NHS Health Scotland

Young people and alcohol: scoping approaches to prevent or reduce harm

July 2013

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Published by NHS Health Scotland

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Edinburgh EH10 4SG

NHS Health Scotland is a WHO Collaborating Centre for Health Promotion and Public Health Development.

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Acknowledgements

NHS Health Scotland acknowledges assistance from all those who commented on the design and content of the scoping questionnaire, all those who returned information in the scoping exercise and those who volunteered to participate in the semi-structured interviews. All details will remain anonymous.

NHS Health Scotland is also grateful for the assistance provided by colleagues on the NHS Health Scotland Cross Organisation Alcohol and Drugs team, the Youth Health team and the Evaluation team.

Abbreviations and glossary

ABI: alcohol brief intervention

ADP: Alcohol and Drug Partnership

GLOW: online community for Scottish schools

Harmful drinking: a pattern of alcohol consumption that causes mental or physical harm to a person's health.

Hazardous drinking: a pattern of alcohol consumption which increases a person's risk of mental or physical harm, if current drinking habits continue.

Young person: for the purposes of this scoping, we have defined a young person as being roughly secondary school age, or age 11/12 up to around the age of 18.

The information provided in this report is only as accurate as the information provided throughout the scoping exercise. NHS Health Scotland does not advocate any particular approach or use of any particular resources when working with young people to prevent or reduce harm from alcohol.

Executive summary

Background

There is currently thought to be a wide range of education and prevention activity being undertaken nationally to prevent or reduce harm to young people from alcohol. This is against a backdrop of concerns that young people often see alcohol consumption as an integral part of growing up and a normal progression into adulthood.

This scoping exercise is intended to provide an overview of the approaches and initiatives being delivered to young people in Scotland and to capture a picture of broad health behaviour development initiatives which potentially support them to make informed decisions about alcohol.

Information was gathered from practitioners in the NHS, Alcohol and Drug Partnerships (ADPs), statutory services and third sector organisations and is primarily intended to inform NHS Health Scotland programme planning, resource development and partnership working.

Aims and objectives

The aim of the scoping exercise was to:

Produce a national overview of the approaches developed and implemented to prevent or reduce harm to young people in Scotland caused by their own alcohol consumption.

Objectives:

- Identify the range of initiatives which are currently being delivered and categorise them by setting.
- Conduct semi-structured interviews with key stakeholders (ADPs, third sector organisations, NHS) to gain more in-depth information to inform the final report (and later consider developing case studies on active projects).
- Incorporate views from young people directly, to inform working practice (see note on page 3).

Method

Mixed methods were employed for the information-gathering:

- Self-administered questionnaire.
- Semi-structured interviews.

Following the initial analysis of the questionnaires, a topic guide was developed to explore the underlying factors and influences in more depth.

Summary of findings

A wide range of approaches were found that raise awareness, inform, provide targeted support, or offer diversionary activities. These approaches were supported by a motivated workforce. There were variations in the training that the workforce had received, in terms of format and also whether specific alcohol or health promotion components were offered. This appeared to be dependent on their role. Although many of the respondents were limited to reporting on intended behaviour change or changes observed in a non-measured way, they appeared to see positive indicators of success.

Both the questionnaire and the interview data suggested that alcohol is only one component within health, wellbeing and personal safety messages to which young people should be exposed. Findings also suggested that motivated and knowledgeable practitioners should start from a holistic perspective to help encourage contemplation of behaviour. They reinforced the importance of recognising the age and stage of individuals within any targeted group when developing services that support young people.

Non-statutory youth services appear to be well-placed to offer holistic and alcohol- focused approaches at different levels. They can, for example, support the universal alcohol education delivered in schools and simultaneously offer more targeted services, particularly when working in partnership with statutory organisations.

There is potential for youth service design and delivery to benefit from wider information-sharing and clearer strategic direction. Aspects of the funding process appear to be particularly challenging, but local or national recognition of successful practice was highlighted as very supportive.

Including young people themselves both in design and delivery of services and resources emerged as a key point for several reasons. This input can:

- assist their learning
- result in services being more inviting for all young people
- help young people to build trusting relationships where personal issues can be raised.

Discussion

Young people today may be influenced by family and friends consuming alcohol and an assumption that it is difficult to socialise without alcohol use. They may not consider, or be aware of, immediate risks from hazardous drinking, such as accidents, injuries, violence and regretful sexual activity. Therefore, provision of education and support to prevent or reduce harm, and follow-up referrals and signposting after risky behaviour occurs is necessary. As part of a health development approach, building skills for positive decision-making and encouraging alternative health behaviour strategies are vital for both wellbeing and personal safety. These should be delivered through a balanced, supportive and non-judgemental approach.

However, it is also notable that there may be an assumption made by non-specialists that all young people consume alcohol frequently or to hazardous levels, when not all young people will drink alcohol to excess, if at all.

Conclusions

There appears to be a highly variable and inconsistent range of youth and alcohol initiatives which are often reactive in nature. High levels of assumption on the effectiveness, and low levels of familiarity with, (or gaps in) the evidence on content, delivery and evaluation of impact is apparent, along with inconsistencies in planning and delivery and measurement of success. However, the project did capture examples of a wide range of initiatives. These were fed back by participants (often anecdotally). They felt that local evaluation evidence indicated a positive impact on young people. They also felt it contributed to a motivated workforce.

Promoting awareness of, and responsibility for, the consequences of alcohol misuse in young people is likely to be more successful when it is within the wider context of personal wellbeing, personal responsibilities and educational attainment.

Young people want information that supports them in making their own choices and to be able to access support if or when they need it. However, there should also be a focus on building personal skills that help young people to make choices to minimise unwanted risks, build resilience and strengthen other protective factors for wellbeing.

There appears to be a lack of accessible youth activities that promote a social culture free of alcohol. Family, carers, friends and communities have a part to play in making alcohol-free activities more attractive and relevant for young people.

Issues for consideration

Having drawn together the findings from both the questionnaire responses and the interviews, the issues to be considered for preventing or reducing alcohol- associated harm to young people have been grouped below. NHS Health Scotland will work with partners to explore how these areas might be progressed.

1. Infrastructure:
Strengthen evidence-informed practice and improve workforce capacity.

2. Delivery mechanism:
Promote effective partnership working and facilitate the sharing of learning.

3. Project content:
Facilitate effective planning and better design of services for young people, ensuring accurate, timely and accessible delivery of alcohol messages.

1. Introduction

This scoping exercise aimed to capture an overview of the range of approaches and initiatives being undertaken across Scotland, in order to show a picture of broad health behaviour development initiatives that potentially support young people to make informed decisions about alcohol.

Information was gathered from practitioners in the NHS, Alcohol and Drug Partnerships (ADPs), statutory services and third sector organisations and is primarily intended to inform NHS Health Scotland programme planning, resource development and partnership working.

1.1 Background

Concerns were expressed about the harmful impact of alcohol misuse among young people in Scotland during the consultation period for the national alcohol policy, *Changing Scotland's Relationship with Alcohol: A Framework for Action* (Scottish Government, 2009). The Framework contains a multi-stranded package of measures to create an environment for individuals (including young people) to examine their own relationship with alcohol.

The Scottish Government, in partnership with Young Scot, set up a Youth Commission on Alcohol which produced a Report of Recommendations (Young Scot, 2010) to address young people's attitudes, behaviour and knowledge about alcohol consumption. The Commission comprised 16 young people between the ages of 14 and 22, who drew on evidence and expertise from a wide range of perspectives. Having considered information directly gathered from over 3000 young people, they identified 8 specific themes and made 38 recommendations (see Discussion, page 19).

With regard to prevalence, the Scottish Schools Adolescent Lifestyle and Substance Use (SALSUS) 2010 study (ISD Scotland, 2011) showed a continued decline in recent years in the reported alcohol consumption of school pupils. The 2010 study showed that 44% of 13-year-olds and 77% of 15-year-olds had ever had an alcoholic drink. This is a drop from the 2008 figures, which showed 52% of 13-year-olds and 82% of 15-year-olds as ever having had a drink.

However, the 2010 study showed an increase in the proportion of pupils who reported having an alcoholic drink in the previous week, (14% of 13-year-olds and 34% of 15-year-olds), compared to the 2008 figures (11% of 13-year-olds and 31% of 15-year-olds), reversing the steady decline in trend between 2002 and 2008. It is advisable to treat these latest figures with caution, particularly in the context of change over time.

The Scottish Health Behaviour in School-aged Children (HBSC) study (Currie C, et al, 2011) supports the decline found in the SALSUS study regarding the reported alcohol consumption by young people, although their figures are

categorised differently. They recorded 10% of 13-year-olds and 27% of 15-year-olds as reporting drinking alcohol every week.

Also of note is data from the Prisoner Survey (Scottish Prison Service, 2011). This showed that 75% of young offenders reported being drunk at the time of their offence, which compares to 46% of adult prisoners, also raising a concern that young people's alcohol consumption can contribute to offending behaviour.

The SALSUS 2010 study (ISD Scotland, 2011) also highlights the health and social harms experienced by young people as a consequence of their alcohol consumption. Of the young people who reported drinking alcohol, 3% had vomited, 2% were injured (requiring medical attention) and 3% were admitted to hospital overnight. In terms of social harms, 29% had had an argument, 14% had been in a fight, 16% had been in trouble with the police and 8% had stayed off school.

This aspect is also referred to within the wider picture of alcohol-related harm, in the Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) 2012 report (Beeston et. al).

The HBSC study (Currie C, et al, 2011) similarly identifies alcohol consumption in young people as a serious health and social issue which can be influenced by several factors. Alcohol consumption should therefore be considered within a wider context of youth health and general wellbeing.

Additionally, many young people today are also directly and indirectly targeted by alcohol media advertising which reinforces a social norm of drinking. This acceptance of alcohol consumption may also be sustained by family relationships and the prominence of alcohol within local communities.

1.2 Aims and objectives

The aim of the scoping exercise was to:
Produce a national overview of the approaches developed and implemented to prevent or reduce harm to young people caused by their own alcohol consumption.

Objectives:

- Identify the range of initiatives which are currently being delivered and categorise them by setting.
- Conduct semi-structured interviews with key stakeholders (ADPs, third sector organisations, the NHS) to gain more in-depth information to inform the final report (and later consider developing case studies on active projects).
- Incorporate views from young people directly, to inform working practice.

The project scope was to capture approaches and initiatives that target secondary- school-age children from S1 upwards (i.e. ages 11/12 up to the age of 18).

The collection of data on delivery of alcohol brief interventions (ABIs) was not within the project scope as our starting point was to explore the approaches and initiatives aimed at a younger population who may or may not already be consuming alcohol.

Note: Due to limited time and capacity to access a representative sample of young people, it was not possible to incorporate the views of young people directly. Consequently, this objective was not met.

2. Methodology

Mixed methods were employed for the information-gathering:

- Self-administered questionnaire
- Semi-structured interviews

A project outline paper was distributed along with the questionnaire in order to provide background information. This contextualised the project and provided guidance for participants to help them decide who were the most appropriate local partners to involve in feedback.

Returned questionnaires were stored electronically, as were the interview transcripts, accessible only by designated NHS Health Scotland staff. The interviews were carried out by the NHS Health Scotland officer leading the scoping exercise.

The returned questionnaire data was analysed and themed (see section 3.1, page 8) as was the data from the interviews (see section 3.3, page 14).

2.1 Survey methods

The questionnaire (Appendix A) was firstly pretested by four of the proposed contacts and further refined following their comments.

A distribution list of ADP Chairs and coordinators and ABI leads and coordinators was used. ABI contacts were included because many have a dual role which involves a wider alcohol remit.

An advance notice email was sent to the distribution list to:

- notify them of the project
- request further contacts in their local area who worked with young people to prevent and reduce harm from alcohol
- invite volunteers for interview.

This resulted in a lengthy distribution list where not all of the recipients were in a position to complete the questionnaire, but this cascading method was used in an attempt to sample a varied range of responses. Further contacts in this field already known to NHS Health Scotland were also included to ensure as wide a distribution as possible.

We had anticipated categorising the work across key settings in which the initiatives were delivered in order to enable comparison, but as data was returned the approach deployed appeared to be a key driver for design and delivery. We have, however, included reference to the settings separately as background information.

The categories of approaches and number of initiatives assigned to each category can be found in **Table 1** (page 7) in the results section.

2.2 Semi-structured Interviews

Informal semi-structured interviews were conducted with a small self-selected group after the survey data had been returned and analysed. Following analysis of the questionnaire responses, recurring themes were highlighted and a topic guide designed to further explore these themes. It was intended that these interviews could provide more information on the underlying supportive or protective factors, as well as the risks and challenges in developing initiatives for young people. They could also potentially yield case studies.

The interviewees received a topic guide prior to their interview and in some instances the interviewees used these to have conversations with their local colleagues prior to interview. Consequently, this feedback potentially captured a wider local dialogue but the interviewees also fed back their own observations and experiences. Four interviews were conducted over the phone and three in person.

The interviews were recorded, and following each one the recording was transcribed, formatted to highlight key themes and subsequently sent back to the interviewee for their final approval. Once returned, the interview information was then treated as final.

3. Results

We distributed **178** questionnaires and received responses totalling **68** separate initiatives. This equates to a response rate of 38%. Questionnaires were returned from third sector organisations and NHS staff in addition to staff employed by ADPs and statutory organisations.

For information purposes the responses have been grouped into three areas:

- North of Scotland: 20 responses
- Central Scotland: 27 responses
- South of Scotland: 21 responses

Following initial analysis of the survey findings, the approaches were categorised and further refined during the interviews:

- **Raise awareness and educate to reduce risk of harm**
  This strand covered several approaches with a health education element either via professional input or through organised peer education. This was delivered 1:1 or in a group in an education or community setting. A drama, music and performance subcategory has been noted under this heading, as they were either directed or supported by a professional and there appeared to be strong elements of alcohol education within these performances.

- **Targeted support**
  A targeted approach was identified as more specific and tailored to individual need and generally only delivered on an individual 1:1 basis.

- **Diversionary activity**
  Providing accessible alternative activities for young people was felt to reduce the emphasis on consuming alcohol and encourage activity to become a normal part of young people's routines. Diversionary activity is noted within the Framework for Action (Scottish Government, 2009) as a potential means to increase the likelihood of positive long-term outcomes for those who participate.

Some initiatives used a blended approach dependent on need, and this resulted in the range of categories containing a degree of subjective interpretation rather than being definitive. However, this was also a reflection of a responsive way of working employed by many of the organisations.

Table 1 overleaf shows the categories and the number of responses allocated to each.

Please note that several responses covered initiatives which included more than one type of approach:

Table 1: Approaches

Category of approach	Number assigned to category
Raise awareness and educate to reduce risk of harm	
Professional led session/programme/drop-in service	26
Peer education/mentor projects	8
Drama/music/performance	4
Community services/outreach	6
Online: educational websites	2
Targeted support	
Counselling/1:1/tailored to need	25
Subsequent to A&E presentation	1
Diversionary activity	
Football/sports/dance class	6
	Total = 78

For added information, the **settings** listed in the responses in which the activity occurs have been included below:

- School premises: drop-in area/small or large group education session
- College premises
- Third sector organisation/social work premises
- Home of young person
- Children's homes
- Dedicated youth café/youth club
- Youth events (festival sites/DJ club nights)
- Public spaces – around a major football ground
- Sports centres
- Street work

3.1 Survey questionnaire results

The questionnaire contained structured and semi-structured response options. Responses have been aggregated into the themes below covering aspects of service design and delivery.

Service delivery

51 initiatives (75%) were part of a planned service to prevent or reduce harm from alcohol, with alcohol issues stated as being a direct focus for 27 (40%) of the initiatives. The remaining initiatives appeared to have more general aims such as:

- delivering broader health and personal safety messages to reduce risky behaviour
- promoting mental and physical health
- reducing antisocial behaviour
- providing a youth restorative justice service.

30 responses (44%) stated that they did target those already consuming alcohol and it was worth noting that 34 (68%) had provision for offering an ABI if a young person was found to be drinking alcohol at a hazardous or harmful level. (Note also, however, that this NHS Health Scotland project focused on non-ABI activity.)

In addition, 47 of the responses (69%) stated that pathways or care referrals had been developed for those identified as requiring support and these were mainly for 1:1 support or counselling, or to a specific support service. The onward support depended on the service provider but covered areas such as alcohol support, mental health, sexual health, social work, young carer support, rape crisis, employment, housing, antisocial behaviour and woman's aid.

Training

55 responses (81%) indicated that the staff involved had received specific alcohol or health promotion training for their role and that there was a mix of formats and content, dependent on the service involved and their role.

The additional more specific training undertaken included:

- health promotion modules
- young people and alcohol
- health behaviour change/motivational interviewing/raising the issue of alcohol
  ABI training/brief intervention training
- life education training
- peer education training
- fetal alcohol syndrome.

Where it was indicated that there had been no specific training provided, this was generally attributed to the setting the practitioner role was based in, for

example A&E, fire safety or counselling services where there was felt to be limited need for specialist alcohol knowledge. Indeed, it was also reported that specialist alcohol knowledge was sometimes provided by external professionals where required, or the initiative would be delivered by teachers and it was felt that no additional training was required.

Evaluation

Although 52 responses (76%) indicated some form of follow-up or evaluation information was available, in many cases this related to a process evaluation of individual sessions, or service delivery, rather than measurement of longer-term impact. Of those who supplied information on this, 30 (44%) did report more in-depth evaluation being undertaken and this was sometimes externally commissioned.

Of the 16 responses (24%) who had no evaluation at present, 7 (10%) were planning future evaluation of their initiative.

Some evaluations involved completion of a questionnaire, while others reported collecting management information (for example, who attended a session or how many complaints of antisocial behaviour were received). Attitudinal surveys, personal development plans and ongoing feedback (from partner agencies and parents) were also used.

Post-session focus groups were mentioned in a few responses as a means to gather information to assess the impact and learning, and in one instance, feedback was obtained where there was ongoing weekly contact. In one whole-school approach, a pre- and post-test evaluation was undertaken and has been written up with a view to academic publication.

47 responses (69%) felt that an impact on behaviour had been observed and although they mainly reported this informally and anecdotally, they observed and reported a range of positive impacts such as:

- increased confidence and resilience of young people who are better informed and more able to make safer choices
- a decrease in frequency of alcohol consumption (self-reported)
- improved engagement between young people and those in authority
- peer pressure influencing behaviour positively
- increased skills and confidence of those involved as peer mentors
- increased discussion initiated by young people about alcohol consumption
- higher numbers of young people subsequently accessing a range of activities and services
- vulnerable individuals being better supported (through more regular needs assessments)
- a reduction of A&E alcohol-related consultations for young people
- reductions in youth-related antisocial behaviour, street drinking and alcohol-related offending
- initiatives being valued by school staff, pupils and parents.

It is important to stress that many of the respondents were limited to reporting on intended behaviour change or changes they observed in a non-measured way, rather than actual behaviour change. However, there were several which included measurable changes in behaviour and these were all positive. One police force had received excellence awards following their project evaluation.

Resources

The questionnaire enquired on the range of resources that practitioners used and any which they had developed locally for their own use. There was no opportunity to quality assure the content of these resources, but this could be revisited in future.

62 responses (91%) indicated that a combination of both local and national resources was employed. These ranged from handouts and teaching packs to posters, presentations and educational DVDs. Websites, apps and social media were also noted. In addition, there were visual aids included; for example, unit measuring cups, 'beer goggles'[1], group games and interactive workshop materials.

32 responses (47%) indicated that they had developed their own resources to meet their needs and these comprised a range of DVDs, educational written material, drinks diaries and presentations. In some cases these were developed with direct involvement from young people themselves, as were the interactive activities such as art, drama or music projects. Also noted were the development of local peer education packs, workshop materials/activities and the support provided by specialist agencies.

Support needs

In relation to the support which the respondents indicated would be helpful, there were a range of topics mentioned from the 40 responses (59%) to this question. The key needs are noted in **Table 2**. **Please note** that some responses indicated more than one topic, and data on who should provide the requested support was not captured in the survey.

Table 2: Support needs

Area requiring further support	Number of responses that highlighted this area for support
Training	22
Evaluation	9
Network support (including providing updates of new developments)	7
Funding	5
Practice examples from other areas, highlighted nationally	5
Partnership working*	3
Knowledge on behaviour change approaches	2

[1] Goggles that can be worn to simulate the effects of being drunk, by distorting vision, coordination and perception.

*****Support for partnership working referred in particular to guidance on holding joint training and events with local partners and for best practice ways to share learning, tools and resources locally.

A total of 7 responses (10%) requested support in terms of resources, evidence, data analysis and referral systems.

Where training needs were indicated this was mainly for:

- health behaviour change and motivational interviewing
- broader substance misuse information and specialist alcohol knowledge
- research analysis.

Supporting factors and challenges for developing services

36 responses (63%) provided some detail regarding the challenges they faced and the supporting factors used to overcome them. **Tables 3 and 4** on the next page provide a breakdown of the details given and the number of responses.

Table 3: Breakdown of supporting factors noted

Supporting factors	Number of responses
Willingness to work with partners to develop strong, positive partnerships	5
Establishing a strong, positive local reputation for the services provided	4
Sharing information	4
Strategic support from NHS and ADP	3
Ability to deliver broad health messages (not just alcohol)	3
Access to a good training programme	2

A total of 5 responses (7%) noted that interested and enthusiastic staff/practitioners and young people made service delivery easier, alongside working creatively to respond to community needs. One respondent highlighted that access to a friendly, welcoming, dedicated base was important, while two initiatives, having won a national award in recognition of their service, felt this was beneficial to future development.

Table 4: Breakdown of challenges noted

Challenge	Number of responses
Funding being limited/cyclical/time-consuming to access	14
Difficulties prioritising workload and maintaining capacity	4
Persuading practitioners and partners of the potential overall benefits	3
Local, smaller, third sector agencies are often not included in a referral pathway as there can be a preference for working with area-wide organisations	2
The time required to build a trusting relationship with a young person to encourage them to open up and be honest	2

A total of 4 responses (6%) also noted challenges due to limited capacity, resources and service availability. There were also challenges in maintaining an adequate number of peer educators/mentors and reaching family members to enable their support.

Summary of questionnaire findings

The responses covered a wide range of initiatives, driven by different needs and delivered by a varied range of practitioner roles and organisations. Additional comments highlighted that having core staff who had received more detailed training on alcohol issues was helpful and enabled them to rely less on external experts. Yet due to the mix of training formats and content that was reported, further exploration of workforce development requirements could be beneficial.

There were several comments where respondents indicated that they were planning to expand and offer additional services such as peer mentoring, young person counselling and working with families. This appeared to be partly due to the success they had already achieved and partly responding to a recognised need. However, it was also noted that there can be an assumption that all young people will consume alcohol at some point and this may not be the case.

Service delivery appears to be fragmented and could perhaps benefit from a wider sharing of local knowledge and clearer strategic direction. This could facilitate partnership working. While it was noted that this could be beneficial and could be best value for communities, one respondent commented that it was a challenge to persuade others of the potential benefits of working together. Building partnerships would also allow practitioners the opportunity to be more aware of evaluation processes.

Forward thinking and innovative strategic support was noted as helpful and the personal satisfaction gained from seeing positive benefits created momentum to continue developing services. Of the challenges noted, aspects of the funding process were most evident and this may impact on service planning and delivery.

For those who had developed their own local resources jointly with young people, it appeared to be important to encourage this involvement as part of the learning process and to include interactive elements. There was support for sharing information, resources, experiences and learning about good practice, both locally and nationally.

3.2 Qualitative semi-structured interviews

Topic guide interview themes, developed from the questionnaire responses covered:

- service delivery – approaches, structures and workforce
- delivery models – partnerships and enhancing learning
- future needs and development – next steps.

Seven practitioners volunteered to be involved in the semi-structured interviews. These were from a range of services and roles:

- NHS practitioners
    - Health promotion specialists (2)
    - ABI lead
- ADP – Lead Officer
- Local authority/ADP – Schools Alcohol and Drug Education Coordinator
- Third sector organisations
    - Service manager
    - Alcohol worker

3.3 Summary of interview findings

Service delivery
It was identified that messages from different sources (parents, school and peers) can be inconsistent and there are gaps in reaching those who do not attend school regularly or do not receive positive parenting. Therefore there needs to be higher visibility of clear messages to prevent or reduce harm from alcohol. The messages should address a continuum of varying needs and be aimed at all sections of society, not just young people.

> 'It would be unrealistic to expect a universal approach to meet the needs of more vulnerable young people, but start in schools and investigate if they are delivering consistent messages then identify how to reach non-attendees'
> (Health Promotion Specialist)

Furthermore, broad alcohol harm reduction approaches treat all young people as a homogeneous group, when in reality they have differing circumstances and needs which influence their choices. The expression '*age and stage'* was repeatedly used and emphasised as being very important. All young people will have different education and support requirements dependent on their maturity, and may not interpret any school-delivered information as relevant to them at the time.

> 'From an early primary-school age, children are often aware that alcohol is bad for you and we are good at delivering this basic message, but as they grow older the effects and influences of developing self-esteem, peer pressure, goal-setting, alternative options and life skills all impact on their decision-making'
> (Schools Alcohol & Drug Education Coordinator).

Interviewees discussed how a targeted secondary approach should be employed, to reach either specific groups or settings and to ensure the messages reach those most in need. It was also felt to be more appropriate to maintain a balance between addressing the issues the young person brings up, and then weaving in alcohol awareness and harm-reduction aspects.

> 'An initial approach would be to blend the topics into one universal message to reduce risky behaviour, and then start to target vulnerable groups and build on the messages and approaches to match ages and stages of development'
> (ABI Lead)

It was stated that alcohol awareness and risk-of-harm messages should be widely embedded into practice and be seen as part of the professional's role, whether working in schools or youth work. Yet an assumption was identified that professionals can be unwilling to only provide information which allows

young people to make their own decisions in the hope that they 'learn from their mistakes'. This is seen as inadequate.

Although this scoping was deliberately not focused on ABI activity, many of those responding to the questionnaire had received ABI training and could potentially be delivering ABIs to those under the age of 16. Following further discussion in the interviews, it was highlighted that ABI training was felt to provide the necessary background in terms of information, skill development and confidence.

In schools, teachers deliver PSE (personal and social education) which may cover basic messages, but they also need confidence to facilitate discussions. Although teachers can access resources on the GLOW network, these are often adapted so it was felt that some standardisation of these resources could be helpful.

Key findings:

1. Consistent messages are required that can be applied to all sections of society before targeting specific populations or settings with alcohol messages (age- and stage-appropriate) to prevent or reduce harm from alcohol.

2. For young people, start from a holistic wellbeing perspective, as alcohol is only one component of information young people may wish to access (e.g. sexual health information, pregnancy advice or personal safety advice).

3. The professional workforce who are in contact with young people need to be knowledgeable on alcohol issues and view raising alcohol awareness as part of their professional role.

Delivery models

The interviewees indicated that that at all ages and stages, young people generally felt that although they knew they required some level of information, they can often become antagonistic towards authority figures (parents, teachers, doctors and nurses) regardless of how appropriate or tailored the message is for them. The interviewees suggested that young people were more likely to listen to a specialist, interact, and relate the knowledge to their own experiences. This was qualified with the advice that it's imperative to get the balance right between listening to young people and supporting them to make their own decisions without making any judgements.

> 'It's about behaviour change, identifying the need, making a connection with them and supporting them'
> (Alcohol Worker)

Interviewees raised the point that professionals often assume that young people are continually exposed to the messages about unit measures of

alcohol and the daily or weekly adult alcohol intake guidelines. Nevertheless, it could still be difficult to visualise a unit of alcohol and relate the information to their own alcohol intake.

Incorporating practical ways to enhance learning and being creative in how sessions are delivered was felt to be important. For example, delivering education sessions in a dedicated mobile classroom, or discussing working out units of alcohol in a maths class (this type of interdisciplinary learning is advocated by the Curriculum for Excellence programme in Scottish schools).

Guidance on building skills for harm minimisation and developing alternative health strategies should also be included, because although young people are told that alcohol is bad for your health, there needs to be that 'light bulb' moment where it starts to make sense to them.

It was also strongly suggested that young people are often more willing to engage with people in non-statutory services and this may be because they feel that a more trusting relationship can develop and that their behaviour will be less judged.

> 'There is a difference in that third sector organisations are often viewed differently from statutory agencies as they can be thought of as more distant from direct healthcare and therefore are often trusted more easily and can foster closer working relationships'
> (Third Sector, Service Manager)

Interviewees identified that partnership working could provide opportunities to provide services with a wider reach and also provide access to a wider range of skills. Partnerships with third sector agencies were viewed positively by all interviewees. Interviewees from the public sector supported the third sector view that third sector services appeared to be considered (by young people) as more approachable than NHS services. There was agreement that while establishing trusting partnerships was fruitful, considerable ground work must happen first to establish roles, responsibilities and timelines.

An understanding of the capabilities and limitations of all partners had been found to be helpful, alongside respecting each other's roles and organisational cultures. Being able to share experiences around partnership working, whether good or not-so-good, was suggested and this could be done in a networking context. There was also a view that partnerships worked better when they had strong leadership developed around an identified shared need, rather than funder-led.

Provision of support, guidance, and a sharing of learning for evaluative methods and validated tools was felt to be helpful. When further explored in the interviews the assumption was that there could be a reluctance (from practitioners) to undertake evaluation. Barriers included limited understanding of design and /or what the value would be, lack of time, financial support and confidence. It was also suggested that practitioners could feel too pressurised to deliver the service and had less time to spend

collating the required data. There could also be a fear that the results might undermine the work undertaken.

Key findings:

4. Those delivering the service need to be able to engage with young people, build trusting relationships with them, which would encourage them to talk about and explore the issues important to them.

5. Supporting networking opportunities would be helpful, particularly for sharing learning around evaluation models and the processes involved.

6. Partnerships between statutory and non-statutory organisations are potentially highly beneficial and should always be considered.

Future needs and development

Young people may not give much thought as to why they drink alcohol, and in fact they may feel unable to socialise without drinking alcohol. The interviewees described this context as 'social hypocrisy', where young people are told how to behave, often receiving a clear message from parents and their school that underage drinking is unacceptable, yet they learn about alcohol by observing the drinking patterns of their friends, their wider family and community.

The influence of media advertising should also be considered. However, in many areas the choices of social activities which do not involve alcohol consumption may be limited.

> 'There needs to be a change in societal attitudes to alcohol and how we socialise'
> (ADP Lead)

Interviewees stressed that services need to engage the young person within their level of understanding and to facilitate their learning by encouraging young people to become involved and engaged with initiative design and development. However, it was also highlighted that establishing what would constitute a representative sample of young people today (either locally or nationally) should be determined, dependent on the service being offered or planned. It should be recognised that not all young people will consume alcohol, but they still need to be able to make informed decisions.

A framework for sharing practice was requested, as this could highlight which tools have worked well in similar initiatives when developing new services. This would be particularly helpful when delivery plans should demonstrate that they are evidence informed in order to access funding. Guidance in identifying and delivering consistent key messages for all settings, whether online or in the form of resource development was also requested, along with support for data analysis.

It was felt to be difficult to design effective initiatives in a constantly changing work environment and the impact of continual staff changes and new organisational roles appeared to be a constant challenge.

One interviewee discussed their local decision that one route to widening the reach of alcohol messages was to influence the training (degree) courses delivered to nurses and occupational therapists and they were building links with a local university to achieve this. They believe that a deeper understanding of alcohol issues for both young people and adults should be an integral part of the role for key professionals, resulting in a better informed workforce.

> 'For primary prevention, there is in the main, an enthusiastic workforce, but for secondary prevention the issues are more complex and we don't seem to have a critical mass of practitioners'
> (Health Promotion Specialist)

Another area had developed an e-learning module (for alcohol education) for teachers to complete and, where possible, the module would be integrated into their local School Improvement Plans.

Key findings:

7. Young people need to feel involved and encouraged to take some ownership of initiatives and to also understand the factors that can influence behaviour.

8. Networking and support to identify and share good practice would be helpful for service design and development.

4. Discussion

Adolescence is often regarded as a time where risk-taking behaviour is expected as a rite of passage, and when young people show a broader disregard for taking responsibility for their personal health and safety. Raising awareness and prevention of harm in both universal and targeted approaches is therefore required, via consistent messages.

Pro-alcohol environments and attitudes may drown out positive health messages from youth interventions. It might therefore be beneficial to enable young people to understand how persuasive media advertising is often designed to glamorise a product and influence behaviour.

It is apparent from both the qualitative questionnaire information and comments that arose independently from the interviewees that societal influences play a major role in influencing and defining young people's behaviour. They described this context as 'social hypocrisy', where young people receive mixed messages about what is acceptable behaviour. This influence of 'cultural norms' is supported by research carried out by the Glasgow Centre for Population Health (2012) and relates to the earlier point that building skills for positive decision-making and alternative coping strategies are crucial.

Both survey respondents and interviewees emphasised that there should be more acknowledgement that not all young people drink alcohol. There is currently very low visibility of positive role-modelling and positive behaviour. It should be remembered that as young people are a very diverse group, they can't all be treated in the same way.

Another recurrent theme was that social choices for young people are often limited. Illustrations were provided of clubs, youth cafes and discos where it's unacceptable or prohibited to consume alcohol and more prominence and acceptance of these alternative choices being a normal fun way to socialise would be helpful.

Provision of wider social opportunities would be an area in which statutory and non-statutory organisations could strengthen joint working and a networking platform for information sharing could potentially support this.

We were fortunate to receive information on schools-based activity and while this was a small sample, further support for teaching staff could ensure a skilled school workforce which is confident and knowledgeable about alcohol-related harm.

The GLOW online resource can be accessed by teachers to deliver aspects of alcohol and drug information, although the content does not appear to be systematically reviewed or quality controlled. Nevertheless, it should be acknowledged that teachers do have many other demands on their time and alcohol awareness will not necessarily be their main priority.

In this scoping, many of the responses regarding evaluation referred to methods which assessed only the implementation process, although it is appropriate to gather this as baseline data. Outcome evaluation showing sustained behaviour change is often seen as the gold standard as there is not necessarily a link between increased knowledge and behaviour change. Fewer evaluations included outcome measurements of factors such as increased self-confidence or improved decision-making skills to show a potential positive change in behaviour.

A lack of shared knowledge, particularly around the evaluation processes being undertaken, was seen to be a contributing factor in the current picture of fragmented activity.

Please see Appendix B for links to further information regarding evaluation support which we have been approved to share.

Although we were unable to directly gather research from young people themselves, it is reassuring that several of the themes we identified correspond to the findings of the Youth Commission on Alcohol (Young Scot, 2010), particularly in terms of:

- changing culture through leisure and lifestyle choices
- education
- emotional support
- influencing treatment services
- personal safety issues.

The full Youth Commission on Alcohol report can be accessed from: www.youngscot.net/media/12177/syca_recommendations.pdf

4.1 Limitations

Although the number of questionnaires distributed was fairly high, there was not an expectation that all recipients would be in a position to complete them and we depended on them being cascaded to appropriate practitioners. However, in the returned questionnaires, not all the questions were completed and in some cases the information that was included was limited. The findings are therefore based on a snapshot collection of information.

One challenge was that respondents came from a range of fields; practitioners working in the NHS, statutory organisations (e.g. fire and road safety) and non-statutory organisations. This resulted in varying degrees of response for example regarding the focus of the initiative or issues such as any training undertaken. As many initiatives indicated a more holistic approach, there was variance noted in the training provided in terms of the length, provider and whether the focus was on alcohol or wider health promotion. Direct comparisons are therefore at times not achievable.

We also were aware that we did not receive responses from every ADP area. This research should therefore not be assumed to be nationally representative, but does indicate a range of current activity in this field.

The small self-selected group who participated in the interviews provided their thoughts and experiences. However, this cannot be assumed to represent the national workforce who work with young people to prevent or reduce harm from alcohol.

We had initially planned to hold a focus group with young people to elicit their views directly and included it as a project objective. Unfortunately, it was not possible to incorporate the views of young people directly, due to limited time and capacity to access a representative sample.

5. Conclusions

This scoping aimed to produce an overview of approaches and initiatives. Having completed this we have also been able to capture some knowledge on the needs of both practitioners and their views of the needs of young people. This can provide further understanding for future service planning and delivery and could enable organisations to envisage how their service fits into the wider alcohol and general wellbeing agenda.

Many references were made to the fact that the whole area of alcohol and young people can be very complex. There is an assumption that all young people drink alcohol and it must be remembered that this is not necessarily the case.

Preventing harm to young people, whether from their own alcohol intake or those around them, cannot be separated out from other aspects of their social, physical and emotional wellbeing. There is therefore a requirement to address these issues with a multi-faceted uniform approach with consistent alcohol messages. There should be provision for direct alcohol education and harm-minimisation set within a framework of more holistic general life choices, including building personal resilience and decision-making skills. This is likely to work best when parents, carers, families and the associated workforce work in partnership. The involvement of young people in the design and delivery of initiatives and the provision of holistic guidance and support, particularly from third sector agencies, appears to be of great value.

Although this scoping did not include ABI delivery, it can at times be hard to separate this out. For instance, staff working in half the initiatives had received training on ABI delivery and could also offer this service opportunistically if it was felt to be appropriate. This helps to identify that many services are designed to address the needs of young people along a continuum, starting with education and prevention of harm up to referral to support services. The ABI training appeared to provide useful knowledge and created confidence to raise the subject of alcohol with young people. However it should be highlighted that at present, as noted in the HEAT Standard: Alcohol Brief Interventions National Guidance 2013–2014 (Scottish Government 2013), there is no evidence to support ABI delivery to those under the age of 16.

This report summarises the information received about work with young people to prevent or reduce harm from alcohol at the time of the scoping exercise. Some initiatives may target only particular ages or stages while others offer a range of services and this presents a more complex picture.

Only a basic level of analysis and interpretation has been undertaken, but it would be reasonable to conclude from the breadth of responses that this appears to be a developing area of activity. It would therefore be appropriate to continue to maintain a focus on alcohol and young people, alongside supporting the emerging requirements of the wider health development approach.

6. Issues for consideration

Having drawn together the findings from both the questionnaire responses and the interviews, the issues to be considered for preventing or reducing alcohol associated harm to young people have been grouped below, along with the links to the key findings. NHS Health Scotland will work with partners to explore how these areas might be progressed.

1. Infrastructure:

- strengthen evidence informed practice and improve workforce capacity

Links to key findings 1, 2, 3, 4

2. Delivery mechanism:

- promote effective partnership working and facilitate the sharing of learning

Links to key findings 5, 6, 7, 8

3. Project content:

- facilitate effective planning and better design of services for young people, ensuring accurate, timely and accessible delivery of alcohol messages.

Links to key findings 1, 2, 7, 8

7. References

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8. Appendix A: Project Questionnaire

Young People and Alcohol: scoping approaches for preventing/reducing harm.

Introduction
NHS Health Scotland are is undertaking a scoping exercise to capture an overview of the range of approaches and initiatives to reduce or prevent harm to young people from their own alcohol consumption.
This scoping aims to capture broad health behaviour development initiatives which potentially promote health behaviour change by supporting young people to make informed decisions about alcohol.

The information gathered in this questionnaire will be used by NHS Health Scotland to inform future decision making for programme planning, resource development and partnership working.
The timeline we are working to is to gather all the required information by the end of 2012 with a report being produced by the end of March 2013.

Type of Approaches
We are interested in approaches which educate and deliver harm reduction messages to young people who may or may not be regularly consuming alcohol.
The approaches listed below are not exhaustive but are included to assist you to categorise your approach:

- Peer education
- Group programmes
- Diversionary activities
- Outreach & Street work
- Befriending & Mentoring
- 1:1 support sessions
- Advocacy support
- Building practical Skills
- Therapeutic or counselling work

Settings
We would also like to identify the settings that these approaches are being employed in as this will inform our learning. As a guide we have suggested the following settings, but again, this is not a complete list and additions can be detailed in the questionnaire:

- School
- Social Work
- Voluntary Service
- Local Authority/Community Service
- Police Service/Criminal Justice
- Prison/Young Offenders Institute

Proposed Project Aim
The aim of the scoping is to:

Produce a national overview of the approaches developed and implemented to prevent or reduce harm to young people from their own alcohol consumption.

As a guide, our inclusion criteria will be **from year 1 secondary school (ages 11/12) up to around the age of 18.**
If you feel it would be of value to include an initiative out with this age range, please feel free to include details.
Guidance on completing questionnaire:
The following pages request information on any services developed in your area which are targeted at young people, to either prevent or reduce harm from alcohol consumption.
Please complete each section with as much information as you can, adding comments where appropriate to ensure clarity of detail.
Please do not include initiatives which are targeted primarily to deliver Alcohol Brief Interventions.

If submitting information on more than one initiative, please complete a separate form for each one. If you are responding about several initiatives, your information can be brief and we will contact you for further details where required.

It would also be of benefit to receive details of any previous initiatives which have been evaluated but are no longer running, such as due to restricted funding or capacity difficulties.

Privacy Statement
The information returned will be checked for clarity and if required, we may contact you for further information to enable us to meet our objectives.
The information will be stored electronically by NHS Health Scotland and accessed only by internal staff. Identifiers will be removed in the published report unless prior agreement is reached.

Please return this form to : nhs.HealthScotland-AlcoholandDrugs@nhs.net

By - Wednesday 10 October 2012

Many thanks for your assistance with this project. Should you have any queries please do not hesitate to contact me. kathleen.laird@nhs.net

Kathleen Laird
Health Improvement Programme Officer
NHS Health Scotland
Thistle House
91 Haymarket Terrace
Edinburgh, EH12 5HE
Tel: 0131 313 7598

Contact details for person completing form:

Name…….

Role…….

Organisation…….

Phone…….. …….

E-mail…….. …….

Name of service or initiative……

Brief description of service or initiative……

It may be helpful for future NHS Health Scotland projects to be able to share your work contact details and brief details of your work with other third parties who request information on initiatives similar to their own current or planned work.
Please indicate if you do not wish your details to be shared for this purpose.

	Insert X
I do not wish my details to be shared	

Please copy this form and complete a separate form for each initiative.

Service delivery

	Yes	**No**
1. Is this initiative part of a planned service to reduce/prevent harm from alcohol?		
2. Is raising awareness of alcohol messages the main focus?		
If not, what is the main focus?		
3. Is the initiative targeted at those who have been identified as already consuming alcohol?		
4. Does this initiative also offer an alcohol brief intervention to those identified as drinking at harmful & hazardous levels?		
5. What age group is the initiative targeted at?		
6. Is any specific group targeted? *e.g. looked after children, school non-attendees*		
7. What led to the initiative being set up?		

Delivery model

8. Where (which setting) does the initiative take place? *e.g. school, youth club, police station*
9. When did the initiative commence?
10. What are the primary aims and objectives of the initiatives?

11. Who is involved – *please detail the job title and role for lead people, and the lead organisation*		
Title	**Role**	**Organisation**
12. Please add any key partners also involved:		
13. What information, if any, is collected on the participants taking part in the initiative?		
Please give details: e.g. age, current alcohol consumption		

	Yes	**No**
14. Is the initiative ongoing?		
15. Is the initiative a pilot?		
16. Are any educational resources used?		
Please detail here: e.g. DVDs, posters, leaflets, apps, social media, websites.		
17. Have you specifically developed any alcohol related educational resources for young people for use with this initiative?		
If yes, please give details here and attach examples or include links:		
18. Have the practitioners delivering the service received any training for this role, specifically around alcohol or health promotion?		
If yes, what format did the training take? e.g. half day/full day, online/face-face		
19. Please indicate who has provided training for the staff:		
• Training provided by NHS Health Scotland trained ABI Trainers		
• Training provided by another organisation – please indicate which organisation		

	Yes	No
20. Is there any follow up or evaluation information available on the initiative?		
Please give details:		
21. If there is no evaluation available, are there plans to evaluate?		
Please give details:		

22. Has any impact on behaviour been observed?
Please give details:
23. Have any pathways or care referrals been developed for those identified as requiring support?
Please give details:

Future needs

24. What forms of support would be beneficial to you?
Please give details: e.g. training, evaluation, network support for similar initiatives
25. Are there any factors which have facilitated or limited development of the initiative, which you wish to share?
Please give details:
26. Any other comments you wish to note?
Please give details:

Thank you for taking the time to complete this questionnaire.

Please return this form to: nhs.HealthScotland-AlcoholandDrugs@nhs.net
By - Wednesday 10 October 2012

9. Appendix B: Evaluation guidance

Contemplating the merits of evaluation can be daunting, but it is vital to undertake evaluation and share the knowledge either locally or nationally. Evaluation should therefore become part and parcel of everyday practice and there are various evaluation tools that can be used and various methods to gather information.

Evaluation checklist:

- Consider what difference you are trying to make (this is different from describing the aims and objectives).
- Define the overall aim (keep it brief and focused) – say what you want to achieve and the broader long-term impact. This will give you the outcomes hoped for and include a timeline.
- List the activities you will undertake to achieve your outcomes and the outputs that will be required. There must be a logical connection between what you plan to do and the impact you want to make.

The outcome will be the change that your activity will make on your target group.

A breakdown of each activity, who should be involved and factors such as costs and time allocations will be required for the planning along with how the activities can be measured. While hard outcomes can be measured numerically, soft qualitative outcomes need more thought by identifying what indicators can be measured.

Evaluation guidance and examples:

- **NHS Health Scotland:** provides advice, practical support, access to resources and tools for evaluation and outcome-focused approaches for planning.
  www.healthscotland.com/scotlands-health/evaluation/index.aspx
- **Evaluation Support Scotland**: work with voluntary organisations and funders so they can measure and report impact by providing access to evaluation tools and support.
  www.evaluationsupportscotland.org.uk/
- **Reversing the Trend**: a joint project involving six voluntary youth work organisations, Lloyds TSB Foundation for Scotland's Partnership Drugs Initiative and Evaluation Support Scotland. This relates to the role the youth sector plays in preventing problem substance misuse by young people. Their web tool guide provides information on the evidence, evaluation examples, a logic model and case studies.
  www.ltsbfoundationforscotland.org.uk/index.asp?cat=Publications

www.healthscotland.com

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