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▶ 'DrinkThink' alcohol screening and brief intervention for young people: A qualitative evaluation of training and implementation.

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The DrinkThink screening and brief intervention for risky drinking was developed with young people (the intended beneficiaries), but not with professionals expected to deliver it. Despite the potential of the intervention, delivery was impaired by obstacles spanning training, working cultures, and attitudes about young people's drinking.

SUMMARY Young people in the UK report some of the highest rates of heavy drinking in Europe (1 2), making it an ongoing public health and policy concern. One way of trying to tackle this is through screening and brief interventions, which have been developed primarily for use with adults, and where tested among young people, have generally involved older young people aged 18–25, in primary care, college, or school settings.

In 2009, a local government area in England (Bath and North East Somerset Council) introduced DrinkThink, an alcohol screening and brief intervention produced with and designed for (this is known as 'co-production') young people in settings which were not specialist alcohol settings. The following describes an evaluation of the acceptability and implementation of DrinkThink from the perspective of staff trained in its delivery.

DrinkThink consisted of three components:
- **Training** for professionals working in health, youth, and social care services.
- **Screening and brief interventions** for young people under 25 years old.
- **Referral** for further treatment and counselling if requested by the young person or deemed appropriate by the professional.

The training was provided by Project 28, a young person's substance use service. It lasted three hours and consisted of introducing national guidelines on adolescent alcohol consumption, calculating 'units' of alcohol [see NHS website for more on units, which provide "a simple way of expressing the quantity of pure alcohol in a drink"], familiarising participants with the screening questions used to identify risky drinking and the brief intervention, role-playing an alcohol screening session using the questions, understanding the importance of brief interventions and the motivational interviewing principles underpinning DrinkThink, and role-playing the delivery of a brief intervention.

Young people attending Project 28 helped design the DrinkThink materials, including a series of flash cards with graphics showing drinking measures and units, a body diagram showing the impact of alcohol, and images with depictions of situations in which alcohol might pose a risk to young people.

A total of 33 members of staff from four agencies took part in focus groups arranged no less than two months after they had been trained. Participants,

DRINKTHINK

What the intervention involved:
- Inviting the young person to share their experiences of drinking using 10 image-based flash cards, each of which contained a different alcohol-related risk.
- Highlighting the health risks

who included school nurses, sexual health clinic nurses, a social care team leader, a school nurse manager, youth services team leaders, a sexual health clinic doctor, social care staff, and youth services staff, were asked open-ended questions about what they thought of the training, the content of the DrinkThink materials, whether they were implementing the DrinkThink intervention, and any views they had concerning the value of the intervention for their work. An additional eight interviews were conducted over the telephone or by email after six months with six team leaders and two recently trained school nurses.

associated with risky drinking using a diagram displaying the effects of alcohol on various parts of the body.
• Discussing how the risks of drinking could be reduced, followed by talking about harm reduction strategies.
• And finally, if necessary, referral to an age-appropriate substance use service (Project 28 if under 18 years, and Developing Health and Independence adult substance use services if 18 years and above) for further treatment and counselling.

Main findings

One of the key findings was that while most staff were using elements of the DrinkThink intervention to conduct informal conversations, few were delivering it in its entirety. Use of the screening questionnaire was sporadic and most staff relied on their own judgement about whether a young person required the intervention. Barriers to implementation spanned (1) training, (2) working 'culture', and (3) participants' attitudes towards alcohol.

Training

Factual information in the training was appreciated by participants. School nurses, for example, said the training helped equip them to initiate conversations about drinking and fitted easily into questions they were already asking about health. However, youth and social care participants felt unsure about how to practically implement the DrinkThink package even after training. For some, the training helped generate useful discussions about drinking, but didn't help in the delivery of the intervention.

Integration within work 'cultures'

Most participants used the flash cards and body diagram to help initiate conversations about alcohol. But the perceived lack of compatibility of the intervention with the complex nature of young people's problems, time available to deliver, and working style and practices, precluded the full implementation of DrinkThink.

When possible, nurses from the sexual health clinic incorporated DrinkThink elements into their routine assessments, but tended to see the intervention as 'competing' with other pressing health needs, as did school nurses.

> *You may recall that in addition to taking a full sexual history and doing a full-risk assessment for blood borne viruses, we also need to get medical, medication and allergy details, and enquire about smoking, recreational drug use and abuse – while aiming to fit in all this and the examination and dissemination of results in around 20 [minutes], which proves quite an ask.* Sexual health clinician, interview

Youth and social care staff described their work culture as ill-suited to the DrinkThink intervention, commenting that it was 'stilted' and 'educational'. This contrasted with their approach which was non-directive and engaged young people according to their individual priorities and needs, and with social care team approaches which tended to respond to what was happening in the moment (rather than being planned in advance).

> *To pull out a tool such as this in a session would arguably feel more formal than our approach to mentoring tends to be.* Social care team leader, interview

Youth and social care teams reported routinely addressing drinking among young people, but according to their specific therapeutic aims and approach.

> *(There's) nothing wrong as such with the [DrinkThink] model. Our mentors tended to work in a person-centred, informal way with their mentees and be led by the mentees conversation. eg, they'd talk about drinking if that arose in a mentoring conversation, and be led by their mentees wish to talk or not around it.* Youth team leader, interview

When working out of the office or in informal settings, staff reported that they did not always have the DrinkThink materials with them, or a suitable space to deliver the intervention. Digital 'apps' were suggested as an easier or more practical tool to use.

Attitudes

Staff did not always perceive drinking to be a significant problem among the young people they saw. For example, a youth team leader reported that of 20 new referrals received that month, only one person was identified as having a drinking problem. Drinking was also often evaluated in relation to other problems, for example ranking behind mental health problems, domestic violence, and drug use.

Sexual health nurses saw their primary role as addressing the sexual health needs of young people. 'Normal' drinking among young people was not much of a concern, but drinking could cross-over into their work when it was associated with risky sexual practices.

> *I think it's the norm that young people go to uni or college and they go out and they drink. And I've done it, and most people have done it, and it's just normal. But obviously then there's the other side where they are having all these unpleasant sexual incidents, which I didn't do. So that's where you need to be picking up, then.* Sexual health clinic nurse, focus group

> *I think equally it is the norm[…], because that is the norm: drinking and having sex is unfortunately the norm these days.* Sexual health nurse, focus group

The authors' conclusions

The evaluators concluded that screening and brief alcohol interventions for young people in community healthcare settings require a degree of flexibility and adaptability in both design and application.

Public health interventions are increasingly being designed (or 'co-produced') with people who fall into the target groups of those interventions. But results from this study suggest that developing youth-focused alcohol screening and brief interventions with the professionals expected to deliver them, as well as the young people whom they may benefit, may ensure greater success in integrating them into working practice.

A limitation of the study was that too few young people were exposed to the intervention in order to include young people in the DrinkThink evaluation.

FINDINGS COMMENTARY The DrinkThink initiative fell within the remit of health, youth, and social care services, rather than specialist alcohol services. One of the (perhaps unsurprising if you read this Effectiveness Bank hot topic) barriers to implementation reported by these professionals was a lack of time to deliver the whole intervention, or the feeling that their time was better spent addressing the myriad problems young people presented or asked for help with, and not to 'dig around' for another problem.

What has been designated the 'ideal scenario' for delivery of brief interventions in the context of primary care is drinking being asked about at every contact, followed if needed by help or advice. However, this admittedly "might not be tolerated by the general public, not to mention the health professionals asked to deliver it". And in this respect DrinkThink runs up against the key problem with generating health gains from screening and brief interventions – the seeming near-impossibility of achieving widespread and high-quality implementation.

Whether *routine* screening and brief interventions would be tolerated among young people seeking or receiving help from non-alcohol specialist services was raised by participants in the featured study. A sexual health clinic nurse said:

> *"I think we have to remember what we're here for, and that's to provide a service of sexual health screening and dealing with people's problems. Yes OK, alcohol could be a contributory factor to it, so that's important. But they actually want what they've come here for. And not to harangue them about the fact that they partied all night last week or whatever."*

What young people – the target group and potential beneficiaries – thought of the brief intervention being delivered in health, youth, and social care contexts could not be gathered from this evaluation. While the co-production of the intervention with young people, if applied in the sense of them being "equal partners and co-creators", would suggest that the intervention was acceptable in principle, the pool of young people involved were from Project 28, meaning they were already involved with substance use services and already having conversations about risky drinking and drug use that their peers might not be having. So to what extent young people not ready for or not expecting conversations about their drinking habits would be open to this intervention remains uncertain without full evaluation.

Set against the backdrop of a considerable drive to encourage a wide range of professional groups to incorporate screening and brief interventions or advice into their everyday practice, one study examined the role of training in facilitating delivery beyond primary health care. Individual professional commitment, including thinking it a legitimate part of their role to ask about drinking, was important if the information and skills learned in training were to be applied in 'real life' working practice. The perceived relevance of the screening and brief intervention itself to working practice was also a major factor in determining whether it would be applied as a standard tool, only partially applied (generally as advice rather than screening), or not applied at all.

From the same research team, case studies of training in housing, probation, and social work settings drew attention to five related elements that impact on the successful translation of training into practice:

• **Professional roles and individual behaviours.** The development and improvement of professional knowledge and skills has been given a lot of attention. But given that many training programmes are short, and include individuals with different professional backgrounds and from different organisations, to what extent can they deal with specific barriers to delivery on top of imparting the necessary knowledge and skills?

• **The specific work context.** Even where training can be delivered or tailored to the needs of a professional group, there is still the issue of the relevance of screening and brief interventions to the specific interactions between client and professional. Less formal forms of screening and brief interventions were frequently mentioned in this study as *more* acceptable. This raises questions regarding what kind of training is needed and how this could potentially incorporate more informal brief intervention approaches.

• **The organisation or agency.** If screening and brief intervention training is to be followed by delivery, support from management (both senior and line management level) is necessary, as well as organisational structures and working practices that are conducive to professionals delivering brief interventions. Organisations and agencies appear to be eager to take up training (especially if free), but few appear to give thought to the role of training in developing organisational capacity and their way of working with clients. Training needs to be related more directly to the attitudes, behaviour and needs reflected in the organisation as a whole, as well as retaining a focus on professional attitudes, behaviour and needs.

• **The broader system of care.** Discussion of organisational factors needs to go beyond individual agencies or organisations and recognise that most agencies and organisations in social care, housing, and probation are part of wider networks and systems of care. For example, social care workers are part of the wider system of social welfare provision and subject to regulations, changes and pressures beyond those imposed by their employer. These factors go beyond training, but have implications for the potential of training to result in delivery of screening and brief interventions.

• **The nature of screening and brief interventions.** Consideration needs to be given to *what* is delivered. A more flexible menu of optional contents and methods of delivery may be required, as a standardised screening and brief intervention approach is unlikely to be implemented in many non-health settings.

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