact of alcohol on individuals' (statement e), and 'what alcohol is and how it affects the body' (statement a).

- Training had the greatest improvement on perceived knowledge levels for 'approaches for assessing levels of risk from alcohol consumption' (statement h) and 'how to deliver harm reduction advice with regards to alcohol' (statement i). This was evident immediately after training and at the 6 month follow up.
- At each stage of the evaluation respondents rated their knowledge lowest on understanding approaches for assessing level of risk (statement h) and understanding what a motivational behaviour change intervention on alcohol is and how to deliver one (statement g).

From the knowledge scores a difference between the values at pre training and post training and at the 3 month and 6 month follow up can be observed.

While there is a difference in the figures, it cannot be assumed that this difference was due to the training that was delivered, rather than simply to chance. One way to test the likelihood of the difference being due to chance is to apply a statistical test, known as a t-test. By computing the test using the two figures to be compared, and analysing the resulting figures, we get an answer to the question:

"Is the difference in knowledge before and after training 'significant' i.e. not due to chance?"

A paired t-test was performed for each knowledge statement comparing the values from pre and post training; pre-training and 3 month follow up; and pre training and 6 month follow up.

The decision on significance is based on the following inference process:

1. State null hypothesis (what is being tested).

Which of these is true?

Null hypothesis: there is no significant difference between the knowledge scores of the two samples

Alternative hypothesis: there is a significant difference between the knowledge values of the two samples

2. Decision rule for rejecting the null hypothesis (how to know which is true).

't value', 't critical' and 'p' are values that are provided from each t-test.

If t value <= t critical (two tail)
If $p < 0.05$ (two tail)

In this evaluation the risk value (alpha) was set at 0.05. This means that in five times out of a hundred a statistically significant difference would be found between the means even if there was none (i.e., by "chance").

If the p value is lower than our risk value (0.05) we can say that the observed difference between the means is significant. So we REJECT the null hypothesis that there is no

difference, and accept our alternative hypothesis that there is a difference between the means (and that it's not due to sampling error or chance).

Tables B, C & D outline the findings computed by the t-test and inform us as to whether the difference observed in the knowledge values are significant or not.

Key findings from the statistical analysis:

- At a 95% confidence level the differences identified between the pre and post knowledge scores across all statements were statistically significant. This indicates that the differences witnessed are unlikely to be due to chance.
- The statistically significant differences were maintained at 3 month and 6 month follow ups across all statements.
- Although the methodology used for this evaluation make it impossible to know if this change was all due to the training alone we can infer that there is a high chance that the training had a positive impact on participants' knowledge levels.

Table B: Knowledge Statement T-test: Pre & post month values			
t critical (two tail) = -2.024394	Risk value (alpha) = 0.05		Df:38
Knowledge Statements	**t Stat**	**P(T<=t) two-tail**	**Significant?**
What alcohol is and how it affects the body...	-5.43112	3.43E-06	Yes
b) What a unit of alcohol is & recommended drinking limits...	-7.80292	2.07E-09	Yes
c) The reasons why people use alcohol.	-4.25	0.000134	Yes
d) The factors which put people at risk...	-3.6964	0.000687	Yes
e) The impact of alcohol on individuals health...	-4.50157	6.21E-05	Yes
f) The impact of alcohol use in Scotland.	-5.96107	6.44E-05	Yes
g) What a motivational behaviour change intervention is..	-4.80169	2.46E-05	Yes
h) Approaches for assessing level of risk ...	-7.47568	5.64E-09	Yes
i) How to deliver brief harm reduction advice....	-7.2111	1.28E-08	Yes
j) When and where to make appropriate referrals ...	-6.74585	5.44E-08	Yes
Table C: Knowledge Statement T-test: Pre & 3 month values			
t critical (two tail) = -2.024394	Risk value (alpha) = 0.05		Df:38
Knowledge Statements	**t Stat**	**P(T<=t) two-tail**	**Significant?**
a) What alcohol is and how it affects the body...	-5.94018	6.88E-07	Yes
b) What a unit of alcohol is & recommended drinking limits...	-5.32524	4.79E-06	Yes
c) The reasons why people use alcohol.	-5.17789	7.61E-06	Yes
d) The factors which put people at risk...	-3.50534	0.001187	Yes
e) The impact of alcohol on individuals health...	-5.40222	3.76E-06	Yes
f) The impact of alcohol use in Scotland.	-5.96015	6.46E-07	Yes
g) What a motivational behaviour change intervention is..	-5.51241	2.66E-06	Yes
h) Approaches for assessing level of risk ...	-5.69286	1.5E-06	Yes
i) How to deliver brief harm reduction advice....	-6.41153	1.55E-07	Yes
j) When and where to make appropriate referrals ...	-5.78214	1.13E-06	Yes
Table D: Knowledge Statement T-test: Pre & 6 month values			

t critical (two tail) = -2.024394	Risk value (alpha) = 0.05		Df:38
Knowledge Statements	**t Stat**	**P(T<=t) two-tail**	**Significant?**
What alcohol is and how it affects the body...	-5.16747	7.86E-06	Yes
b) What a unit of alcohol is & recommended drinking limits...	-5.50628	2.71E-06	Yes
c) The reasons why people use alcohol.	-4.90362	1.79E-05	Yes
d) The factors which put people at risk...	-4.71634	3.21E-05	Yes
e) The impact of alcohol on individuals health...	-5.14974	8.31E-06	Yes
f) The impact of alcohol use in Scotland.	-5.93171	7.06E-07	Yes
g) What a motivational behaviour change intervention is..	-4.88501	1.9E-05	Yes
h) Approaches for assessing level of risk ...	-5.87952	8.33E-07	Yes
i) How to deliver brief harm reduction advice....	-6.39327	1.65E-07	Yes
j) When and where to make appropriate referrals ...	-6.41613	1.53E-07	Yes

The overall improvement in knowledge is further supported by the qualitative data collated in the post-course questionnaire and in the interviews:

"I gained more information on something I didn't really know a lot about"

"Very useful on giving awareness of signs and assessment for indicators of alcohol and a method of approaching this with customers"

"Gaining knowledge and learning about services to refer to"

4.5 ATTITUDES TO ADDRESSING ALCOHOL ISSUES

Respondents were asked to rate on a likert scale of 1 to 5 (1=strongly disagree and 5= strongly agree) how much they agreed or disagreed with a range of statements relating to how alcohol issues can be addressed. This question, and the specific statements, was taken from the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ).

The AAPPQ is a well established tool for measuring changes in staff attitudes and perceptions about working with people who have alcohol problems.

As the AAPPQ has only been validated for use with primary care staff it was felt necessary to adapt the questions and to only use a selection of those most relevant to the practice of staff within Cyrenians.

The questions included as part of this evaluation are outlined in Table B along with the average ratings given for each statement in the pre and post questionnaires. At least one statement, from the 6 specific areas of interest that the AAPPQ explores, was included in this question.

<u>The areas of interest within the AAPPQ are</u>:

Role Adequacy: Workers' perceptions of how well they feel able to carry out this kind of work. (Statement 3)

Role Legitimacy: Workers' perceptions of whether this kind of work forms a legitimate part of their job and whether they feel that clients would consider it a legitimate part of their job. (Statement 1, Statement 2, Statement 5 and Statement 6)

Role Support: Workers' perceptions of how easily they could find help from people or resources to carry out this kind of work. (Statement 9)

Motivation: How workers feel about carrying out this kind of work. (Statement 4, Statement 10)

Satisfaction: Workers' perceptions of how satisfying it would be to carry out this kind of work. (Statement 8)

Task Specific Self Esteem: Workers' perceptions of how good they would be at carrying out this kind of work. (Statement 7)

The attitude statements were:

1. I feel I have a clear idea of my responsibilities in helping clients who are considered to be risky drinkers.
2. I should not be expected to work with clients who have problems relating to their alcohol consumption.
3. I feel I can appropriately advise people about risky drinking and its effects.
4. I feel that there is little I can do to help risky drinkers.
5. I feel that I have the right to ask clients, who I come into contact with at work, questions about their drinking.
6. I feel that clients I work with would think I have the right to ask them questions about their drinking.
7. I feel I am as able to work with people who are risky drinkers as with people who are not risky drinkers.
8. I often feel uncomfortable when working with risky drinkers
9. If I felt the need I could easily find someone who would be able to help me formulate the best approach to the person I was working with.
10. Clients can make good progress towards healthy drinking levels with the right support

To allow easy comparison across the attitude statements before and after the training and at the 3 and 6 month follow ups the mean value for each statement has been calculated and represented in Graph D.

Key findings that emerged from the analysis:

- For the majority of statements there was some positive improvement in the average ratings given by respondents when comparing the mean scores from before the training and immediately following the training.
- The exception to this was statement 2 'I should not be expected to work with clients who have problems relating to their alcohol consumption' (AAPPQ: *Role Legitimacy*) which showed a very slight negative average increase (>0.2) at post training. However

it should be noted that respondents already strongly disagreed with this statement prior to the training.

- Across the majority of statements a positive increase was maintained at 3 and 6 month follow up, however for some statements there was a slight dip at 3 months.
- The exceptions to the above were statement 2 and statement 6 (*role legitimacy*) which show a slight change at 3 month follow up (0.1) and equal scoring at 6 month follow up.
- Statements which showed the greatest change in attitudes both immediately following training and at 6 month follow up were:
    - Statement 1: I feel I have a clear idea of my responsibilities in helping clients who are considered to be risky drinkers (*role legitimacy)*
    - Statement 3: I feel I can appropriately advise people about risky drinking and its effects (*role adequacy)*

While there is a difference in the figures, as with the knowledge scores it cannot be assumed that this difference was due to the training that was delivered, rather than simply to chance. One way to test the likelihood of the difference being due to chance, is to apply a statistical test, known as a t-test[1].

A paired t-test was performed for each attitude statement comparing the values from pre and post training; pre-training and 3 month follow up; and pre training and 6 month follow up.

Tables E, F & G outline the findings computed by the t-test and inform us as to whether the difference observed in the attitude values are significant or not

Key findings from the statistical analysis:

- At a 95% confidence level the differences observed between the pre and post attitude values were statistically significant across three statements. These were:
    - Statement 1: I feel I have a clear idea of my responsibilities in helping clients who are considered to be risky drinkers (*role legitimacy)*
    - Statement 3: I feel I can appropriately advise people about risky drinking and its effects (*role adequacy)*
    - Statement 9: If I felt the need I could easily find someone who would be able to help me formulate the best approach to the person I was working with (role support)

- The statistically significant differences were maintained at 3 month and 6 month follow ups across these three statements.
- Across the remaining statements the differences observed were not statistically significant at any time period i.e. pre-post; pre-3 months or pre-6 months.
- The reasons for the majority of the attitude statements not being statistically different are not fully known. However, it may reflect the already favourable attitudes help by participants prior to the training. It may also reflect some ongoing concerns by some

1 See page 30 & 31 for detailed explanation of t-tests.

participants about the legitimacy of them asking questions about alcohol in some situations.

Table E: Attitude Statement T-test: Pre & post values			
t critical (two tail) = -2.024394	Probability level = 0.05		Df:38
Attitude Statements	**t Stat**	**P(T<=t) two-tail**	**Significant?**
I feel I have a clear idea of my responsibilities ...	-7.40161	7.08E-09	Yes
I should not be expected to work with clients ...	-1.31773	0.195485	No
I feel I can appropriately advise people ..	-6.63962	7.59E-08	Yes
I feel that there is little I can do to help	-1.59574	0.118831	No
I feel that I have the right to ask clients questions...	-2.29228	0.027518	No
Clients would think I have the right to ask questions ...	-0.77689	0.442033	No
I feel I am as able to work with risky drinkers as ...	-1.67003	0.103132	No
I often feel uncomfortable working with risky drinkers...	-0.82738	0.413187	No
If I felt the need I could easily find someone ...	-5.64544	1.74E-06	Yes
Clients can make good progress	-2.03901	0.048449	No
Table F: Attitude Statement T-test: Pre & 3 month values			
t critical (two tail) = -2.024394	Probability level = 0.05		Df:38
Attitude Statements	**t Stat**	**P(T<=t) two-tail**	**Significant?**
I feel I have a clear idea of my responsibilities ...	-6.40724	1.58E-07	Yes
I should not be expected to work with clients ...	-0.97266	0.336876	No
I feel I can appropriately advise people ..	-6.02303	5.29E-07	Yes
I feel that there is little I can do to help	1.768214	0.085053	No
I feel that I have the right to ask clients questions...	-1.27502	0.210044	No
Clients would think I have the right to ask questions ...	-0.40765	0.685816	No
I feel I am as able to work with risky drinkers as ...	-1.35599	0.183106	No
I often feel uncomfortable working with risky drinkers...	0.674603	0.504012	No
If I felt the need I could easily find someone ...	-3.63235	0.000826	Yes
Clients can make good progress	-0.74572	0.460425	No
Table G: Attitude Statement T-test: Pre & 6 month values			
t critical (two tail) = -2.024394	Probability level = 0.05		Df:38
Attitude Statements	**t Stat**	**P(T<=t) two-tail**	**Significant?**
I feel I have a clear idea of my responsibilities ...	-6.75479	5.29E-08	Yes
I should not be expected to work with clients ...	-0.37377	0.710651	No
I feel I can appropriately advise people ..	-8.1252	7.81E-10	Yes
I feel that there is little I can do to help	2.012258	0.051321	No
I feel that I have the right to ask clients questions...	-1.35599	0.183106	No
Clients would think I have the right to ask questions ...	0.128537	0.898402	No
I feel I am as able to work with risky drinkers as ...	-0.75783	0.453227	No
I often feel uncomfortable working with risky drinkers...	1.797636	0.080184	No
If I felt the need I could easily find someone ...	-2.79912	0.008007	Yes
Clients can make good progress	-1.67748	0.101656	No

Respondents were asked to rate on a scale of 1 to 5 (1=Very important to 5= Not at all important) how important they think it is for Cyrenians staff to be able to address clients' drinking behaviour.

As outlined in Graph E the majority of staff indicated that it was very important at all stages of the evaluation.

Count of responses

4.6 CONFIDENCE IN ADDRESSING ALCOHOL ISSUES

1 = I would not be confident about managing this situation and would not know what to do/say.
2 = I think I could manage this situation but would be a little unsure of what to do/say.
3 = I think I would manage this situation well and I would have a good idea of what to do/say.
4 = I am sure I would manage this situation well and feel confident about what to do/say.

Respondents were asked to rate how confident they would feel in managing alcohol related statements according to the scale shown opposite.

The statements that survey respondents rated their confidence on were:

a) Explain what alcohol is and how it affects the body.
b) Describe the short term implications of alcohol use on physical and mental health, including hangovers, mood and personal safety.
c) Describe the long term implications of alcohol use on physical and mental health.
d) Describe the social harm associated with alcohol use to clients.
e) Be able to use information about drinking provided by clients to calculate units consumed and assess levels of risk.
f) Explain units of alcohol and know the alcohol content of common drinks.
g) Give sensible drinking advice including daily and weekly drinking limits and harm reduction strategies.
h) Understand and use basic motivational interviewing techniques in relation to alcohol consumption.
i) Understand and use basic behaviour change techniques when talking about alcohol with clients.
j) Understand the role and function of a range of alcohol organizations (including specialist services), when individuals should be referred to these services and how to make such referrals.

To allow easy comparison on confidence levels before and after the training the above statements have each been given a confidence scoring (outlined in Graph F). This applies the same system as the knowledge score outlined above i.e. maximum potential score of 156 if all respondents give maximum rating '4' and minimum potential score of 39 if all respondents give minimum potential rating '1'.

Key findings from the statistical analysis:

- Participant's confidence for each statement increased after the training.
- The increase in respondents confidence ratings evident between the pre and post questionnaires were largely maintained at 3 month and 6 month follow up.
- Statements which showed the greatest increase in confidence both immediately following training and at 6 month follow up were:
    - 'being able to use information about drinking to calculate units and assess levels of risk' (statement e),
    - 'Give sensible drinking advice including daily and weekly drinking limits and harm reduction strategies' (statement g).
    - Explain units of alcohol and know the alcohol content of common drinks (statement f)
    - Understand and use basic motivational interviewing techniques in relation to alcohol consumption. (statement h)
- Although improvements had been made in the general confidence rating at 6 month follow up respondents gave the lowest confidence rating to
    - Understand and use basic behaviour change techniques when talking about alcohol with clients.
    - Understand the role and function of a range of alcohol organizations (including specialist services), when individuals should be referred to these services and how to make such referrals.

While there is a difference in the figures, as with the knowledge and attitudes scores it cannot be assumed that this difference was due to the training that was delivered, rather than simply to chance. One way to test the likelihood of the difference being due to chance, is to apply a statistical test, known as a t-test[2].

A paired t-test was performed for each confidence statement comparing the values from pre and post training; pre-training and 3 month follow up; and pre training and 6 month follow up.

Tables H, I & J outline the findings computed by the t-test and inform us as to whether the difference observed in the confidence values are significant or not

Key findings from the statistical analysis:

2 See page 30 & 31 for detailed explanation of t-tests.

- At a 95% confidence level the differences identified between the pre and post confidence scores across every statement were statistically significant. This indicates that the differences witnessed are unlikely to be due to chance and are as a result of the training.
- The statistically significant differences were maintained at 3 month and 6 month follow ups across all statements.

Table H: Confidence Statement T-test: Pre & post values			
t critical (two tail) = -2.024394	Risk value = 0.05		Df:38
Confidence Statements	**t Stat**	**P(T<=t) two-tail**	**Significant?**
a) Explain what alcohol is and how it affects the body.	-6.34261	1.93E-07	Yes
b) Describe the short term implications of alcohol use...	-7.17683	1.42E-08	Yes
c) Describe the long term implications of alcohol use... on	-5.74614	1.27E-06	Yes
d) Describe the social harm associated with alcohol use ...	-6.245	2.63E-07	Yes
e) Be able to use information...to calculate units and assess risk..	-11.4783	6.47E-14	Yes
f) Explain units of alcohol and know the alcohol content ...	-7.40656	6.98E-09	Yes
g) Give sensible drinking advice including daily and weekly...	-8.25457	5.3E-10	Yes
h) Understand and use basic MI techniques ...	-6.93064	3.05E-08	Yes
i) Understand and use basic behaviour change techniques ...	-7.69399	2.89E-09	Yes
j) Understand the role and function of alcohol organisations...	-5.99692	5.75E-07	Yes
Table I: Confidence Statement T-test: Pre & 3 month values			
t critical (two tail) = -2.024394	Risk value = 0.05		Df:38
Confidence Statements	**t Stat**	**P(T<=t) two-tail**	**Significant?**
Explain what alcohol is and how it affects the body.	-7.80485	2.06E-09	Yes
b) Describe the short term implications of alcohol use...	-6.09109	4.27E-07	Yes
c) Describe the long term implications of alcohol use... on	-6.2	3.03E-07	Yes
d) Describe the social harm associated with alcohol use ...	-5.96015	6.46E-07	Yes
e) Be able to use information...to calculate units and assess risk..	-9.03635	5.28E-11	Yes
f) Explain units of alcohol and know the alcohol content ...	-6.87593	3.62E-08	Yes
g) Give sensible drinking advice including daily and weekly...	-7.59446	3.92E-09	Yes
h) Understand and use basic MI techniques ...	-6.96573	2.74E-08	Yes
i) Understand and use basic behaviour change techniques ...	-5.93275	7.04E-07	Yes
j) Understand the role and function of alcohol organisations...	-4.84113	2.18E-05	Yes
Table J: Confidence Statement T-test: Pre & 6 month values			
t critical (two tail) = -2.024394	Risk value = 0.05		Df:38
Confidence Statements	**t Stat**	**P(T<=t) two-tail**	**Significant?**
Explain what alcohol is and how it affects the body.	-7.82567	1.93E-09	Yes
b) Describe the short term implications of alcohol use...	-6.57739	9.23E-08	Yes
c) Describe the long term implications of alcohol use... on	-7.45795	5.96E-09	Yes
d) Describe the social harm associated with alcohol use ...	-6.78177	4.86E-08	Yes
e) Be able to use information...to calculate units and assess risk..	-8.7388	1.26E-10	Yes
f) Explain units of alcohol and know the alcohol content ...	-7.72938	2.59E-09	Yes

g) Give sensible drinking advice including daily and weekly...	-7.3236	9.01E-09	Yes
h) Understand and use basic MI techniques ...	-7.06913	1.98E-08	Yes
i) Understand and use basic behaviour change techniques ...	-6.65833	7.16E-08	Yes
j) Understand the role and function of alcohol organisations...	-6.35122	1.88E-07	Yes

PART THREE: GENERAL POST COURSE FEEDBACK

After the training, in addition to repeating key questions from the pre-course questionnaire, respondents were asked to provide comments on their experience of the course, their intention to integrate the approaches into their practice and their ongoing support and training needs.

4.7 USEFULNESS OF COURSE

The majority of respondents indicated that they had found the training very useful (n.29) or useful (n.8) (Graph G)

Count of responses

The majority of respondents indicated that the course had been useful because it had improved their knowledge and skills and developed their confidence.

> *"I found the course very informative and [it] has given me confidence in approaching people's drinking"*
>
> *"First training on this subject so lots of ideas and information"*

Others indicated that it had consolidated previous learning and had given them opportunities to reflect on their practice.

> *"Really helpful for consolidating information"*
>
> *"Already trained - but always good to get refreshers"*

Specific topics and approaches that respondents indicated as being most useful were:

- Units information (& unit calculators)
- Ways in/approach to talking about alcohol
- Motivational interviewing techniques

All respondents were very positive about the style and competence of the trainers. Specific comments include:

> *"Very competent and confident - great personal style"*
>
> *"Very well presented"*
>
> *"Very knowledgeable and enthusiastic"*
>
> *"Good theory based approach with practical solutions"*

4.8 INTEGRATING ALCOHOL INTERVENTIONS

All respondents (n=39) indicated that they would integrate alcohol interventions into their practice. Some of the reasons given for their response were:

- Very relevant as alcohol is an issue for clients
- See this as an important part of full 'holistic' support
- Recognise importance of minimising harm associated with alcohol
- Alcohol questions being part of assessment will make it easier

In addition to the above many respondents indicated that they will integrate alcohol interventions into their practice because they now feel that they have the confidence and knowledge to do so.

> *"I feel more confident in approaching this topic or if it comes up naturally during assessment".*
>
> *"I feel more comfortable in advising and signposting"*

4.9 SUPPORT, INFORMATION, RESOURCES AND TRAINING

Respondents were asked what support information and resources they require to talk about alcohol with their clients. Responses were:

- Resources i.e. leaflets and unit calculators (n=10)
- Further information about services/referral (n=8)
- Materials available in training pack (n=5)
- Cyrenians website (n=5)
- Support buddy (n=3) i.e. experienced colleague whom you can partner up with
- Updates on statistics (n=1)
- More time with clients (n=1)
- Regular supervisions on cases (n=1)

Following this respondents were asked what other training needs they had. Respondents indicated that they would welcome:

- Training on drugs (n=11)
- Motivational Interviewing training (n=7)
- Refresher courses and further more in-depth training on alcohol (n=7)

Other issues that fewer respondents indicated they would like more information on included effects of alcohol on the body (n=2) and issues relating to dependence and working with ex-drinkers (n=2).

4.10 ADDITIONAL COMMENTS

Finally respondents were asked to provide any other comments about the course, this included:

"Thank you - lots of food for thought"

"Really enjoyed the day. Jenny and George were fab"

"Just to stress - I thought the trainers were very good." "Everybody participated & it was really informative & enjoyable – thank you!"

"Like the personal way each of our needs were met at end of day rather than just as a group - never seen this done before and much more effective"

"I thought the information was helpful and developed/ expanded on my knowledge of alcohol and misuse"

5.0 FINDINGS: QUALITATIVE APPROACHES

Interviews and case file analysis were carried out in order to provide a more in-depth picture of the impact of the AI training on staff knowledge, skills and confidence. This section outlines the findings from these approaches.

PART ONE: INTERVIEWS

5.1 INTERVIEWEE CHARACTERISTICS

12 interviews were carried out with staff representing the following services:

- Homelessness Prevention Service
- Drug and Alcohol service
- Cyrenians Communities
- People with Potential
- Learning and Work
- Enterprise
- Amber mediation
- Smart Move

5.2 IMPACT ON PRACTICE

The majority of interviewees indicated that the training had positively impacted on their practice (n=8). This included feeling more confident talking about alcohol and raising the issue with clients, improved understanding of alcohol including units and drinking limits and greater awareness of how alcohol impacts wider society.

> *"It's given me more confidence to discuss this quite openly with people and people have been very responsive to it."* **Participant A**

> *"I think now I know more about what the units are, so when a client is telling me he had drank so much I can then put it into units and show them how much they are going over the limit. They wouldn't even realize they were out with the limit"* **Participant J**

> *"It impacted greatly on my practice. Prior to undertaking the AI training I would not have been that confident speaking to service users about their alcohol intake, including asking them questions about the level of drinking that they were consuming. I didn't have a great knowledge about the units and measurements. So what the training did was give me the awareness, the understanding and the confidence to speak to service users about their drinking habits."* **Participant K**

A smaller number of interviewees indicated that the training had not impacted on their practice. The most common reason given was that as yet they hadn't had the opportunity.

This related to feeling that the approach wasn't relevant to their client group or that the type of service they provided didn't lend itself to raising the issue of alcohol use. This is discussed further in 'barriers to implementation'.

> *"We can't do very deep support, but I think with those clients who have alcohol issues it could be useful in the future"* **Participant C**

The only other reason given, by considerably fewer interviewees, for the training not impacting on skills was that they already had the skills introduced as part of the training.

> *"Very little impact as have been working on alcohol for a number of years so it hasn't been an issue"* **Participant G**

5.3 BARRIERS TO IMPLEMENTATION

Interviewees were asked to reflect on the barriers to implementing alcohol interventions within their service.

As outlined above the most common barrier was felt to be the type of service provided and the type of clients their service worked with. This related to services that used the Key Worker Light approach[3] (or where they were in transition to this). This included services that have one off meetings with clients or provide a very specific type of support to clients. This was raised by interviewees with experience within employment services, mentoring services and also within the social enterprises. Within the latter further issues were raised relating to the difficulty in balancing the need to support vulnerable people with the need to run a business. This included the potential conflict of interest where there are consequences to any suspicion of coming to work under the influence of alcohol or excessive alcohol use leading to missed shifts, being late etc.

In addition to the type of service questions were raised about the appropriateness of the AI approach with some client groups, in particular younger clients i.e. under 18's, clients with learning disabilities and clients that indicate that they don't have 'alcohol issues'.

> *"It's just when people come into me to look for a CV and they'll get a CV and I might not see them again, so I'm not going to ask them about their alcohol, because it doesn't fit in."* **Participant E**

> *"It can be difficult to bring up in their own tenancies because i feel that they shut down alittle bit when you try to ask them outright about alcohol issues but to be honest that could happen in any setting."* **Participant F**

> *"For myself it is the type of service that I am in … There has got to be trust there before I can mention it. It's really got to be done after*

3 See page 7 for overview of Key Worker Practice Model and Key Worker Light approach

building up that rapport and for some clients they are only coming in here to discuss work issues." **Participant B**

"I know that alcoholism can be quite a big factor of homelessness, but just from working with younger people it's not that much of a problem….I think it could maybe be altered a bit for people that work with younger clients." **Participant J**

Other barriers raised by interviewees included:

- Denial of alcohol use by client/cultural attitudes that 'normalise' alcohol use

  "I think it has a lot to do with the person you are working with and where they are in terms of admitting that their drinking has become problematic." **Participant I**

- Knowledge and confidence lost if not used soon after training

  "If you don't use the skills regularly then you get out of practice" **Participant A**

  "Training was brilliant and resources are great. However, if left to own devices it's easy to forget things and for it not to get embedded." **Participant H**

- Feeling that alcohol is a taboo subject

  "I think it is still a taboo subject…I am conscious of cultural factors." **Participant H**

  "It's about phrasing the question to be honest. It moving from saying you have an alcohol problem to saying look can we have a look at your alcohol intake to see what you are drinking at the moment, and then beginning to have that discussion….so it's all about re-educating the service user to look at what's an acceptable an appropriate level of alcohol, and a safe level of intake." **Participant K**

5.4 FACILITATORS TO IMPLEMENTATION

Interviewees were asked to reflect on what helps to facilitate the implementation of alcohol interventions within their service. Key facilitators included:

- Units information and the unit calculators

  "Well I found that the units information and the effects on the body [very effective] when I have taken out this to clients… when I have explained to them how many units they are allowed each day and how

much they are actually drinking it shocked them as they didn't realise how much they are actually drinking." **Participant F**

"Having visual things is very useful – like the wheels." **Participant L**

- Knowledge and confidence developed by training

  "Top of the list is the initial intervention training. We all have our own thoughts and as a nation we all have our thoughts, but seeing it in black and white seeing the full context of the issue within the intervention training and what we can actually do about it is a big eye opener." **Participant K**

  "Knowing about it [alcohol]is biggest thing so that if it arises I have that knowledge and background." **Participant D**

- Opportunities to put knowledge and learning into practice & having alcohol questions as part of the personal plan

  "Seeing an effect in doing them, seeing that people aren't as offended when you bring alcohol into the conversation, having confidence in using the AI helps." **Participant I**

  "It's part of their personal plan that's within their file, alcohol is, and so you record how many units they've taken on I think their heaviest drinking day, so with that it makes it easier to bring up and discuss." **Participant J**

- Having an awareness of Motivational Interviewing

  "The training touched a bit on motivational interviewing and as a follow up I took part in the MI training, and the two of them together have been quite a good combination. **Participant I**

The majority of interviewees indicated that they had accessed the Cyrenians Getting the Measure website (n=9). Most had done this immediately after their training course and not much since then. However, although the website was not being widely used on regular basis all interviewees felt that it was helpful to know that the information was there if they need it.

"I think it's very clear, it's done well and it's easy to find information on it. I went there after the course a couple of times because I was thinking about something and I wanted to find information on it." **Participant D**

"Absolutely brilliant. Fantastic, both in terms of having all the resources in one area, but also having the measurement tools available so that

you're able to work out units of alcohol and all that sort of stuff as well. So it's a brilliant one stop shop really for alcohol interventions."
Participant K

5.5 AI AS AN APPROACH AND ONGOING SUPPORT

Overall interviewees were very positive about AI as an approach to working with clients on issues surrounding their alcohol use.

> *"It's a good intervention for trying to help people to address harm reduction for their alcohol intake rather than abstinence and stopping completely. It's trying to help them focus on that and then the other aspects such as tenancy, benefits or financial aspects may be benefited more if they are able to be more focused and more clear and clarify things that they want to get dealt with."* **Participant A**

> *"Really fantastic tool to get people looking at their drinking"*
> **Participant G**

> *"It is definitely useful but it really just depends on who comes through the door."* **Participant B**

However, there were some notes of caution. This was in recognition that alcohol is only one aspect in a clients life and that it is not always a priority for them. It was also felt to be important for Cyrenians staff to raise alcohol at a time and place that is appropriate.

> *"As long as it is just part of what we offer like a tool in our toolbox then it's very helpful. But as the main focus not helpful as needs to be as part of the relationship as otherwise it would be intrusive"* **Participant H**

One interviewee also highlighted that some clients have literacy issues and due to this some of the materials that have been produced may not be suited to their needs.

> *"If I was to score it 1 to 10 I would score it a 9. The only thing I would say is some of the literature might need to broken down further again for some of our service users who may have literacy and numeracy difficulties, or who may have difficulty picking up some of the key concepts."* **Participant K**

Interview participants were asked for their views on their ongoing support needs for the development of AI in their practice. Suggestions were:

- Revision courses
- Advanced training (with more on MI approaches)
- Peer support
- Inputs from specialist agencies to team meetings

- Having resources visible in services and ensuring that support literature is appropriate for clients i.e. literacy and numeracy issues.

> *"As long as resources are in place – website, person I can speak to, then that will be enough for me."* **Participant D**

PART TWO: CASE FILE ANALYSIS

5.6 OVERVIEW OF FILES

The findings from this analysis are based upon 22 client case files. This included files from before and after the training. Due to some of the limitations of this analysis we were not able to come to any authoritative conclusions. For example, we are unable to conclude whether the findings from the analysis were reflective of the quality of practice between staff and service users or due to the quality of record keeping, or a combination of both.

5.7 KEY ISSUES

The analysis of files has however provided some valuable indicators of areas where improvements in practice have taken place and areas that may benefit from further development. In summary the analysis of case files indicated that following training:

- In general, there were some indications of a greater and improved focus on alcohol;
- In general, staff would appear to be more likely to raise the issue of alcohol with clients and engage in conversations about drinking and related problems.
- There is some evidence that client's alcohol consumption and related problems are being more effectively monitored and recorded as part of the ongoing case management process.
- There are some indications that some staff are exploring alcohol consumption more effectively at initial contact including assessment of risk in relation to consumption and recommended guidance/limits.

There were also some areas that may benefit from further exploration and further development. These issues included:

- Some indications of inconsistencies in terms of how some staff are assessing 'risk' in relation to levels and patterns of consumption. It was noted that amongst a few staff there were interpretations and assessments of risky drinking based upon levels and patterns of consumption that would not have been screened as such by a validated alcohol screening tool;
- This finding was further supported in some cases by matrix scores which did not necessarily reflect levels of consumption and related risk.

- Some evidence amongst a few staff of inaccurate unit calculations- suggesting that staff would benefit from some additional information and guidance on units and unit calculations.
- Some evidence of inconsistencies in terms of quality of staff-worker discussions on alcohol and/or information being recorded within case notes;
- This finding related to different interpretations of certain terms within the case record paperwork. This included the term 'agreed actions' where this was being interpreted as an action that did not necessarily relate to an alcohol behaviour change within the context of the alcohol intervention
- Actions were often described in very vague and general terms rather than as SMART goals, suggesting that staff would benefit from some additional guidance in this area.
- Difficulties in identifying from the case notes whether certain stages and elements of the taught alcohol intervention were being applied in practice. For example there was no evidence of whether particular motivational interviewing techniques and tools were being applied.
- It should be noted however that this does not necessarily mean to say that this is not actually happening in practice.

6.0 DISCUSSION AND CONCLUSIONS

The findings from the evaluation indicate that staff feel that the Alcohol Intervention advocated on 'Getting the Measure' training is important and that they want to implement it. It is also evident that the training has had a positive impact on the knowledge and confidence levels of staff and to a lesser extent on staff attitudes. This would lead us to conclude that overall the training and resources provided have been effective in encouraging frontline workers to discuss alcohol use with service users.

Whilst it is important to acknowledge the positive impact of the training it is also important to explore the findings in a more in-depth way, in particular across different staffing groups. From the findings there is evidence that some staff groups feel they already use the AI model – particularly motivational interviewing techniques. This was specifically within substance misuse services. In addition, there is some indication that some staff have been less able to implement alcohol interventions than others.

Within this discussion section we outline the key areas of interest that have emerged from the findings. We feel that it is useful to discuss these in relation to the sequence in which they would arise when implementing an alcohol intervention, mainly:

- Raising issue with clients
- Assessment of risk with clients – including understanding of units and limits
- Use of MI approaches and behaviour change theory

In addition to the above we discuss the impact of resources and monitoring frameworks on staff skills and confidence and finally draw conclusions as to the effectiveness of the alcohol intervention model across Cyrenians services.

6.1 RAISING THE ISSUE WITH CLIENTS

A key aim of the evaluation was to assess the effectiveness of the training and resources in encouraging frontline workers to discuss alcohol use with service users.

The findings indicate that overall staff were more effective in raising the issue of alcohol with clients and that this was largely due to the impact of the training on staff knowledge and levels of confidence.

However, there was also some indication from the findings that this wasn't universal across all staff. This is reflected in the following:

- Lack of retention for some staff in the skills and confidence initially gained from the training – evident in a slight drop off in scores at the 3 and 6 month follow-up.
- Mixed picture in staff attitudes particularly for questions relating to role legitimacy i.e. workers perceptions of whether asking about alcohol is a legitimate part of their role and whether clients would consider it a legitimate part of their role.

- Views from interview participants that it can be difficult in some types of services for the issue of alcohol to be raised in a way that feels relevant and appropriate.

This issue was explored in some depth as part of the validation process.

Although the benefits of the training were discussed it was also felt that the ability to raise the issue of alcohol was dependent upon the type of service being delivered.

There was some indication that services that use the Key Worker Light approach found it more difficult to raise the issue of alcohol with clients. This was most relevant to services that have one off meetings with clients and/or meetings that are focused on a specific area such as CV writing. Other types of services mentioned were the social enterprise businesses within Cyrenians.

Generally this related to 'Role Legitimacy' – feelings that clients accessing particular services would not see it as the legitimate role of that service to be asking personal questions about alcohol consumption. In addition, staff feeling reluctant to ask questions about alcohol because a relationship had not yet been developed. Among social enterprises the concern related to a potential conflict of interest in managers supporting volunteers with alcohol issues whilst also being required to run an efficient business where there could be consequences for alcohol misuse if it impacted on a volunteers ability to work i.e. being late for work, lacking concentration etc.

It is important to note that the barriers identified within this evaluation for particular staffing groups and services within Cyrenians are not new, unique to the homelessness setting or Cyrenians as an organisation. On the contrary they are the same barriers and concerns that have been identified by previous research (Kaner et al 1999). It is our view that the ways to overcome the identified barriers are the same approaches advocated by research (Raistrick et al 2006), in particular the implementation of training tailored to specific job roles/settings.

However, it is also important to recognise the current gap in evidence relating to the legitimacy of non-health care practitioners enquiring about alcohol use. Due to this gap we feel that it would be beneficial for Cyrenians as an organisation to explore this issue with clients in more depth, across all of their services.

In conclusion, the findings from this study would indicate that in general the Getting the Measure training has had a significant impact on staff ability to raise the issue of alcohol. Where there has been less impact is among the services and staffing groups that work to the Key Worker Light approach[4]. This is an important issue when reflecting on the suitability and effectiveness of the alcohol intervention model that is currently advocated by the Getting the Measure training.

4 See page 7 for explanation of Key Worker Practice Model and Key Worker Light approach

6.2 ALCOHOL UNITS AND LIMITS

Analysis indicates that for many staff the training had a positive and sustained impact on their knowledge and skills relating to the assessment of risk. However, for others there were some inconsistencies in their approach to assessing risk. Key related findings include:

- Knowledge statements which relate to the assessment of risk include statement b ('what a unit of alcohol is, alcohol content of common drinks and recommended drinking limits for adults'), statement d ('the factors which put people at risk of developing drinking problems') and statement h ('approaches for assessing level of risk from alcohol consumption').
- Across each of these statements – as with all knowledge statements – there were significant improvements in scores. However, for statements b and h there was some drop off in these improvements at 3 and 6 month follow ups. In addition the knowledge score for statement h at 6 months was given the lowest rating by participants across all knowledge statements.
- Within the interviews an identified facilitator for the delivery of alcohol interventions was felt to be the knowledge gained on alcohol units and the provision of unit calculators to use in practice. Although the case file analysis supports this and indicates that generally staff were more effectively exploring alcohol consumption there was also some indication of inconsistencies in terms of how staff assess risk.

Taking the above into account the findings indicate that some staff may benefit from further information and guidance in relation to units of alcohol and recommend limits, particularly in relation to:

- The calculation of alcohol drinks into units of alcohol
- The assessment of alcohol health 'risk' in relation to levels and patterns of drinking including effects of alcohol i.e. what do certain levels and patterns of drinking mean in terms of risk/s to health (alcohol and their effects)
- Assessing a client's suitability for the Cyrenians alcohol intervention i.e. when it would and would not be appropriate to use the approach promoted by training and when it would be appropriate to signpost/refer to another service for a different level of intervention and support?

The validation group process provided some scope to explore these particular evaluation findings and conclusions.

It was felt by the validation process that particular alcohol consumption questions relating to weekly/daily and heaviest day do not necessarily capture the drinking patterns and related risk of many of the clients that staff work with. The example that was given related to clients being alcohol free for one or two weeks and then going on a large 'bender' (binge).

Sets of validated (by research) alcohol screening questions are designed to capture and assess different levels and patterns of 'risky' drinking as accurately as possible. The validation groups were shown examples of the FAST alcohol screening tool and were asked whether the use of such a tool could potentially be useful for supporting the process of identifying alcohol risk and problems amongst service users.

There was a mixed response to the idea of using a formal screening questionnaire with clients. One validation group concluded that the use of such a tool would not necessarily over formalise the assessment process or impact negatively upon the relationship between

worker and client, and that a tested set of questions (used systematically) may be more effective than a set of un-validated questions.

However, the other validation group were not as supportive of the idea of using a formal process and questionnaire. This was possibly reflected by the greater number of services present in this group that did not have a key worker relationship with clients and where it was felt that any exploration of alcohol with clients was already challenging and not always appropriate.

Both groups concluded and agreed that the use of more formal tools would be useful as an option but not necessarily as a requirement for staff as part of the AI process.

The literature presented in this report was not able to identify any research or practice relating to the use of such tools in non-healthcare community settings. We were therefore unable to draw any clear conclusions about the transferability and applicability of such tools for Cyrenians services. We have however presented some of the evidence relating to the strengths and weaknesses of formal and informal approaches as well as Warners (2009) critical appraisal and guide to evaluating the use of screening tools in practice.

6.3 USE OF MI APPROACHES & BEHAVIOUR CHANGE THEORY

As with all areas of learning there is some indication that the Getting the Measure training had a positive impact of staff knowledge about motivational interviewing approaches and confidence in implementing these approaches and wider behaviour change approaches.

Specific issues that arose from the findings were:

- Some staff were already using AI model – particularly motivational interviewing techniques. This was specifically within substance misuse services.
- Some of the largest increases in knowledge and confidence related to statements that were specific to MI approaches and behaviour change theory. However, in contrast to this some of these statements at each stage of the evaluation were given the lowest knowledge and confidence scores.
- Within the case file analysis it was difficult to assess whether MI techniques and tools were being applied.

Within the qualitative findings it was interesting to note that many participants indicated that refresher training on MI would be useful. Others indicated that they had found the subsequent training on MI that they had attended (via STRADA) to be very complimentary to the Getting the Measure training and helpful to their practice.

Within the validation groups both groups indicated that within the Getting the Measure training specific MI approaches covered by the training included the motivation matrix and the confidence ruler. Staff indicated that they had found these techniques to be helpful and that they would welcome visual prompts that could be used with clients as a way of supporting their practice.

Specific suggestions included the development of visual prompts which are closely aligned to the matrix scores system that guides how they work with clients.

Within the validation group there was discussion around the usefulness of the motivation matrix with younger clients i.e. 16 to 18 year olds. It was felt that for this age group a greater focus needs to be placed on the immediate effects of alcohol (rather than longer term). In addition, for some young clients the process of the motivation matrix can affirm that they are not yet willing to change their drinking behaviour.

Overall, there is some suggestion that the Getting the Measure training has had a positive impact on staff knowledge and confidence levels in using MI and behaviour change approaches. However, at the moment there is no system in place for measuring or monitoring the extent to which staff implement these approaches.

We feel that it would be useful to provide staff with visual prompts that reinforce the learning they gain from the training. However, it may also be useful to provide staff with a practice reflection sheet that breaks down the different components of the AI approach – particularly the specific MI and behaviour change techniques. This practice reflection sheet could then be used by individual staff members and/or as part of refresher sessions within teams or across the organisation to help staff to work through how and when they are using specific MI and behaviour change approaches. Potentially this information could then be gathered and used as 'case study' examples.

The issue of how relevant and useful the AI approach is for younger clients i.e. 16 to 18 year olds arose not only in relation to behaviour change techniques but across the evaluation. This issue is discussed more specifically within section 6.5 'Model Applicable to all Settings?'.

6.4 ONGOING SUPPORT MATERIALS/TRAINING

Staff gave a range of suggestions on what resources would help them to more fully implement alcohol interventions into their practice. The opinions and suggestions given by staff are summarised here and in our view should be given due weight and consideration by Cyrenians.

As outlined above all participants agreed that the Getting the Measure training supported the acquisition of staff knowledge, skills and confidence in relation to alcohol and the AI approach. Specific factors that were felt to support the process of raising the issue of alcohol and carrying out an alcohol intervention were:

- Development of staff confidence and recognition that clients generally won't be offended (through training).
- The recent change in paperwork – both for providing prompts and also supporting the issue to be brought up in a natural and fluid way.
- Materials provided i.e. wheels, cups etc. Useful as seen as non-threatening, tactile and visual.

Many staff stated that they had accessed the Getting the Measure website and had found it helpful. However, in many instances staff indicated that this had been immediately following

the training and that they hadn't accessed it since. It is our experience that this is commonly how practitioners use websites. Although the website may have useful and downloadable resources staff are more likely to use (often the same) resources when they are provided to them in other formats such as laminated sheets, leaflets etc. It is recognised however that this approach has financial implications.

Where it was identified that staff hadn't implemented the AI approach at all or as much as they would have liked suggestions given for helping them further included:

- Refresher courses on alcohol interventions
- Opportunity for peer support – particularly inputs from specialist teams and opportunities to see/hear about alcohol interventions being put into practice

The validation process was used as an opportunity to further explore the effectiveness of training and resources in encouraging frontline workers to discuss alcohol use with service users. In particular, to get staff views on what specific adaptations/available tools would be helpful to their practice.

Participants identified the need for greater and clearer visual prompts to use with clients, in particular to support discussion on alcohol units and limits, related risk and effects and behaviour change approaches.

It was felt that the continuum of risk arrow, which is promoted by the training, would be a useful tool to use with clients. Staff felt that it would be helpful when assessing alcohol risk and providing feedback on limits and risk to clients.

A version of the continuum of risk arrow, which is promoted by the training, was shown to participants. They indicated that the visual arrow supported by more detailed information relating to cut off points for increasing and higher risk drinking would be useful to use with clients.

It was felt that written information (leaflets) for clients that would support the AI process would be useful. This should include information on units, limits, risk, and alcohol and their effects i.e. what does increasing and higher risk drinking mean in terms of risk to health and in relation to particular diseases and illness. It was felt that this information would also be useful for staff to access, to support the process of providing personalised feedback and guidance to clients on alcohol consumption.

It was felt that particular information and guidance relating to units and limits for under 18 year olds would be useful for both clients and staff. It was felt that for this age group there should be a greater focus upon immediate rather than long term effects of alcohol, harm reduction and the use of more accessible and appropriate language.

Create would broadly support all the ideas and suggestions that emerged from the validation groups for the design and production of further information, guidance and resources in relation to alcohol units, limits, risk, and alcohol and their effects.

6.5 AI MODEL APPLICABLE TO ALL SETTINGS?

This evaluation has highlighted that the Getting the Measure training and the AI model advocated by the training is particularly useful for staff who work to the key worker model. However, within services that do not use this model or where there are other types of approaches within a service, the use of the AI approach as advocated by the training is more difficult to put into practice.

In conclusion, a key challenge for Cyrenians is finding solutions to the identified barriers and to develop approaches that ensure that staff across all services feel able to raise the issue of alcohol in a natural and non-threatening way. It is our view that the following recommendations will support this process:

1. Development of tailored training for different staffing groups

This could take different forms including a core training programme (based on existing Getting the Measure training) which all staff attend with follow up sessions for specific staffing groups. Follow up sessions with practitioners using the Key Worker Light approach could focus on the more traditional brief intervention approach with discussion on ways to harness opportunistic opportunities to raise alcohol use and respond to this within one off or time limited meetings.

2. Development of refresher sessions for staff

The format of these refresher sessions could take different forms and may also include wider initiatives such as shadowing or observation of practice. However, it is important that they incorporate the following elements:

- Opportunities for staff to practice their skills and receive constructive feedback
- Sharing of good practice/specific examples from practice
- Opportunity for reflective practice – supported by a Practice Reflection sheet that outlines the core components of the AI approach

3. Ongoing development of visual and tactile resources to help assess risk and carry out specific behaviour change techniques

A range of resources have been suggested by staff to support the implementation of AI in practice. We would support the development of visual resources that are appropriate for the client group. We recognise that the website is a useful resource for staff however, would encourage Cyrenians to prioritise core resources which they also provide directly to staff. In particular:

- continuum of risk arrow
- visual prompts for MI and behaviour change techniques

4. Further exploration into potential use of validated screening tool

Further investigation may be required to be able to properly critique and appraise the transferability and applicability of more formal (validated) processes and tools which are designed to identify alcohol (health) risk and problems. Any such appraisal should include consideration of issues such as whether service users would perceive the use of such tools to be a legitimate part of the role of Cyrenians staff and should also take into account the

differences in relationships that workers have with clients across the diverse range of Cyrenians services

5. Development of 2nd stage research with a focus on the engagement of clients to explore issues around role legitimacy and impact of the intervention

It is important that any training highlights the existing evidence that most individuals expect health professionals to enquire about their drinking and that this is a legitimate part of their practice. However, in absence of research that explores this issue with non-health care practitioners we feel that this would be a useful 2nd stage research project for Cyrenians.

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APPENDIX

Appendice A: About Cyrenians www.cyrenians.org.uk

Edinburgh Cyrenians is an independent Scottish Charity (number SCO11052) with an outstanding track record in pioneering creative solutions to the contemporary problems faced by people on the margins of society, such as; homelessness, poverty, deep unemployment, recovery from addiction and recidivism.

The charity also has an environmental brief, seeing the connection between valuing people and valuing our planet as part of the solution to a sustainable and happy future for society. Cyrenians trade-mark approach is to do new things really well and use the evidence of benefit to inform and inspire wider change.

Key statistics include:

- 71 people recovering and progressing following a period of substance misuse
- 290 people accessing our People with Potential Project accessing education, training and employment opportunities, including 56 people off benefits and into jobs
- 400 people helped to avoid homelessness through our Homelessness Prevention Housing support Service's
- 330 people housed through our SmartMove deposit guarantee schemes in Falkirk and West Lothian
- 52 key workers trained to deliver our getting the measure project
- 104 families having better relationships as a result of our Amber Mediation Service
- 27 young people, and 30 residential volunteers accommodated at Cyrenians Communities
- 1,700 Tonnes of food waste diverted from landfill by CORE for renewable energy and composting
- 396 tonnes of fit for purpose food diverted to homeless people by the Good Food Project