Lancashire: Brief Intervention Online Training Evaluation

Final Report

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Executive Summary

Severe, chronic or hazardous alcohol consumption, as well as binge drinking has numerous harmful effects for example on health, mortality, offending. Brief interventions (BI) can be used to target harmful and hazardous drinking behaviours. These short interventions can be given *ad hoc* by lay or specialist individuals providing information on harms and sources of advice/treatment. In order to increase the number of individuals in the workforce with the skills to provide BI, NHS Central Lancashire has utilised Lancashire Local Area Agreement funding to commission DeltaNet International Limited to construct an online training programme on the theory and practice of delivering BIs that aims to reach a wide audience. The Centre for Public Health at Liverpool John Moores University was commissioned to evaluate the programme.

For those taking the training, a series of four questionnaires were designed: pre-training, post-training, three month follow-up and for those, who did not complete the course, a questionnaire to uncover reasons for non-completion. Each questionnaire included a mix of open and closed questions. Participants also completed a knowledge assessment, prior to the training, upon completion and three months after the programme. Training was rolled out through Lancashire alcohol networks workplaces and via word of mouth. The online resource was freely available and thus not restricted to the workforce within Lancashire.

In total 115 initiated the training and completed the initial assessment and a brief discussion of key findings and recommendations follows. Prior to training, 51% of the participants assessed themselves to have a fair knowledge (qualified on a five point scale from excellent to very poor) of alcohol issues and 43% had fair knowledge of brief interventions. The participants' scores on the assessments were analysed using non-parametric statistics, comparing pre-training and post-training (second attempt) assessment. There was a statistically significant increase in participants' scores, demonstrating that their knowledge of BI was increased. After the training the majority of the participants rated the sections of the programme positively, either recording a rating of good or excellent. In response to a question on where had they completed the training, the most frequent answer given was at work at their desk (56%), followed by at home (36%). Participants commenting on the information presented remarked that the level of information presented was more suited to an individual new to the profession, than someone with previous alcohol intervention knowledge. Some participants remarked that there were technical and operational issues with the programme. Technical issues included the online tutorial freezing, and multiple logins being required which could be frustrating and time consuming. It is difficult to access to what extent these issues result from technical issues with the participants' computer system, especially since a considerable number completed the training at home, or the program itself. Around half of those that completed the three month follow-up questionnaire had conducted brief interventions and at this point the majority had not encountered any barriers. For those that did not complete the training, lack of time and technical issues surrounding the loss and retrieval of login details were the main reasons given for this. However the report cannot be comprehensive as a result of the low response rates for successive questionnaires. Smaller cohorts render statistical analysis difficult and where used statistics should be viewed with caution.

There are two central recommendations arising from the evaluation. Firstly, commissioners and/or DeltaNet International Limited should examine the IT systems used to house the program and to make recommendations to the participants regarding the technical specifications of equipment and basic computing skills required. Secondly, given that many participants found the material basic (and this was confirmed by high knowledge scores prior to starting the course) we suggest commissioners should examine whether the profile of the participants who took part matched the intended target audience. If not, effort should be made to roll the programme out to those less experienced at delivering BIs. Commissioners could consider tailoring the programme for those with differing levels of expertise and analyse the cost effectiveness of this (e.g. by combining both beginner and advanced modules), although this would clearly have financial implications.

Contents

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1. Introduction

Severe, chronic or hazardous alcohol use, as well as binge drinking has numerous harmful effects, on health, mortality and offending. For example, the national indicator (NI39) hospital admissions for alcohol related harms show yearly increases from 1144 (2004/05) per 100, 000 of England's population to around 1500 by 2007/08 (North West Public Health Observatory, 2009). The costs of such levels of alcohol misuse are significant and include the costs of alcohol treatment as well as economic cost for example; as a result of absences from work 17 million working days are lost as a result of alcohol; (Strategy Unit, 2004).

Government policy seeks to prevent increases in alcohol-related harms and economic costs (Strategy Unit, 2004; H.M Government, 2007). While recognising that the majority of drinkers do not misuse alcohol, it aims to combat the problems with severe and binge drinkers through a number of avenues. Working in concert with local government, health agencies, police, drink manufacturers, individuals and other interested groups, the national government aims to employ four strategies: better communication, improvement of health and treatment services, combating alcohol-related crime and disorder, and working with the alcohol industry.

Brief interventions (BI) can be used to target harmful and hazardous drinking behaviours. These are short interventions (on average five minutes), which can be given *ad hoc* by lay or specialist individuals. They are designed for drinkers who consume alcohol excessively but are not yet dependent, providing information regarding harms as well as sources of advice and or treatment. Numerous studies have shown the positive effects of brief interventions: a meta-analysis[1] by Kanner et al, (2009) showed, in comparison to control interventions[2], brief interventions facilitated a reduction in consumption of around four to five units of alcohol (UK) per week, after one year. Studies have reported decreases in the adverse effects of consumption: Gentillelo, (1999) and Crawford, (2004) noted decreased emergency admissions others have shown reductions in binge (Curry, 2003; Fleming, 1997) and heavy drinkers (Kanner et al, 2009) as a consequence of BI.

In order to expand the capabilities of practitioners in delivering brief interventions, Preston Primary Care Trust (PCT), now a part of NHS Central Lancashire, has investigated a number of training methods. Firstly a training package was developed, which, whilst proving to be a valuable tool, was resource intensive if it was to be delivered across Lancashire (Burrell et al, 2006). Secondly, the PCT investigated the use of a train the trainer[3] programme but difficulties in identifying the most appropriate stakeholders led to the programme stalling beyond the initial delivery point (Morleo et al, 2007). To overcome these issues, NHS Central Lancashire has utilised Lancashire Local Area Agreement funding to commission the pilot of an online alcohol brief intervention training programme, taking advantage of online resources to reach wider audiences and capitalise on the relative ease with which participants can complete the course (at home or at work). The Centre for Public Health at Liverpool John Moores University has been commissioned to evaluate the training programme. This report details the main findings from the evaluation and provides recommendations for taking the project forward.

[1] Meta-analysis is a statistical technique that combines the results of a number of studies, with similar research hypothesis, to provide an overall understanding of impact with the advantage of higher statistical power and larger effect size.
[2] Control interventions, where only assessments and not intervention were given to the participants.
[3] Training was provided to stakeholders on how to deliver BI training with the intention that the stakeholders would roll out the training.

2. Methodology

A series of four questionnaires were designed using the course materials and intended learning outcome: pre-training, post-training, three month follow-up and for those who did not complete the course a questionnaire to uncover reasons for non-completion. Each questionnaire included a mix of open and closed questions to add depth and generality to the evaluation (see appendix one for copies of the questionnaires). The pre- and post-training questionnaires were built into the online tool. The other two were e-mailed to participants for completion at a later date; prompts were given to participants to encourage a response.

2.1 Sample

The sample consisted of those who began the training, in total 165. The most prevalent age group (44%) were aged between 25 and 34, 1% were either under 18 or above 65; 61% were female and 39% were male. In total 89% identified themselves as having White British nationality, 4% as Asian or Asian British and just 1% described themselves a Black or Black British. Response rates for the questionnaires were comparatively low. Just 46 individuals completed the post training: questionnaire, 11 completed the non completion questionnaire and 17 the three months follow-up questionnaire.

2.2 Questionnaires

2.2.1 Pre - Training Questionnaire

This questionnaire was completed prior to the training session (n=165). It established a number of key demographics, such as occupation, gender, as well as previous training. The responses to this questionnaire are detailed in section 3.1.

2.2.2 Post-Training Questionnaire

This questionnaire was completed after the training session (n=46). The questionnaire was designed to examine the participants' estimations of the usefulness and applicability of the training, behavioural intentions (to carry out brief interventions) and recommendations for alteration. The responses to this questionnaire are discussed in section 3.2.

2.2.3 Post-Training Not Completed Questionnaire.

Those not completing the training course (n=11) were asked to complete this questionnaire, which was designed to examine the reasons for their withdrawal. Alongside this, participants were asked to score the relevance and quality of each section of the training scheme. The responses are discussed in section 3.3.

2.2.4 Three Month Follow-up Questionnaire

Three months after completion, the participants were asked to complete a final questionnaire (n=17) designed to assess confidence, performance of brief interventions as well as barriers and improvements to the programme. Examination was also made of the retention and consolidation of knowledge. In this way the researchers were able to examine the effectiveness of the training over time; results are discussed in section 3.4

3. Results

Table 1 shows the number of people that started each of the training modules. The programme had lost almost half of the participants by its end. These data cover only those that started the module and not how many successfully completed them. The table shows that 27 participants dropped out prior to the welcome and introduction module.

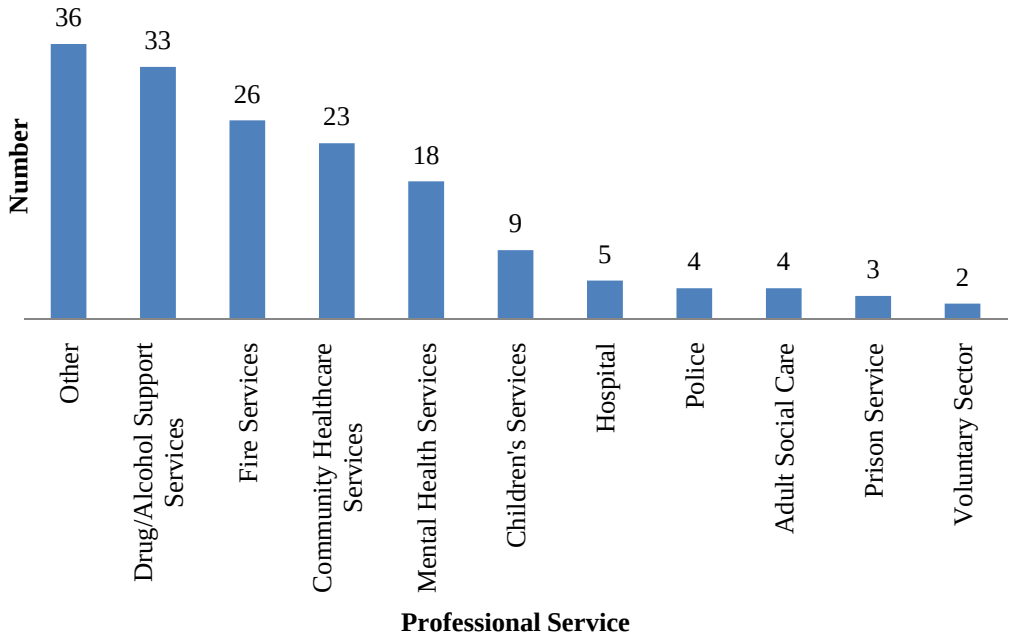
Table 1: Number of trainees that started each module

Module	Number
Welcome and Introduction	138
Pre Course Assessment	115
Understanding Alcohol Use	94
Delivering Brief Interventions	94
Using Screening Tools	76
Responding to Alcohol Problems	76
Post Course Assessment	76
Post Course Questionnaire	68
Post Three Month Questionnaire	17

3.1 Pre - Training Questionnaire

The majority of the participants who began the training (n=165) worked in the Drug and Alcohol Support services; the second most prevalent groups came from the fire services and Community healthcare services (Figure 1). The voluntary sector drew the least participants with just two, joint with the National Offender Management Service (NOMS)

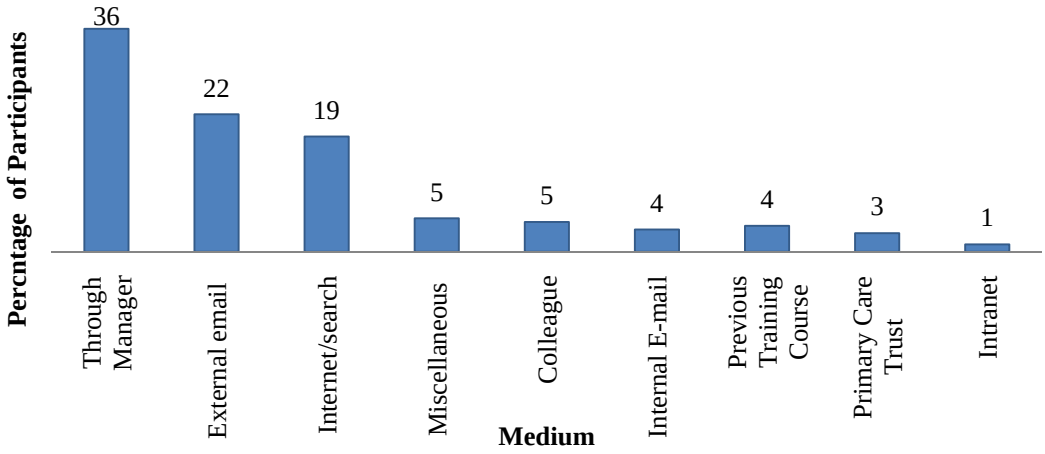
Figure 1: Participants by profession



The training scheme drew participants from across the area in order: Burnley area (36) followed by Preston (31), West Lancashire (29), Chorley (27) and Blackpool (11).

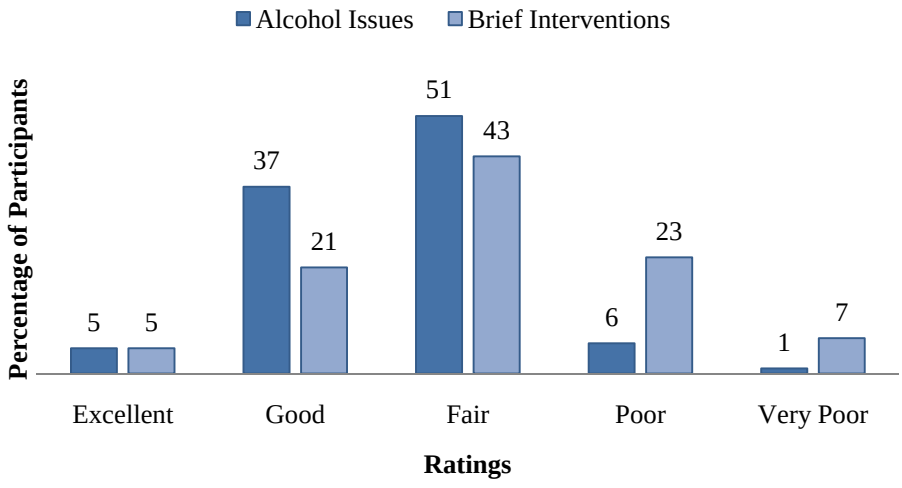
The largest proportion of participants **heard about brief intervention training** through their managers (36%), followed by external e-mails (22%). In total 19% heard about the course through an internet search and 5% were made aware by colleagues (Figure 2).

Figure 2: Medium though which the participants heard about Brief Intervention Training



Participants were asked if they **had any brief intervention training**, a total of 31% reported that they had. Participants were asked to rate their **knowledge of alcohol related issues.** Half (51%) rated their knowledge as fair, just five percent as excellent and one percent as very poor (Figure 3). Further, participants were asked **to rate their knowledge of brief interventions,** 43% of the participants rated themselves to have fair knowledge. When asked about the **frequency of contacts with individuals that may benefit from alcohol brief interventions**, 34% and 33% responded that they came into contact daily or weekly respectively, only seven percent were rarely in contact with these individuals.

Figure 3: Percentage of participants' ratings of their knowledge of alcohol-related issues and Brief Interventions



Had the participants set aside time to complete the training, was the next question asked, again the group was split, 55% had not set aside appropriate time while 45% reported that they had done so.

In an open question Participants were asked to report **what they expected to gain from the training programme.** Common answers included being able to see if the training scheme was right for their organisation and to be given to staff, while others stated that they wished to discover the benefits of using brief interventions and to widen and update their current knowledge concerning alcohol and intervention strategies. In addition the participants reported that they expected to gain training on the brief intervention programme, to enhance interactions with clients and deliver appropriate interventions (Table 2).

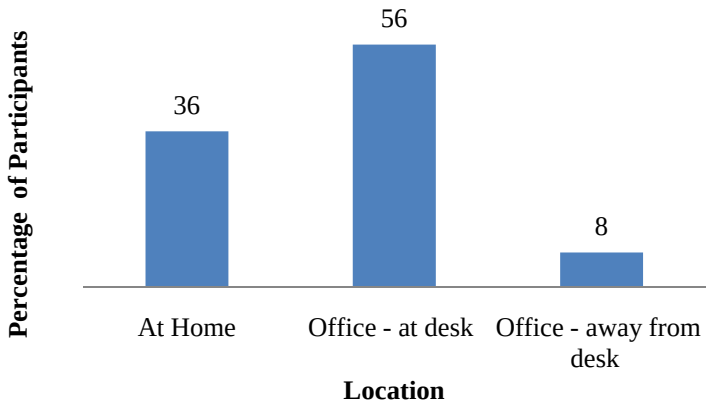
Table 2: Participants' expectations from the programme

Theme	Example Participants' Responses
Client - focused response	*"How I can intervene and help others suffering from the effects of alcohol, including family and children."*
About brief intervention	*"How to deliver effective brief interventions to help clients address their alcohol use/misuse."* *"Practical advice that can be given to clients who disclose that they drink alcohol and strategies they can employ to reduce their alcohol consumption A format/structure of the consultation that can be followed when."*
Assess the programme for deployment to other staff	*"The benefits of brief intervention training and how they can be used in the workplace."* *"To determine if this training will help my front line staff deal with clients or staff with alcohol issues."*

3.2 Post-Training Questionnaire

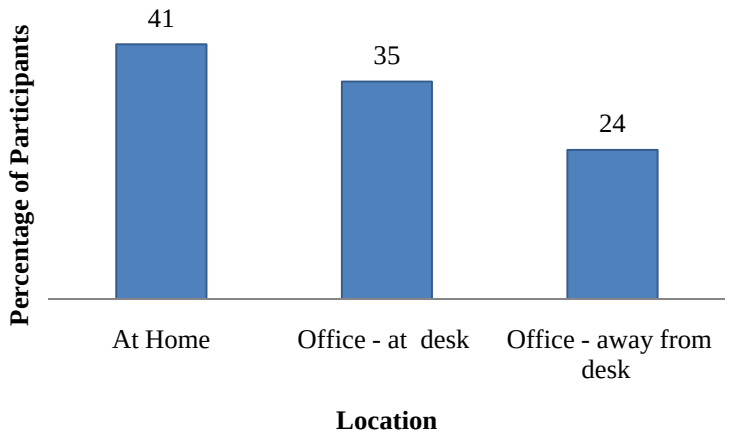
Over half (n=68) **completed the training course** at their desks (56%), 36% at home and eight percent at their office, away from their desks. Two participants made multiple selections, choosing at home and away from their desks, and at home and at their desks (Figure 4).

Figure 4: Percentage of respondents who completed the training at: Home, in the Office at or away from their desks



Participants were then asked to state the **location they would have preferred to complete the training in** (Figure 5). The majority (41%) chose their home as the preferred location closely followed by at their desk (35%) and then away from their desks (24%).

Figure 5: Percentage of participants who preferred location to complete the training: at home, in the office at their desk or away from their desk



When asked why (Table 3), those who would prefer to train at home did so because there would be fewer distractions, interruptions and increased comfort. For those that chose the office at their desk, reasons given were to fit the training in with other work commitments, to have the resources at hand to complete the course and to learn while in a work frame-of-mind. Finally participants reported that the reasons for choosing at the office away from your desk were fewer distractions and a quieter environment as well as having 'tier one'[4] interventionists on site.

Table 3: Participants' reasons given for their preferred location

Location	Example Participants' Responses
At home	*"At home I could control to an extent the level of interruption which is not possible in an open plan office."* *"No distractions from colleagues or from phones ringing also it is a more comfortable environment."*
Office - at your desk	*"Because I would rather learn about something like this whilst being in my work environment and frame of mind where I can apply it best."* *"So that modules or elements can be done at time convenient to fit in around other work commitments i.e. you can 'dip' in and out of the package in stages."*
Office - away from your desk	*"To benefit from being able to ask questions of a specialist and network with other tier 1 interventionists".* *"It would provide a quieter environment in which to complete the training."*

[4] Tier one interventions provides the identification of hazardous, harmful and dependent drinkers, information regarding sensible drinking, brief interventions and referrals (Models of care for alcohol misusers, 2006)

Participants were then asked to rate each element of the training with regards to the quality of content and relevance to them [5]. When asked about **background information on brief intervention and its benefits:** of the 46 participants the majority (42, 92%) found the relevance and quality of this section to be good or excellent (Figure 6).

Information on Brief Intervention techniques: for this section the majority of participants reported that the relevance and quality were excellent or good (34, 73%), ten (22%) found it to have fair relevance and quality (Figure 7).

Information on appropriate responses and the referral process: for this section, 34 participants (74%) found the quality and relevance to be good or excellent. Seventeen percent (8) found it to be fair and just nine percent (4) found it poor (Figure 8). One additional comment highlighted that the telephone number for Lancaster referrals was incorrect.

Information on and the positive and negative effects of alcohol use: again most of the participants (40, 87%) believed this section to have good or excellent relevance and quality (Figure 9). However one participant stated that:

"Most of this information was common sense."

Details of the AUDIT screening tool: results for this section were more dispersed, over half found the section good or excellent (27, 59%), nine (20%) found the quality and relevance of this section to be fair and a further nine to be poor (Figure 10). Two additional comments were made, wrongly arguing that the course discussed the FAST screening tool not AUDIT, and that it discusses FAST incorrectly. Finally they stated that there was no information on where to get the AUDIT system from or when or who it is best used on.

[5] Ranging from excellent, good, fair, poor and very poor

Figure 6: Rating for background information on Brief Interventions and its benefits.

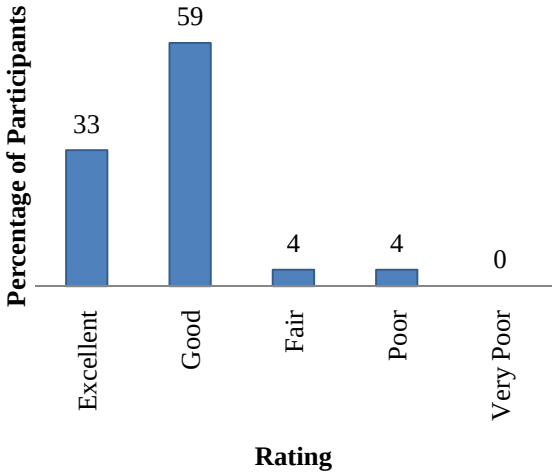


Figure 7: Information on Brief Intervention Techniques

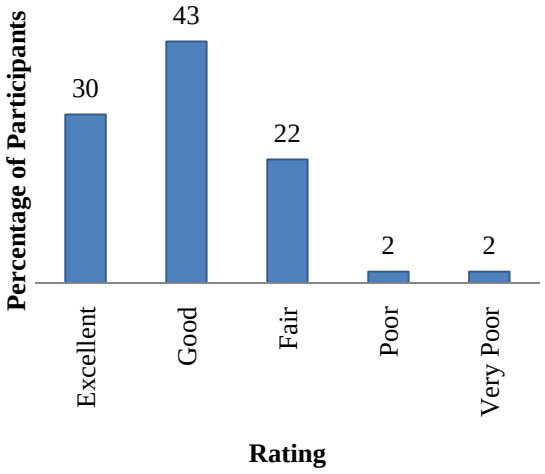


Figure 8: Information on appropriate response and the referral process

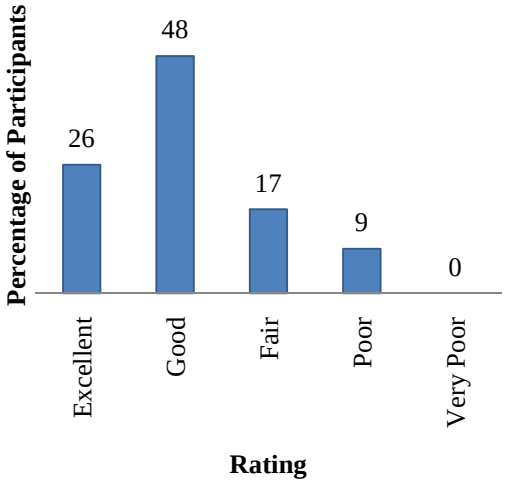


Figure 9: Rating for information on alcohol use and the positive and negative effects of alcohol

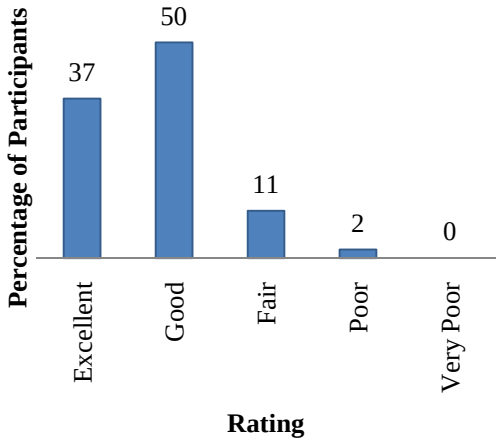
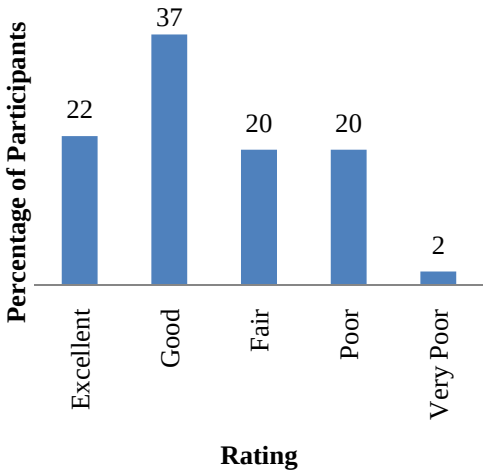


Figure 10: Details of the AUDIT screening tool



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When asked **if there were any specific exercises that the participants found useful**, over half (59%) answered negatively. These participants explained that they had found all of the exercises to be equally useful or that they were mostly common sense and they learned little new information. Those that answered yes (41%) chose to single out the section involving Brief Intervention techniques tests (AUDIT) or the test questions (Table 4).

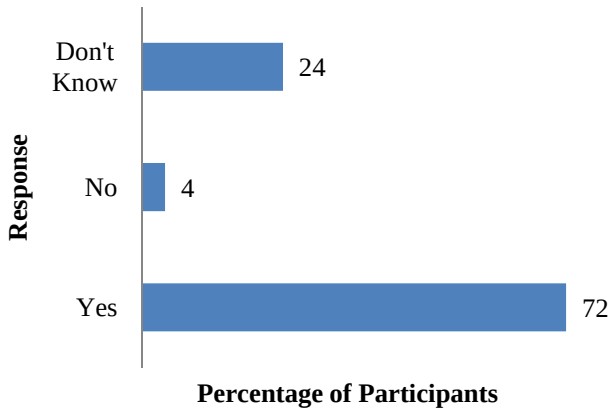
Table 4: Participants explanations of the usefulness of specific course exercises

Was the course useful?	Example Participants' Responses
Yes	*"Information on brief intervention techniques and details on the audit screening tool."* *"Nice clear explanation of the FAST tool."*
No	*"I found all the exercises equally useful and thought the course was well structured and balanced."* *"It's a good refresher tool but I haven't really learnt anything new. Will be a very good tool for new employees with little or no experience."* *"Most of this is common sense."*

Was there a specific exercise that was not useful: of the 46 participants, just two (4.3%) answered yes. Explanations indicated confusion over the number of units acceptable during pregnancy and remarks about the generality of the information.

In total 89% (41 respondents) stated that the training was **suitable for their jobs**, just 11% did not believe it to be suitable. When asked **if they intended to carry out brief interventions following this training.** The majority (72%, 33 respondents) stated that this was their intention, 24% reported that they did not know (Figure 11).

Figure 11: Do you intend to carry out brief interventions



Further questions asked if the participants **anticipated barriers to implementing Brief Interventions in work settings.** Sixty-one percent (28 respondents) stated that they did not see any barriers to implementation, 22% (10) did anticipate barriers and 17% (8) did not know. Anticipated barriers included time constraints, lack of motivation; many interpreted these as client barriers rather than their own barriers to delivery for example, volatile temperaments or misunderstandings. Those that did not anticipate barriers stated that they had similar alcohol intervention systems in place already. (Table 5)

Table 5: Participants' responses to anticipated barriers

Barriers	Example Participants' Responses
Yes	*"Time constraints"* *"There will always be barriers or rather added complications such as drug misuse and mental health problems - negative symptoms re: motivation to address issues etc."*
No	*"We already carry out triage assessments of substance misusers and this includes an alcohol intervention."*

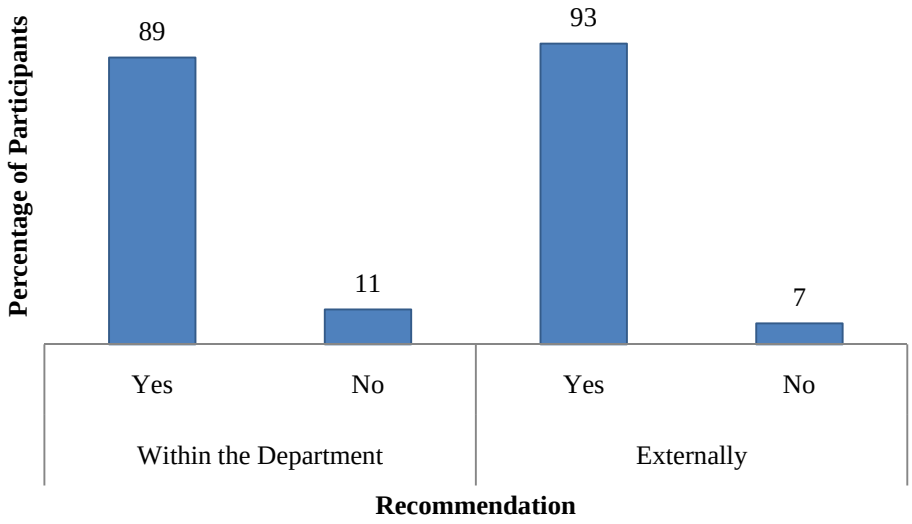
Did the training meet your expectations, the participants were asked. Out of 46, 38 (83%) answered in the affirmative. Almost a fifth (17%; 8 participants) stated that the training did not meet their expectations. When asked to detail their expectations a number of participants, those that answered no thought such a serious topic required more than a computer exercise. Others thought that it provides basic (though relevant) information and that they thought there would be more detail. Those that answered yes, thought it to be a useful tool that was not too specialist so as to render it obtuse to those without existing knowledge (Table 6).

Table 6: The participant's expectations

Expectations	Example Participants' Responses
Yes	*"Found it better than expected. Was expecting the course to be very "specialist" and feel out of my depth due to relative inexperience. However, was pleasantly surprised at the ease to glide through subject."*
No	*"I think people need more than a computer exercise. This is a mammoth issue that needs mammoth resources putting behind it, rather than a cheap initiative such as e-learning! no offence intended"* *"I found it a bit lacking in details with usage of it with people who suffer with mental health problems."*

The participants were asked **would you recommend the training course to others (in your department and externally)** and **would you consider e-learning again**. The majority of the participants reported that they would recommend the course to others in their department (89%, 41 participants) only five (11%) would not (Figure 12). When asked if they would recommend the training externally, 93% (43 participants) would, just seven percent would not. Finally 91% (42) agreed that they would consider e-learning again no one said that they would not and four (nine percent) did not know.

Figure 12: Percentages of participants who would recommend the e-learning programme, externally and with their department



The final question asked if **they had any suggestions for improvements.** The recommendations given varied; some suggested that the programme should provide printer friendly versions of the course content as well as additional references and information. Others reported that there were technical problems with the website (multiple 'login' or multiple attempts to complete a number of sections). Acknowledgements or a certificate upon completion of the course were also highlighted as something that would benefit the course. Other suggestions included the need to clarify information about the applicability of brief interventions; the number of answers in multiple choice questions; and information on the number of alcohol units that can be safely drank per week/day (Table 7).

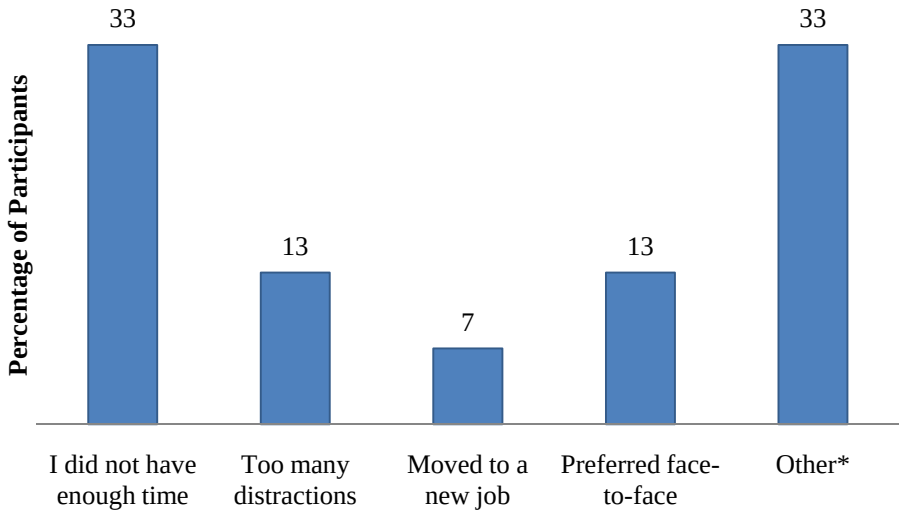
Table 7: Participants suggestions for improvements to the training course

Theme	Example Participants' Responses
Technical Difficulties	*"I had a few problems with the programme, the screen kept freezing which resulted in me having to repeat the modules and assessments a number of times…"*
Additional Information	*"Provide more details on the kind of support available… Explain where the AUDIT tool is used and what it consists of."*
Clarification of information	*"In the information sessions it states that the recommended daily consumption for an adult male is 3-4 units. It also clearly states that it is recommended that an individual have at least two alcohol free days. If using this information to determine the weekly usage one would calculate it as follows: 3-4 units x 5 days = 15-20 units per week. However, the post course assessment statement which is marked to be true is: The recommended weekly amount for an adult male is 21-28 units. Either removal of this statement or further explanation in the information section should be considered."* *"It talks about this "helping people who have alcohol problems". Brief interventions are really NOT about helping people with alcohol problems. They are about helping people who may be drinking alcohol in a way that may be damaging to their future health. Most people appropriate for brief interventions will not be aware that they may be drinking too much (or more than what may be good for their health) and will not consider themselves to have an alcohol problem."*
Incorrect use of Information	*"I also note that you do not provide any information about what "Brief Advice" to give. Just asking the FAST questions seems to be the only advice? You use the FAST questionnaire incorrectly and you fail to use the FULL AUDIT to give you a more accurate score to decide on the intervention needed"*
Extras	*"Perhaps a short assessment at the end of each module, to help to reinforce learning."* *"More information on how to approach the subject"*

3.3 Post-Training Not Completed Questionnaire

Participants (n=11) were asked to **state the reasons why they did not complete the training programme.** The main reasons were: lack of time and other (which includes technical website and password problems). Two participants would have preferred face-to-face training, two felt that there were too many distractions and one changed job (Figure 13). When asked to **state the main reason for not completing the course,** the most prevalent responses were: lack of time and other, qualified as technical problems with the website, the inability to retrieve the passwords with ease and no longer having access to the website (this was a time controlled pilot and the website may have been taken down prior to some participants completion). Another responded that they were unaware that it was incomplete.

Figure 13: Reasons for not completing the training course.



*Other refers to in this instance, technical difficulties with the training programme (passwords) or no longer having access to the website.

Participants were then asked to **indicate how useful aspects of the training programme were in terms of relevance and quality.** Participants rated each section predominantly good, however just under half (45%) had left the course prior to completing the final two sections.

All participants reported that they **would consider brief intervention training again** and that the **information about brief interventions that they received was beneficial to their work.** Finally only one person did not know if they would **consider e-learning again.** Overall the information that was provided was useful as was the medium through which the training was given.

Asked to **state how the training could have been improved or made more relevant** responses included: more obvious ways to retrieve login credentials and prompts to remind the participants to complete the training course, as with busy individual's tasks such as these may easily be overlooked. Again one participant commented on the course being more appropriate for a novice rather than someone who has working in this field for a time.

"The part of the training programme I completed was ideal at the time as I was starting a new job as … It was very clear and built my confidence…"

3.4 Three Month Post-Training Questionnaire

Just 17 participants completed this questionnaire. This low response rate means that the data are not statistically robust, so results should be viewed with caution. It is however important to add the views of those who completed the questionnaire to the evaluation.

When asked **how confident do you feel about performing brief interventions,** two reported very high confidence, nine, high confidence and six reported having neither high nor low confidence. No participants reported having low or very low confidence in performing brief interventions. Those that reported high or very high confidence in performing brief interventions came from professional backgrounds where they acted in a *de facto* counselling role, were from drugs and alcohol support or mental health services. Those that reported neither high nor low confidence were (predominantly) administration or support staff.

The second question asked if participants **had performed brief interventions following the training.** Of the 17, just seven (under half), had performed a brief interventions. A follow up question asked **how many times had they used brief interventions in the past three months,** three had used BI more than six times, two used BI three to five times and two, once or twice. Interestingly those that performed brief interventions were predominantly those with high or very high confidence. Fewer of those who reported that they had neither high nor low confidence in conducting brief interventions went on to conduct brief interventions.

Six participants stated that they did intend to carry out interventions. Of this group over half (four) had already given them. With such a small sample it is difficult to provide anything more than anecdotal evidence to show the link between intention and behaviour.

The next question enquired if the participants had **encountered any barriers when using or preparing to use brief interventions.** The majority responded that they had encountered no barriers. Two reported barriers, for example: confusion surrounding units and drinks (a drink may consist of more than one unit); the participants believed that this distinction required careful explanation and management in the training.

Participants were then asked about **additional resources that they would find useful.** Answers included the availability of the information in printable format and the provision of summary booklets for reference. Additionally, participants thought that unit calculators and lists of organisations that they can refer hazardous drinkers to would be useful.

Do you plan to continue to use brief interventions, the participants were then asked. Out of 17, three answered in the negative, while 14 reported that they would continue to use brief interventions.

Finally, the participants were asked how **this training could be improved to encourage further use of brief interventions.** Responses included the provision of booklets outlining BI to hand to staff during school visits, or downloadable information sheets (detailing how and when to intervene and safe unit statistics). Other participants believed that the inclusion of test scenarios or role play as well as feedback to the participants would improve the training.

Negative comments given regarding the programme were more likely to have come from those that were introduced to the training programme through friends or work. Comments made by those that found the programme by accident were generally positive. One participant remarked that the programme was effective for a novice, though it was not appropriate now that they had been

working in the area longer. While another participant indicated that even with prior knowledge the programme proved challenging commenting that:

"I am undertaking a day of training on Brief Interventions in the near future. I was doing some pre-course research online and happened upon your site using GOOGLE... Although I have a good prior knowledge I still failed the course at the first attempt so it shows the value of really looking at the modules properly. Thank you for providing this online tool. I think it is excellent."

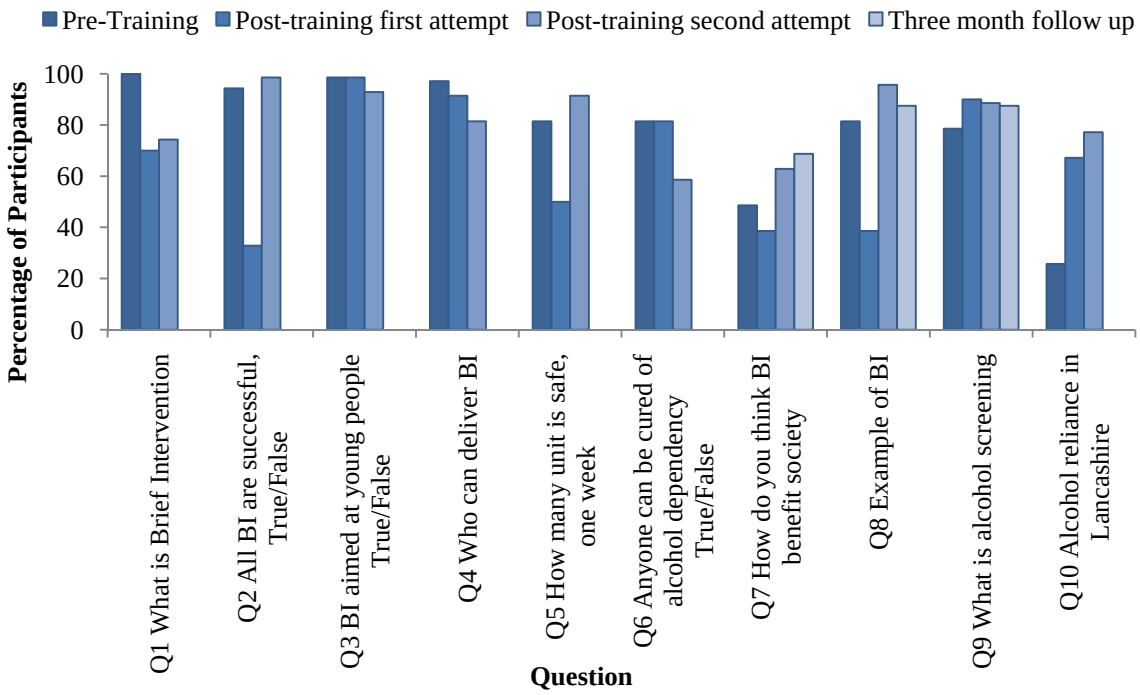
3.5 Assessment Data

Assessments were given prior to the training and upon completion, these consisted of ten questions (see appendix, section 6.1.5) covering the topics detailed in the training. Problematically for analysis the participants were able to take both assessments multiple times. In light of this, to provide a basis against which to assess knowledge gained the participants' score from their first completed assessment were taken for analysis. Additionally only those that completed the pre-and post-training (both the initial and second attempt) assessment were included in the analysis (to show the effects of training of participants' knowledge of brief interventions and alcohol issues). In total 70 participants' scores were analysed, though only 17 from the three month follow-up were used.

Examining the data (Figure 14), we see that the majority of the questions in the pre-training assessment were answered correctly. With the notable exception of question 7 (**how do you think that brief interventions can benefit society**) and question 10 (**how many people in Lancashire are recorded as having an alcohol-related problem**), 80 to100 percent of the participants answered each of the other questions correctly. These included questions on what brief interventions are; who they are aimed at; and who can deliver them. This indicates that participants had practical knowledge of brief intervention but lacked knowledge of the use of such interventions in a wider context and specialised knowledge of alcohol use in the Lancashire area prior to beginning the training.

For the post-training assessment the data have been recorded here in terms of the first and second attempt as participants were allowed to complete the assessment multiple times until they achieved sufficient marks for successful completion. Comparing the first attempt with the post-training yielded surprising results; showing a marked decrease in the percentage participants answering the questions correctly. Question one (**what do you think a brief intervention is**) which had a 100% correct response rate in the pre-training assessment, dropped to 70%. Question two, asked **whether all alcohol brief interventions are successful in solving an individual's alcohol problems**; in the pre-training assessment, 94% were correct, during the first try of the post assessment this dropped to just 33% (less than chance) which may mean that as a result of the training, participants in fact gave the wrong answers to the questions believing them to be correct. Question nine (what did they think that alcohol screening is) saw modest increase in the percentage that gave correct answers, from 79% to 90% and question ten (**How many people in Lancashire are recorded as having an alcohol-related problem**) a large increase from 26 to 67%.

Figure 14: Percentage of questions answered correctly for pre-, post- first and second attempt and three month follow up. (For full questions see appendix one)



Non-parametric inferential statistics (Wilcoxon test) were employed, as the data violated the assumptions of parametric data[6], was employed to examine the difference between the participants' scores on the pre-training assessment and the scores on the post-training assessments (both first and second attempts). Findings show that participants' scores on the first attempt at the post-training assessment were significantly lower than their scores on the pre-training assessment [T (70) = -5.10, $p<0.001$]. However after the participants had taken their second attempt at the post-course assessment, there was a significant increase in the participants scores, in comparison to their scores on the pre-training assessment [T (70) = -2.41, $p<0.05$]. While it would have been valuable to conduct a comparison between those that reported excellent to fair prior knowledge regarding both alcohol and brief interventions and those that reported poor or very poor knowledge, this was not possible as a result of low participants numbers in the post assessment and the low number of those that reported poor or very knowledge initially.

A brief assessment was conducted at the same time as the three month follow up questionnaire. The three month assessment asked ten questions concerning alcohol and brief intervention knowledge (of which three were in common with the pre- and post- assessment). From the 28 marks available for the knowledge assessment, the participants (n=16) scored on average 21.5 out of 28 (77%). When comparing the participants' scores on the three questions with their baseline scores, we can see an increase in the percentage of participants that provided the correct answers, however, there have been slight decreases from the post-training second attempt assessment (see Q7,8,9; Figure 14; appendix, section 6.1).

[6] In this case data gathered was not parametric and did not conform to a normal distribution.

Interestingly, when the participants were asked specific intervention questions regarding who can intervene, and details of the AUDIT tool (questions: two, three, seven and eight see appendix, section 6.1), they scored on average lower than in questions that regarded general alcohol knowledge questions (questions: five, six and nine). This suggests that more general information presented by the programme is retained (perhaps as a result of priming) but specific/detailed information may be less easy to recall, which raises the question of the efficacy of the programme in that course specific knowledge is less well retained. However with such few numbers we cannot be sure that this is the case.

Across all three assessments for question seven (**how do you think that brief intervention can benefit society**) there was a consistently lower percentage of participants' answering correctly.

4. Discussion.

The study aimed to evaluate the effectiveness of an online brief intervention programme and is intended to give meaningful insight into the participants' opinions about the validity, accessibility and accuracy of the programme, as well as recommendations to improve it for future learners. We start by discussing recruitment and retention to training and then report key findings from the questionnaires. Finally we follow with a discussion of comments raised by the participants as well as officering a number of suggested actions.

Recruitment and retention was via the commissioners' usual methods of roll out and retention. Though it is beyond the remit of this evaluation to investigate effort spent advertising and rolling out the programme, 165 people at least tried the programme initially. Researchers did take responsibility for following up non-completers for an evaluation and the three month follow-up of those that completed the programme. The researchers made multiple attempts to contact and encourage the participants to complete the follow-up evaluation questions, to the point of retrieving passwords and usernames from DeltaNet International Limited for those participants who had forgotten them, but scenarios such as these are notoriously difficult. Smaller numbers renders the use of statistical tests difficult, though they have been applied where possible. With this in mind the results should be interpreted with caution. Table 8 shows the number of participants who completed each questionnaire. By the third questionnaire the number had dropped substantially and though there were many prompts sent to participants only 16 completed this questionnaire. One reason for the disparity between the numbers completing questionnaire could be the differing delivery methods: pre- and post-questionnaire were given during the programme and with the follow up questionnaire, a web link was sent to each participant.

Table 8: Number of participants that completed each evaluation

Pre-assessment	Pre-assessment questionnaire	Post-assessment (incomplete)	Post-assessment questionnaire	Post-assessment	Three month follow up assessment
70	165	11	47	70	17

4.1 Key Findings Include:

- In total 51% and 43% participants had fair prior knowledge of alcohol issues and brief interventions respectively.
- More than half (55%) had not set aside time for the completion of the training programme.
- The most frequently preferred location to complete the training (41%) was to complete the training at home, the reasons that were given for this include the ability to control the level of interruption and distraction.
- Following the training the majority of participants when asked to rate the individual sections, rated each section as good or excellent.
- Over half (59%) of participants reported that they did not find a specific exercise useful and 96% found no specific exercise that was not useful.

- Only around a fifth reported that the training had not met their expectations while 89% and 93% would recommend the programme within and external to the department respectively.
- Just under half of those that completed the follow-up questionnaire had conducted brief interventions since the training. Three months after the training the majority had not encountered any barriers while doing so.
- The main reasons for not completing the training were given as a lack of sufficient time (though more than half had not sent aside time to complete the course) and the loss of login credentials and other technical issues.
- Statistically significant increases were found between the baseline and the post-training assessment, however these increases were found only between baseline and their second attempt to complete the post assessment.

4.2 Informational Content of the Material

The training scheme has been well received by the majority of the participants who completed the course; however there are a number of issues reported during the evaluation, that require discussion. Comments made argue that the training used FAST and not AUDIT and did so incorrectly. This confusion may have been due to the fact that a shortened version of AUDIT was used, rather than the full AUDIT tool. Additionally no information was given on how best to use the assessment tool.

Suggested Action:

i. Explicitly state that the assessment taught is in fact a shortened version of AUDIT.

Participants reported problems with the information presented. There was confusion in the training material over the number of units that pregnant women can safely drink, for example, one part said four units of alcohol another presented the answer as zero units. As well as information on the number of units/drinks that can be safely consumed per week/day as for example one part states that daily consumption (for a male) is 3-4 units with two days of rest (without alcohol) a week, equalling 15-20 units while another states that weekly consumption at 21 units, in line with government recommendations regarding alcohol consumption. Secondly information regarding the applicability of brief interventions as well as overtly informing participants when multiple choices are required was remarked by participants as lacking. It was also suggested that the telephone number given for the referrals in Lancaster is incorrect.

Suggested Action:

i. The commissioners should ensure that contradictory information is not given to the participants.
ii. Information should be presented clearly delineating between glasses and units as well as the number of alcohol units that can be imbibed in a day/week.
iii. Investigating and changing if needed, the contact number for Lancaster referrals.

Comments were made with regard to the depth of information that was presented. Numerous participants regarded the information as ‘common sense’ and suggested that information regarding alcohol and mental illness was lacking.

A number of participants stated that the information was presented in an understandable way. They felt that a lack of information regarding alcohol issues and brief intervention on their part did not render the programme obtuse and so was not a barrier to successful completion of the course. Clearly then, the course, in its current incarnation, is geared towards a novice or individual new to the discipline or as a means of refreshing intervention information, providing good initial education to be built upon.

Suggested Action:

i. It would be a difficult exercise to create a programme that adequately accommodates both new and experienced alcohol professionals; in light of this the commissioners should make careful examination of their target participants and should tailor the programme accordingly.
ii. Additionally the commissioners could examine the scope and validity of creating both a beginners and an advanced course to accommodate both the experienced and the novice; however there are financial and logistical considerations to be taken into account. Instead the commissioners could build more advanced modules alongside the foundation modules.

The assessment provided the participants at three months follow-up indicated that they had greater difficulty is recalling specific information (in this case AUDIT), than details about brief interventions or general alcohol information.

Suggested Action:

i. Participants should be given additional tuition on the more detailed areas of the course (AUDIT) as well as supplementary chances to consolidate knowledge such as through role playing exercises or beginning new section by reviewing previous ones.

4.3 Technical Issues

A number of participants reported technical issues. These problems included issues with login detail retrieval, screen freezing and the training requiring, at times, multiple logins and attempts to complete sections. These problems are highly frustrating and time consuming (especially important for those fitting the programme into their working schedule). It was hard to assess to what extent this was due to the performance of the website or participants own computers/networks.

Suggested Actions:

i. A review of current Information Technology systems in order to attend to these technical issues, with a view to examining whether any changes can be made.
ii. Review the basic computing skills and system requirements that are needed to complete the training programme and detail these requirements to future trainees.

4.4 Administration of the Programme

A number of participants who did not complete the training programme cited a lack of time to complete the programme and the loss of login credentials as primary causes and also the inability to retrieve details with ease. In fact the process to retrieve these details consisted of e-mailing DeltaNet International Limited International Limited with a request and awaiting a response.

However, with around half of the participants not completing the training because of a lack of time, having to wait for the details to be retrieved is a constraint on their available time. Others suggested that as busy individuals there is a possibility that they forgot to complete the course due to heavy time demands and workloads.

Suggested Action:

i. The training programme could have a more obvious, simple and expedient way for the trainers to retrieve their details. Participants suggested that there could be prompts to remind them that they still have the training to complete; these could include password reminders.
ii. In the introductory information, emphasis could be placed upon the need to set aside sufficient time to successfully complete the course. Half of the participants did not and this was a main reason for non-completion.

4.5 Suggestions for Future Development

Participants were also asked to make suggestions regarding improvements that could be made. A number of practical responses were given. They included the provision of downloadable information or a pamphlet containing the most important information. Some suggested that there should be an additional assessment at the end of each section to aid in memory consolidation as well as test scenarios and feedback. Suggestions also included providing unit calculators to aid in delivering brief interventions and a list of organisations where individuals can be referred.

Suggested Action:

i. Actions may include providing printable information (more fiscally viable that providing booklets for each of the trainees) for reference.
ii. Secondly there could be an examination of the potential for building additional assessments and more practical scenarios (to aid consolidation) into the online tool.

Clearly participants' confidence in their abilities is important for the transition from training to actively providing brief interventions. Results indicate, anecdotally, that those with high levels of self reported confidence in conducting brief interventions were those that continue to give brief interventions. What is also apparent is that those who reported high confidence were from professions where they have already had experience with brief interventions. Participants suggested providing practical or role playing scenarios. Such practical aspects may increase the confidence of the participants by giving them the ability to try out process prior to carrying out brief interventions professionally and so aid in the translation of training to practical application. In a review of the use of role play and simulated patients in communication skills training, they found, that for the majority of studies the use of role play or practical experiences (simulated patients) leads to a significant improvement in the participants' communication skills (Lane and Rollnick, 2007). When compared with the instructive methods employed in the training scheme presented in this report, the use of interactive/role playing scenarios could provide a better learning environment. Rabin et al, (1994) found that when the use of simulated patients and written materials were compared with the use of written materials alone significantly more questions were asked by the group that received the practical training. Arguably they became more invested in the training programme, hence the increased number of questions. Finally Kleinman et al, (1996) suggests that through the use of role play scenarios the interpersonal skills of the participants are developed.

While the content is aimed at the novice, it seems that to translate knowledge gained into practice requires more than the training scheme currently provides.

Suggested Action:

i. An examination of the possibility of including an interactive component should be made.

4.6 Conclusion

The assessments given provided insight into both the baseline knowledge, of the participants', as well as the knowledge that they gained as a consequent of the training programme. Ideally the assessment data would have been compared across three time domains, as it was we anticipated more recruitment to the programme would be made (a finding in itself). However due to the relatively small initial pool of participants, the small response rates for the three month follow up (which are notoriously difficult scenarios in which to recruit participants) and the incompatibility of the questions that were asked during the follow-up assessments with the questions asked during the assessments given in the training programme, we are unable to do so. As such the results should be interpreted with caution.

The assessment data indicate that going into the training, the participants already had a great deal of knowledge regarding alcohol brief interventions, as evidenced by the high percentages that correctly completed the assessment, and while there was a significant increase between the baseline and post-assessment scores (second attempt), this was only a small increase in effect size. As such the training appears to have had little major impact on the knowledge that the participants already possessed and perhaps in its current form is targeted at the wrong audience. This programme seems to have made little impact on those that already have alcohol knowledge and/or work within this sector and as such is perhaps more suitable for more novice individuals. However it does highlight a lack of knowledge by the participants as to when alcohol brief interventions can be employed (question eight) and the wider effects of performing brief interventions (question seven). In these areas, providing a context for brief intervention, the training programme does provide increases in the knowledge of brief interventions and alcohol knowledge.

5. References

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6. Appendices

6.1 Appendix One: Evaluation Questionnaires

6.1.1 Pre-training Questionnaire

Pre training questionnaire

Please complete the following details **before the training session** to enable us to establish your role, experience and expectations. The information supplied will support the development and improvement of the Alcohol Brief Intervention training and will remain confidential. **Thank you for your help.**

1. Which service do you work in? (Tick only one)

Adult Social Care	❑
Children's services	❑
Community healthcare services	❑
Drug/alcohol support services	❑
Fire Service	❑
Hospital	❑
Mental health services	❑
NOMS	❑
Police	❑
Prison service	❑
Voluntary sector	❑
Other (please specify)	❑ ……..

2. What is your job title/position? ……

3. Please state which area in Lancashire you work in (Tick all that apply)

Blackburn with Darwen	❑
Blackpool	❑
Burnley	❑
Chorley	❑
Fylde	❑
Hyndburn	❑
Lancaster	❑
Pendle	❑
Preston	❑
Ribble Valley	❑
Rossendale	❑
South Ribble	❑
West Lancashire	❑
Wyre	❑

4. How long have you been in this post? (Tick only one)

❑ Under 1 year ❑ 1-2 years ❑ 3-5 years ❑ 6-10 years ❑ More than 10 yrs

5. How long have you worked in this field? (Tick only one)

❑ Under 1 year ❑ 1-2 years ❑ 3-5 years ❑ 6-10 years ❑ More than 10 yrs

	Yes	No
6. Have you previously had any alcohol related training?	❑	❑
7. Have you previously had any Brief Intervention training?	❑	❑

8. How would you rate your knowledge of alcohol related issues? (Tick only one)

Excellent ❑ Good ❑ Fair ❑ Poor ❑ Very poor ❑

9. How would you rate your knowledge of Brief Interventions? (Tick only one)

Excellent ❑ Good ❑ Fair ❑ Poor ❑ Very poor ❑

10. How often does your team come into contact with people that may benefit from receiving an Alcohol Brief Intervention? (Tick only one)

Daily ❑ Weekly ❑ Monthly❑ Rarely❑ Don't know ❑

11. Have you been set aside time to complete this training?

❑ Yes ❑ No

12. Do you currently work… (Please tick all that apply)

At home ❑ In an open plan office ❑ In your own office ❑

13. Where do you intended to complete the training? (Please tick all that apply)

At home ❑ Office – at your desk ❑ Office – away from your desk ❑

14. Where did you hear about Brief Intervention training? (Please tick all that apply)

Through manager ❑
External email ❑
Previous training course ❑
Other (please specify) ❑ ……..

15. What are you hoping to learn from the training session? (Please provide as much detail as possible).

About you:

Age Under 18s ❑ 18-24 ❑ 25-34 ❑ 35-44 ❑ 45-54 ❑ 55-64 ❑ 65+❑

Gender Male ❑ Female ❑

Ethnicity

White British ❑ Black/Black British ❑
White European ❑ Asian/Asian British ❑
White Irish ❑ Chinese/Chinese British ❑
Mixed Race ❑ Other ❑ Please specify ……..

Thank you for taking the time to complete this questionnaire

This questionnaire is being used to evaluate the value of the training programme. We would like to contact you further to discuss your experiences. Please provide your contact details below:

Contact details (Please note that comments are confidential and will not be attributed to individuals or individual organisations. Contact details will only be used if further research is conducted).
Name:
Phone number:
E-mail address:

If you have any questions about the questionnaire or the evaluation more generally, please contact either Kerin Hannon or Michela Morleo using the details provided below.

Kerin Hannon, Public Health Researcher
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Centre for Public Health, Liverpool John Moores University, Castle House, North Street, Liverpool L3 2AY

6.1.2 Post-training Questionnaire

Post training questionnaire

Please complete the following details **immediately after your final training session** to enable us to record your thoughts on the course and provide the opportunity for making recommendations. The information supplied will provide information to support the development and improvement of the Alcohol Brief Intervention training and will remain confidential. **Thank you for your help.**

1. Were you given sufficient time away from your phone/other distractions to complete the training?

Yes ☐ No ☐

2. Where did you complete the training? (Please tick all that apply)

At home ❑ Office – at your desk ❑ Office – away from your desk ❑

3. What would be your preferred location to complete the training? (Tick one only)

At home ❑ Office – at your desk ❑ Office – away from your desk ❑

Why? ……..

4. For each element of the training, could you please indicate how useful it was in terms of the relevance and quality of the content. (Tick one for each)

	Excellent	Good	Fair	Poor	Very poor	Further comments
Background information on Brief Interventions and its benefits	☐	☐	☐	☐	☐	…….. …….....
Information on alcohol use and the positive and negative effects of alcohol	☐	☐	☐	☐	☐	…….. …….....
Information on brief intervention techniques	☐	☐	☐	☐	☐	…….. …….....
Details on the AUDIT screening tool	☐	☐	☐	☐	☐	…….. …….....
Information on appropriate responses and the referral process	☐	☐	☐	☐	☐	…….. …….....

5. Was there a specific exercise that you found particularly useful?

Yes ☐ No ☐

Please explain:

6. Was there a specific exercise that was not useful?

Yes ☐ No ☐

Please explain:

7. Was the training suitable for your job role?
Yes ☐ No ☐

8. Do you intend to carry out Brief Interventions following this training?
❑ Yes ❑ No ❑ Don't know

9. Do you anticipate any barriers to implementing Brief Interventions in your work setting?
❑ Yes ❑ No ❑ Don't know
Please explain:

10. Did the training meet your expectations?

Yes ☐ No ☐

Please state what you expected:

11. Would you recommend the training to others?
In your department? Yes ☐ No ☐
Externally? Yes ☐ No ☐

12. Would you consider e-learning again?
❑ Yes ❑ No ❑ Don't know

13. Can you suggest any improvements for this training course?

Thank you for taking the time to complete this questionnaire
This questionnaire is being used to evaluate the value of the training programme. We would like to contact you further to discuss your experiences. Please provide your contact details below:

Contact details (Please enter your details below if your contact details have changed. Please note that comments are confidential and will not be attributed to individuals.).
Name:
Phone number:
E-mail address:

If you have any questions about the questionnaire or the evaluation more generally, please contact either Kerin Hannon or Michela Morleo using the details provided below.
Kerin Hannon, Public Health Researcher
Email: k.hannon@ljmu.ac.uk
Tel: 0151 231 4552
Michela Morleo, Alcohol Research Manager
Email: m.j.morleo@ljmu.ac.uk
Tel: 0151 231 4535
Centre for Public Health, Liverpool John Moores University, Castle House, North Street, Liverpool L3 2AY

6.1.3 Post-training Not Complete Questionnaire

Post training. Not completed

Please complete the following details **if you have decided not to complete the Alcohol Brief Interventions training** to enable us to record your thoughts on the course and provide the opportunity for making recommendations. The information supplied will provide information to support the development and improvement of the Alcohol Brief Interventions training and will remain confidential. **Thank you for your help.**

1. Can you please state the reasons why you did not complete the Brief Interventions Training (please tick all that apply)

- I did not have enough time ❑
- There were too many distractions ❑
- I have moved to a new job ❑
- The content was not relevant to my position ❑
- I did not like using the computer for the course ❑
- I did not understand what was required of me ❑
- It was too complicated ❑
- I would have preferred face to face training ❑
- Other (please specify) ❑ ……

2. Please state the <u>main reason</u> why you did not complete the course (please tick only one)

- I did not have enough time ❑
- There were too many distractions ❑
- I have moved to a new job ❑
- The content was not relevant to my position ❑
- I did not like using the computer for the course ❑
- I did not understand what was required of me ❑
- It was too complicated ❑
- I would have preferred face to face training ❑
- Other (please specify) ❑ ……

3. For each element of the training, could you please indicate how useful it was in terms of the relevance and quality of the content. (Tick one for each)

	Excellent	Good	Fair	Poor	Very poor	Not completed	Further comments
Background information on Brief Interventions and its benefits	☐	☐	☐	☐	☐	☐	…… ……
Information on alcohol use and the positive and negative effects of alcohol	☐	☐	☐	☐	☐	☐	…… ……
Information on brief intervention techniques	☐	☐	☐	☐	☐	☐	…… ……
Details on the audit screening tool	☐	☐	☐	☐	☐	☐	…… ……
Information on appropriate responses and the referral process	☐	☐	☐	☐	☐	☐	…… ……

4. Would you consider Brief Interventions training again?

❑ Yes ❑ No

5. From the information you have received, are Brief Interventions beneficial in your work?

❑ Yes ❑ No ❑ Don't know

6. Would you consider e-learning again?

❑ Yes ❑ No ❑ Don't know

7. Please state how this training could be improved or made more relevant:

Thank you for taking the time to complete this questionnaire

This questionnaire is being used to evaluate the value of the training programme. We would like to contact you further to discuss your experiences. Please provide your contact details below:

Contact details (Please enter your details below if your contact details have changed. Please note that comments are confidential and will not be attributed to individuals).

Name:

Phone number:

E-mail address:

If you have any questions about the questionnaire or the evaluation more generally, please contact either Kerin Hannon or Michela Morleo using the details provided below.

Kerin Hannon, Public Health Researcher

Email: k.hannon@ljmu.ac.uk

Tel: 0151 231 4552

Michela Morleo, Alcohol Research Manager

Email: m.j.morleo@ljmu.ac.uk

Tel: 0151 231 4535

Centre for Public Health, Liverpool John Moores University, Castle House, North Street, Liverpool L3 2AY

6.1.4 Post-training: Three Month Questionnaire

Post training: three months

Please complete the following details **three months after your final training session** to enable us to record your thoughts on the course and provide the opportunity for making recommendations. The information supplied will provide information to support the development and improvement of the Alcohol Brief Intervention training and will remain confidential. The questionnaire should be returned to JMU as soon as it is completed using the details provided overleaf**. Thank you for your help.**

1. How confident do you feel about performing Brief Interventions?

Very high ☐ High ☐ Neither high or low ☐ Low ☐ Very low ☐

2. Have you performed Brief Interventions following the Alcohol Brief Intervention training?

Yes ☐ No ☐

3. If so, how many times have you used Brief Interventions in the last 3 months?

Once or twice ☐ Three to five times ☐ More than six times ☐

4. Have you encountered any barriers when using Brief Interventions or preparing to do so?

Yes ☐ No ☐

If yes please state what these are:

5. Please list any additional resources that you would find useful:

6. Do you plan to continue using Brief Interventions?

Yes ☐ No

7. Please state how this training could be improved to encourage further use of Brief Interventions:

Thank you for taking the time to complete this questionnaire

This questionnaire is confidential and is being used to evaluate the value of the training programme.

Post training: Quick assessment

Please complete the following short assessment consisting of 10 multiple choice questions. These will cover the information you learnt in your Brief Intervention course and will be used to rate how memorable the course material is. The information supplied will provide information to support the development and improvement of the Alcohol Brief Intervention training. The questionnaire should be returned to JMU as soon as it is completed using the details provided overleaf**.** Please remember some questions may need more than one answer. **Thank you for your help.**

1. Which of the following are examples of when a Brief Intervention is required? (please tick all those which are correct).

❑ A young person is going out on regular binge drinking sessions and exceeding the safe alcohol limit each week
❑ There is reason to suspect that someone is inflicting domestic violence on someone else, which could be due to alcohol abuse
❑ A person is suffering from stress and regularly drinks in the evenings to try to ease this
❑ Someone who is regularly taking time off from work due on the effects of alcohol

2. Which of the following statements are true? (please tick all those which are correct).

❑ A brief intervention is using ways to find out if someone has an alcohol problem, such as talking to them or providing them with useful information that can help solve it
❑ A brief intervention is a way of breaking up a potentially violent disagreement between drunken people
❑ The recommended safe limit of alcohol that can be consumed by males in one week is 22 units
❑ The recommended safe limit of alcohol that can be consumed by females in one week is 8 units

3. Why is it important to carry out a Brief Intervention if it is necessary? (please tick one answer).

❑ If problems are not dealt with they can escalate and get worse, causing more harm to the person who has the alcohol problem, as well as to their family and friends
❑ Otherwise individual staff members could be fined for not carrying out Interventions
❑ Doing Interventions improves your own personal development at work
❑ Because delivering an Intervention is a guaranteed way to solve someone's alcohol problems

4. Which of the following are examples of people who can carry out Interventions? (please tick all those which are correct).

❑ Housing services
❑ Fire service
❑ People who work permanently from home
❑ Trading Standards
❑ Police
❑ Schools
❑ Office staff who have no contact with the public

5. Which of the following are questions from the AUDIT PC screening tool? (please tick all those which are present in AUDIT).

❑ Do you drink mostly beers or spirits?
❑ How often do you have a drink containing alcohol?
❑ How often during the last year have you found that you were not able to stop drinking once you had started?
❑ Has a relative or friend or health worker been concerned about your drinking or suggested that you cut down?
❑ How much do you spend per week on alcohol?

6. Which of the following should you do when you ask AUDIT questions? (please tick all those which are correct).

❑ Be non-judgemental in your approach
❑ Take the opportunity to ask more in depth questions that are not included in the AUDIT screening tool
❑ Ask questions on other health related subjects along with questions about alcohol use
❑ Ask open questions
❑ Only ask questions that are appropriate
❑ Be non judgemental, unless the person scores over 5 in the AUDIT screening

7. What do you think alcohol screening is? (please tick one answer).

❑ A blood test to see the extent of damage done to a person by alcohol
❑ A questionnaire to help identify an alcohol problem. It may include questions about quantity and types of alcohol consumed and any negative effects
❑ The free showing of an educational film regarding alcohol abuse to at risk members of society, to raise awareness
❑ A selection process to determine who is allowed to carry our Brief Interventions

8. Is the following true or false? If a person scores over 5 points in the AUDIT PC screening tool they are in need of further help and advice.

❑ True ❑ False

9. Where can you refer clients for further help and advice? (please tick all those which are correct).

❑ Their GP
❑ NHS Direct
❑ Information leaflets
❑ Preston Drug and Alcohol Service
❑ Try to counsel them yourself

10. How do you think Brief Interventions could benefit society? (please tick all those which are correct).

❑ By reducing violence and anti-social behaviour
❑ By helping to save lives or improve the health of people who have or could develop an alcohol problem dangerous to their health
❑ By raising money for alcohol awareness
❑ By reprimanding people who commit alcohol related crimes
❑ By helping the families and friends of people with alcohol problems; as the stress has a knock on effect on them

Thank you for taking the time to complete this questionnaire
Contact details (Please enter your email address if your contact details have changed. Please note that comments are confidential and will not be attributed to individuals.).
E-mail address:

If you have any questions about the questionnaire or the evaluation more generally, please contact either Kerin Hannon or Michela Morleo using the details provided below.
Kerin Hannon, Public Health Researcher
Email: k.hannon@ljmu.ac.uk
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Tel: 0151 231 4535
Centre for Public Health, Liverpool John Moores University, Castle House, North Street, Liverpool L3 2AY

6.1.5 Assessment Questions

These assessment questions were given during the training programme.

You are about to do a short assessment which has 10 multiple choice questions.

These will assess how much you already know about Brief Interventions, and your views about them, before you study the course.

Please remember some questions may need more than one answer.

Q1. What do you think a brief intervention is?

- Using ways to find out if someone has an alcohol problem, such as talking to them or providing them with useful information that can help solve it
- Breaking up a potentially violent disagreement between drunken people
- Placing a ban on alcohol for a brief amount of time
- A period of medical treatment for someone with an alcohol problem

Q2. Is the following statement true or false?

All Alcohol Brief Interventions are successful in solving an individual's alcohol problems.

Yes, the answer is false. All Alcohol Brief Interventions are not successful in solving an individual's alcohol problems.

Q3. Is the following statement true or false?

Alcohol Brief interventions are aimed mostly at young people as they are more likely to become alcohol dependent.

Yes, the answer is false. Alcohol Brief interventions are aimed at any age group.

Q4. Who can deliver brief interventions?

- Anyone working with the public, including health professionals, emergency services, employers, social or community services, people working in criminal justice or education
- Only medically qualified staff working in hospitals or surgeries
- Only trained counsellors working for alcohol support groups

Yes. Anyone working with the public, including health professionals, emergency services, employers, social or community services, people working in criminal justice or education can do a Brief Intervention.

Q5. How many units do you think it is safe to drink in a one week period?

Q6. Is this true or false? Anyone can be cured of alcohol dependency.

Yes, the answer is false. Not everyone can be cured of alcohol dependency

Q7. How do you think brief interventions can benefit society?

- By reducing violence and anti-social behaviour

- By helping to save lives of people who have or could develop an alcohol problem dangerous to their health imbibe
- By raising money for alcohol awareness
- By reprimanding people who commit alcohol related crimes
- By indirectly helping the families and friends of people with alcohol problems; as the stress has a knock on effect on them

Correct

Yes. Brief Interventions can benefit society by reducing violence and anti-social behaviour; by helping to save lives of people who have or could develop an alcohol problem dangerous to their health and by indirectly helping the families and friends of people with alcohol problems; as the stress has a knock on effect on them.

Q8. Which of the following are examples of when Brief Intervention is required?

- A young person is going out on regular binge drinking sessions and exceeding the safe alcohol limit each week
- There is reason to suspect that someone is inflicting domestic violence on someone else, which could be due to alcohol abuse
- A person is suffering from stress and regularly drinks in the evenings to try to ease this
-

Correct all…

Q9. What do you think alcohol screening is?

- A scan to see the extent of damage done to a person by alcohol
- A questionnaire to help identify an alcohol problem. It may include questions about quantity and types of alcohol consumed and any negative effects
- The free showing of an educational film regarding alcohol abuse to at risk members of society, to raise awareness
- A selection process to determine who is allowed to carry our Brief Interventions

Correct

Yes. Alcohol screening is a questionnaire to help identify an alcohol problem. It may include questions about quantity and types of alcohol consumed and any negative effects

Q10. How many people in Lancashire are recorded as having an alcohol related problem?

6.2 Appendix Two: Data Tables

Table 9: Profession of Participants

Profession	No of Participants
Community Healthcare Services	23
Drug/Alcohol Support Services	33
Adult Social Care	4
Mental Health Services	18
Fire Services	26
Hospital	5
Children's Services	9
Police	4
Voluntary Sector	2
Prison Service	3
National Offender Management Service	2
Other	36

Table 10: Location of Participants

Location	Number
Blackburn with Darwen	25
Blackpool	11
Burnley	36
Chorley	27
Fylde	17
Hyndburn	23
Lancaster	15
Pendle	23
Preston	31
Ribble Valley	23
Rossendale	18
South Ribble	22
West Lancashire	29
Wyre	15
Other	44

Table 11: Percentage of participants' ratings of knowledge of alcohol related issues and brief intervention

	Knowledge	
Rating	Alcohol Issues	Brief Interventions
Excellent	5	5
Good	37	21
Fair	51	43
Poor	6	23
Very Poor	1	7

Table 12: Frequency of contact with individual that would benefit from brief interventions

Contact	%
Daily	34
Weekly	33
Monthly	16
Rarely	7
Don't Know	11

Table 13: Medium through which the participants heard about brief interventions training

Medium	Number	%
Though Manager	60	36
External email	37	22
Previous Training Course	7	4
Colleague	8	5
Internal E-mail	6	4
Internet/search	31	19
Intranet	2	1
Primary Care Trust	5	3
Miscellaneous	9	5

Table 14: Number of respondents that completed the training at: home, the office at or away from their desk.

Location	Percentage
At Home	36
Office - at your desk	56
Office - away from desk	8

Table 15: Preferred location to complete training

Location	Percentage
At Home	41
Office - at your desk	35
Office - away from desk	24

Table 16: Percentage of participants rating of background information on brief intervention and its benefits

Rating	Percentage
Excellent	33
Good	59
Fair	4
Poor	4
Very Poor	-

Table 17: Information on alcohol use and the positive and negative effects of alcohol

Rating	Percentage
Excellent	37
Good	50
Fair	11
Poor	2
Very Poor	-

Table 18: Information on brief alcohol techniques

Rating	Percentage
Excellent	30
Good	43
Fair	22
Poor	2
Very Poor	2

Table 19: Details on the AUDIT screening tool

Rating	Percentage
Excellent	22
Good	37
Fair	20
Poor	19
Very Poor	2

Table 20: Information on appropriate response and the referral process

Rating	Percentage
Excellent	26
Good	48
Fair	17
Poor	9
Very Poor	-

Table 21: Do you intend to carry out brief intervention

Response	Percentage
Yes	24
No	4
Don't Know	72

Table 22: Percentage of participants who would recommend the e-learning programme externally and within their department

Recommend		%
Within the Department	Yes	89
	No	11
Externally	Yes	93
	No	7