Public Health Scotland

Alcohol Brief Interventions: A review of strategy and recommendations for policy

Publication date: 29 October 2024

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Executive summary

There is an urgent need to address the adverse consequences of harmful alcohol consumption on people's health, families, communities and public services.

Scotland has the highest rate of alcohol-specific deaths of all the devolved nations in the UK. The rate of alcohol-specific deaths has increased since 2011,[1] despite a policy of Minimum Unit Pricing of alcohol which is estimated to have reduced deaths by 13% in the first two years of its implementation. More needs to be done to reverse the high levels of harm.[2]

The need for a refreshed approach

Scotland has had a programme to implement alcohol screening and brief interventions since 2008 and a comprehensive alcohol prevention framework since 2009. The stated aim of the current Scottish policy on Alcohol Brief Interventions (ABIs) is to mainstream delivery. Given emerging evidence over 15 years, changes in the NHS landscape (including contractual changes) and considerable societal disruption due to global financial and health crises, it is timely to consider whether and in what form the Scottish programme should continue.

About this review

In July 2022, the Scottish Government asked Public Health Scotland to undertake a review of the Alcohol Brief Intervention programme in Scotland.

A programme board was established consisting of those with frontline experience of delivering interventions, those who provide training and support for the programme, academic and public health experts, and people with lived experience. A series of six online workshops were held with the programme board to inform this report.

Overarching recommendations

The recommendations have been developed by Public Health Scotland based on the discussions and findings of the programme board. Three overarching recommendations are proposed.

The Scottish Government should:

- reaffirm its commitment to the programme and its reorientation to flexible, evidence-informed conversations about alcohol
- set out the steps by which its vision of embedding conversations about alcohol can be achieved over 10 years
- seek engagement and leadership from the Chief Medical Officer, the Chief Nursing Officer, the Royal College of Midwives and other relevant professional organisations to normalise conversations about alcohol.

Recommendations

The recommendations should be seen as interdependent and synergistic. The recommendations are divided into short-term actions (to be delivered within two years) and medium-term actions (delivered over a longer period as these require system change).

Action area 1: Making the conversation about alcohol a routine wellbeing conversation

Short-term recommendations

- The Scottish Government should as an immediate measure consider removing the requirement for 80% of interventions to be delivered in priority settings.
- Public Health Scotland should strengthen available quantitative indicators on population alcohol consumption to describe high-risk patterns of consumption

(including binge drinking) and patterns of consumption among women, older adults and people with co-existing chronic health conditions.

Medium-term recommendations

- The Scottish Government should work with primary care leads to make conversations about alcohol a requirement for preventative health elements of national contract frameworks (e.g. dentistry, primary care and pharmacy).
- Public Health Scotland, in partnership with other stakeholders, should work with behaviour change experts to develop multicomponent strategies to support the normalisation of opportunistic conversations about alcohol in health and social care settings. Implications for delivery, such as the inclusion of other health-harming behaviours, should be considered.

Action area 2: Describing what conversations should look like in practice

Short-term recommendations

- The Scottish Government should establish an expert advisory group to produce evidence-based policy briefings and provide ongoing strategic oversight to the revised policy approach.
- Public Health Scotland should undertake a revised review on elements of effective conversations including the role of any screening tools and support the translation of research into practice.
- The Scottish Government should ensure a pathway is in place to assess effectiveness of digital innovations in this space and enable roll out of impactful applications. It may want to consider the role of the existing Accelerated National Innovation Adoption (ANIA) pathway in this.

Medium-term recommendations

- Local areas should use techniques of continuous improvement to achieve the revised policy aims and objectives. The revised policy should recognise the importance of local innovation in achieving ambitions of integrating alcohol into wider wellbeing conversations and remaining fit for purpose into the future.

Action area 3: Reducing inequalities in alcohol-related harms

Short-term recommendations

- The Scottish Government should reflect the need for universal and targeted approaches in its revised policy approach.
- The Scottish Government should update policy guidance to move away from specific needs assessment for Alcohol Brief Interventions and towards an integrated approach with strategic commissioning plans of statutory agencies and partnerships.
- The Scottish Government should explore options for developing a specification template that can be made available to local partners. This would ensure that appropriately tailored conversations about alcohol are included in service specifications for locally commissioned support services (e.g. mental health support, welfare rights and housing support) in line with the outlined above and available evidence.

Medium-term recommendations

- Public Health Scotland should develop a plan to improve the quality and use of data relevant to reducing alcohol harm and inequalities in alcohol harm in Scotland.

Action area 4: Workforce development, training and health information resource requirements

Short-term recommendations

- The Scottish Government should explore options to ensure that learning resources developed by different areas are pooled and shared. This should be seen as an opportunity to create a dynamic toolkit or platform that includes notes on appropriate use and considers currency of included resources.

- The Scottish Government should explore options to provide direct support to local areas that have skilled trainers in place who are able to share learning and expertise with other areas. This would reduce the risk of losing knowledge and skills while working towards the creation of a sustainable learning system.

- The Scottish Government should explore options to support a managed network that functions as a community of practice. Additionally, this could provide a forum for local leadership to exchange learning and management of training resources.

Medium-term recommendations

- The Scottish Government should work with higher education policy leads, education providers and organisations leading on education standards and curricula to include core communication skills and alcohol and stigma awareness in their training programmes. These would include higher education institutions providing undergraduate and postgraduate education for health and social care professionals and practitioners, and equivalent bodies for workplace-based training.

- The Scottish Government should identify options for sustainable procurement of health information materials. Any procured materials should not be affiliated with the alcohol industry.

- Public Health Scotland should offer stakeholder support and guidance to support good practice in relation to identifying and managing conflicts of interest. This includes interaction with the alcohol industry to protect independence of public health policies and health information materials from commercial and other vested interest and influence.

Action area 5: Reduce stigma by having conversations about alcohol

Recommendations

- The Scottish Government should ensure that the reviewed policy and associated materials to support implementation and delivery include components related to stigma and consider the consequences of stigma associated with multiple circumstances.

- The Scottish Government should consider how the framing and implementation of structural interventions to reduce alcohol harm (e.g. price, availability, marketing and labelling) can also contribute to reducing the stigma associated with problem alcohol use.

Action area 6: Ensure conversations about alcohol are embedded as part of a wider comprehensive population-wide prevention strategy to promote health and reduce inequalities

Recommendations

- The Scottish Government should maximise all available evidence-based approaches to reduce hazardous and harmful alcohol consumption, including:

    - maintaining Minimum Unit Pricing of alcohol

    - enacting and enforcing comprehensive restrictions on exposure to alcohol advertising

    - enacting and enforcing restrictions on the physical availability of retailed alcohol.

- The Scottish Government should work across policy directorates to reflect the contribution that reducing hazardous and harmful alcohol consumption would have on wider population health outcomes.

Action area 7: Embedding learning at the heart of governance and accountability mechanisms

Short-term recommendations

- The Scottish Government should clarify implementation and strategic roles, responsibilities and accountability.

- The Scottish Government should support local areas to reorientate information collection systems to focus on data which enables improvement in the effectiveness of interventions.

- The Scottish Government should reduce the burden of reporting and recording placed on local areas with a view to eventually replacing national reporting of the number of interventions with a validated outcome indicator.

- The Scottish Government should identify and assess options for an outcome indicator that can be reported at a national level and set out feasible options and requirements for local-level outcome reporting.

- The Scottish Government should encourage collaborative links between research and practice by setting clear priorities for research and supporting the provision of mutually beneficial ways of working including research networks and learning events.

Medium-term recommendations

- The Scottish Government should explore options to develop an effective national learning platform that collates evidence-based practice and emergent learning to ensure effective collaborations between researchers and local areas.

Introduction

The continued need to reduce alcohol harms in Scotland

There is an urgent need to address the adverse consequences of harmful alcohol consumption on people's health, families, communities and public services.

Scotland has the highest rate of alcohol-specific deaths of all the devolved nations in the UK. The rate of alcohol-specific deaths has increased since 2011,[1] despite a policy of Minimum Unit Pricing of alcohol, which is estimated to have reduced deaths by 13% in the first two years of its implementation. It is clear that more needs to be done to reverse the high levels of harm.[2]

In Scotland, 22% of adults drink at levels that increase their risk of breast cancer and other cancers, stroke, heart disease and type 2 diabetes.[3] If current alcohol consumption trends continue, life expectancy across the UK will be 0.8% lower by 2050. At the same time, each person will have to pay approximately a further £200 per year on healthcare expenditure to cover the additional burden due to alcohol.[4]

Assuming no change in population-level alcohol consumption or other lifestyle factors, Scotland is forecast to see a 21% increase in overall disease burden[5] by 2050.

Currently, the levels of harm are felt most acutely by people who live in areas of socioeconomic disadvantage.[6] The objective of reducing alcohol harms is central to the Scottish Government's ambitions of increasing the wellbeing of people living in Scotland and reducing inequalities.

Context

In May 2022, the World Health Assembly recognised the harmful use of alcohol as a public health priority.[7] The World Health Organization European Region published the European framework for action on alcohol 2022–2025, which draws on the latest evidence about harms attributable to alcohol. The framework recommends an

expanded provision of screening and brief interventions in health and social care settings and in other contexts based on the evidence[8] recognising that such interventions are key components of an evidence-based multicomponent strategy to prevent alcohol harms.

The need for a refreshed approach

Scotland has had a programme to implement alcohol screening and brief interventions since 2008 and a comprehensive alcohol prevention framework since 2009. The stated aim of the current Scottish policy on Alcohol Brief Interventions is to mainstream delivery. Given emerging evidence over 15 years, changes in the NHS landscape (including contractual changes) and considerable societal disruption due to global financial and health crises, it is timely to consider whether and in what form the Scottish programme should continue.

History of the review

The Scottish Government convened a group in 2018 to address action 17 as set out in the Alcohol Framework (2018)[9]:

> 'We will review evidence on current delivery of Alcohol Brief Interventions to ensure they are being carried out in the most effective manner, look at how they are working in primary care settings where the evidence is strongest and whether there would be benefit in increasing the settings in which they are delivered.'

This group commissioned the University of Stirling to present an overview of the evidence. Additionally, a workforce survey was produced by NHS Health Scotland. (These can be provided on request.) The group identified a range of core objectives. The work of this group was discontinued during the COVID-19 pandemic.

About the programme board

In July 2022, the Scottish Government asked Public Health Scotland to continue with a review of the Alcohol Brief Intervention programme in Scotland.

A programme board was established through existing networks including Scottish Health Action on Alcohol Problems, Scottish Directors of Public Health Alcohol Special Interest Group, Scottish Health Promotion Managers Group and Alcohol and Drug Partnerships. Additionally, membership was sought from among those with frontline experience of delivering interventions, those who provide training and support for the programme, academic and public health experts and people with lived experience. Frontline experience was drawn from the acute, primary care and third sector. A list of programme board members can be found at appendix 1.

Methods

The programme board met on six occasions throughout 2022. The focus of each meeting included topics such as strengths and weaknesses of the current programme, monitoring and reporting, evaluation, features of a good conversation and health literacy.

Programme board members were presented with the following evidence and information to support group discussions:

- The summary of evidence presented by the University of Stirling.
- Evidence on the impact of inequality and models for evaluating complex public health interventions were provided by Public Health Scotland.
- National Alcohol Brief Intervention performance reporting and data quality was presented by Public Health Scotland.
- Public Health Scotland also shared evidence collected by NHS Health Scotland including a workforce survey.

Hypothetical case studies of individuals who might receive an Alcohol Brief Intervention in different settings were developed by Public Health Scotland. These were constructed based on clinical experience of delivering an Alcohol Brief Intervention within a range of settings including emergency departments, primary care, maternity services and justice settings.

Thematic analysis of the small group discussions led to the identification of areas of focus and recommendations. Findings and early recommendations were shared with the programme board at subsequent meetings and discussed again at the final meeting. Final recommendations were developed by Public Health Scotland based on the discussions and feedback of the programme board. These have been organised into short- and medium-term actions.

Peer review was completed by a consultant in public health medicine from NHS Grampian.

Aims and objectives of the review

Taken together with implementation evidence[10,11,12,13,14,15,16,17] and considering the scale of implementation activity and momentum generated by the national programme,[12,18] it is reasonable to conclude that:

- Scotland has been successful in initiating and scaling up a programme of screening and brief interventions from a very low baseline
- the Alcohol Brief Intervention programme was more likely than not to have made a significant positive contribution to reducing alcohol-related harm in Scotland.

The programme board noted that delivery of the Alcohol Brief Intervention programme was challenging from the start, and some locations and priority settings were more successful in embedding Alcohol Brief Interventions into routine practice than others.[12,13,14,15,16,19] The programme was later disrupted by the COVID-19 pandemic which occurred on top of a longer-term picture of declining delivery in priority settings.

In the meantime, alcohol harms continue to contribute to widening inequalities in Scotland and increased demand for health and care services. Programme board members concluded that there is still a need to enable people to have conversations about alcohol. Clinically and ethically, it is important to inform the public that alcohol may be a factor in the condition or issue for which they are seeking help or accessing a service, and to empower and enable them to take action to change, or access appropriate support with alcohol consumption, should they wish to do so.

The discussions of the programme board and the subsequent recommendations set out a vision for change designed to achieve the following:

- Increase the proportion of people who would benefit from receiving an evidence-informed conversation about alcohol, who receive that conversation and are then motivated to reduce their consumption.
- Ensure that evidence-informed conversations about alcohol can become a routine and regular part of practice for those working with the public in settings where alcohol use may be relevant to the aims of the service provided.
- Ensure that conversations about alcohol reflect the risk of experiencing harm (including recognition of the contribution of trauma and poor mental health, where relevant) and that modes of delivery prioritise the needs of communities experiencing the highest risks of harm.

Overarching recommendations

The consequences of harmful and hazardous alcohol use and opportunities to intervene exist across Scottish society. This review makes recommendations for national organisations, local government, NHS boards, third sector and other organisations as contributors to a whole-system approach to reducing alcohol harms.

Public Health Scotland proposes a series of recommendations based on programme board discussions and concludes that the strategic direction and mechanism of delivery of the alcohol brief intervention programme is reoriented to promote tailored

conversations about alcohol. The recommendations should be seen as interdependent and synergistic. The recommendations are divided into short-term actions (to be delivered within two years) and medium-term actions (delivered over a longer period as these require system change).

The emphasis of the programme should shift to developing and building capacity for evidence-informed practice. The programme should acknowledge and be flexibly informed by practitioners' expertise about their service and the people who use their services. Efforts should be made to move away from the use of the term Alcohol Brief Intervention due to its interpretation as being a fixed, inflexible intervention.

A dynamic system is envisioned where evidence and practice evolve in tandem to improve outcomes for the public and reduce alcohol-related harms. To achieve this, the Scottish Government should:

- reaffirm its commitment to the programme and its reorientation to flexible, evidence-informed conversations about alcohol
- set out the steps by which its vision of embedding conversations about alcohol can be achieved over 10 years
- seek leadership from the Chief Medical Officer, the Chief Nursing Officer, the Royal College of Midwives and other relevant professional organisations to normalise conversations about alcohol.

Action area 1: Making the conversation about alcohol a routine wellbeing conversation

Internationally and in practice, the term 'brief intervention' covers a family of conversations which vary in content, length, mode of delivery, the person delivering the intervention and the intended target group. It has historically involved identifying alcohol-related risks or harms and providing tailored support to reduce the risk of this harm.

The Scottish programme definition for Alcohol Brief Interventions is as follows:

> 'A short, evidence-based, structured conversation about alcohol consumption with a person who uses a service that seeks, in a non-confrontational way, to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm.'
>
> Fitzgerald N and Winterbottom J (2011). Alcohol Brief Interventions Training Manual. Edinburgh: NHS Health Scotland.

The programme board discussed the Scottish Government's stated long-term aim of the Alcohol Brief Intervention programme, which is to embed Alcohol Brief Intervention delivery. Programme board members agreed with this vision.

Participants would know that this had been achieved when a person-centred, evidence-informed conversation about alcohol is routine practice where indicated, across all relevant public and third sector services, and considered normal and acceptable by practitioners and the public. Surveys of the general population in Scotland show that providing information and routine inquiry about alcohol by health professionals are already among the most acceptable types of alcohol control measures.[20]

The programme board recognised that changing routine practice is an ambitious and challenging goal which would be expected to require multifaceted efforts over a long

period, similar to other efforts on handwashing and human immunodeficiency virus (HIV) testing.[12] The programme board also recognised the need for conversations to draw on the established evidence base, recognising the risk that, badly done, a conversation can further isolate and entrench drinking.

To what extent are Alcohol Brief Interventions embedded in routine practice?

Scotland has had a comprehensive alcohol prevention framework since 2009 and a programme to implement alcohol screening and brief interventions since 2008. The stated aim of the current Scottish policy on Alcohol Brief Interventions is to mainstream delivery.

The Alcohol Brief Intervention programme was originally delivered using performance targets for health improvement, now known as a Local Delivery Plan* standards, which set out a minimum number of Alcohol Brief Interventions to be delivered within each NHS board. This was calculated using estimates of adults drinking above guidance levels and data on healthcare use for conditions which may be associated with alcohol consumption. Later, delivery was divided by settings, with a target of 80% being delivered in three priority settings: primary care, accident and emergency departments and antenatal care. The choice of antenatal care and accident and emergency departments was made due to perceived clinical need in these settings.

The target required 61,000 Alcohol Brief Interventions to be delivered nationally. This target has been consistently achieved at a national level between 2011/12 and 2019/20. However, not all NHS boards achieved their allocated proportion of the target.

* Local Delivery Plan standards are priorities set and agreed between the Scottish Government and NHS boards to provide assurance on the performance of NHS Scotland.

The number of Alcohol Brief Interventions recorded in Scotland[21] peaked at over 100,000 in 2014/15 and since declined to 75,000 in 2019/20. During the COVID-19 pandemic, recording of Alcohol Brief Interventions was paused. In some cases, reporting stopped during the recovery phase of the pandemic, leading to a lack of data available at a national level.

The performance target required 80% of the interventions to be delivered in the three priority settings. Between 2015/16 and 2019/20, a declining trend in reported delivery numbers has been recorded in primary care, accident and emergency and antenatal care. This ranges from a 5% average annual reduction in primary care and accident and emergency to 10% in antenatal care. The programme board heard that reasons for this decline include competing priorities and increasing demands on health service professionals, workforce recruitment challenges, ending of focused investment and inadequate recording systems.

Since 2012, it has been possible for interventions delivered in 'wider' settings to count towards a proportion of the target. Wider settings can include NHS settings and staff outside of the three priority settings, as well as non-NHS services such as justice, social work, youth work, housing, job centres and specialist commissioned services. Since the introduction of wider settings, there has been year-on-year growth in the reported number of interventions delivered.

A widely held view by programme board members was that the priority given to the programme was generated by the existence of a national target and dedicated resourcing. At the same time, programme board members reflected that the existence of a target had created a large and cumbersome infrastructure for reporting and created some other negative consequences.

In particular, members felt that the focus of the current programme was on reporting numbers and meeting the target and that this sometimes compromised their ability to mainstream approaches. Examples were cited where interventions were not developed in wider settings, despite evidence of need, because it would not contribute to the 80% priority setting requirement and the wider setting target requirement had already been met. Other examples included not providing support to settings to implement Alcohol Brief Interventions because a robust reporting and

recording structure did not exist or was not easy to establish and without this, the area would not get credit of the work being undertaken.

Programme board members concluded that the current approach being taken to performance managing this issue was not conducive to an aim of widespread embedding of effective conversations into routine practice. Although there were numerous examples of local services delivering ABIs, these were limited in their scope and scale. For example, individual wards instead of an entire acute service. This suggests that the objective of embedding ABIs into routine practice has not been achieved.

Priority setting one: Alcohol conversations as a routine part of consultations in primary care

In general practice across Scotland, financial reimbursement, through the development of locally enhanced services which followed a national service specification, was used to incentivise opportunistic screening and brief interventions in primary care settings. Evidence has since emerged in primary care, from Scotland and elsewhere, presenting mixed findings and views on the value of financial incentives and provided other strategies for overcoming barriers to delivery.[32,22,23,24,25]

Programme board members reflected on findings from research on implementation challenges conducted by NHS Health Scotland in 2018–19 (available on request) where some areas reported that they had stopped or were looking to stop the enhanced service contract. Among the reasons for this were a re-prioritisation of needs and limited time available to deliver the enhanced service. Stopping enhanced services contracts for Alcohol Brief Interventions would be expected to lead to a reduction in the total number of Alcohol Brief Interventions recorded and reported as delivered, but it is unclear what effect it would have on actual delivery.

Delivery of Alcohol Brief Interventions in primary care in Scotland has largely focused on general practice. Locally, initiatives have also been developed with pharmacies[26] and dentistry.[27] The barriers to scaling up here were described by programme board

members as the lack of a coordinated national approach and limited availability to invest in developments at a local level.

Evidence also suggests that the delivery of a person-centred approach would require capacity-building and support to change current conversational approaches, which have been found to remain paternalistic, despite recognition of the importance of person-centred care.[28]

Opportunities include a clear recognition of the link between harmful and hazardous alcohol consumption and specific aspects of health and wellbeing relevant to the service.

To improve service delivery in primary care, greater awareness among professionals and the public of the relationship between alcohol and common chronic conditions is necessary. An important opportunity is the recognition of general contractual requirements for prevention and the potential contribution of the wider primary care workforce to deliver ABIs.

Priority setting two and three: Alcohol conversations in antenatal and urgent care

It was beyond the scope of this review to consider in detail the findings from published and unpublished work on antenatal and urgent care settings, or systematically consider evidence from outside Scotland. However, the former will be particularly important to inform the development of a strategy of normalising conversations in these settings.[12,13,14,15,16,28]

The programme board discussed antenatal settings. Programme board members felt that there was a clinical and ethical imperative to ensure everyone is clear on their role in supporting pregnant women to abstain from alcohol and to reduce prenatal exposure to alcohol in line with the recommendations of the UK Chief Medical Officer. Programme board members felt that the Chief Medical Officer message might not be widely understood:

> ‘If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum. Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.’

A person-centred conversation would need to start from a position of seeking to understand the person’s perspective, and not predetermining the outcome.

Some of the difficulties faced in antenatal settings were discussed, including competing priorities and the need to establish trust with a woman versus the risk of alienating her because of the stigma associated with alcohol use in pregnancy. Further, it was recognised that efforts to reduce alcohol consumption to zero in all pregnant women need to avoid alienating the most at-risk women who may be drinking at high levels while pregnant but feel unable to disclose this where there is a high emphasis on the risks of low-level consumption.

Members felt there was mixed messaging from the industry in marketing and on labels about the risks of alcohol consumption in pregnancy. In addition, members felt that more could be done to create a supportive environment for pregnant women and those trying to conceive who wish to avoid alcohol.

Alcohol conversations in wider settings

A further important contribution was the work done across Scotland to evaluate local initiatives in justice, homelessness and other settings that were, at that time, not directly supported by the national programme.[18,29] Programme board members reflected on how much of the growth and interest in wider setting delivery had come from settings such as criminal justice,[30] social work and housing support officers.

Opportunities in these settings arose from a greater recognition of promoting wellbeing as a key service objective. Feedback from programme board members highlighted the importance of being able to adapt the conversation to the core aims and objectives of the person and the service and raised the challenge of many of the

training materials being framed in the context of health conditions and disease prevention rather than wider social or other impacts of alcohol consumption.

Considerations for policy implementation

Successful implementation will require planning, piloting and adaptation of approaches bespoke to specific teams rather than a predefined inflexible model.[31]

It was noted that the use of a theoretical framework has been useful to understanding how to overcome some of the barriers to implementation faced in one study[42] focused on general practice. This study identified multiple barriers, many of which were linked to more than one domain (capability, motivation and opportunity). The study authors concluded that multicomponent strategies would be needed to address some barriers. Multicomponent ideas from the programme board members included involving the wider care team, raising awareness about how harmful and hazardous alcohol consumption were distributed in the local population, linking to the promotion of self-management or chronic conditions, and building the capacity and confidence of those involved.

Therefore, using an established framework for designing flexible interventions in different settings and using behaviour change techniques to narrow the implementation gap could be important tools in further developing a strategy of mainstreaming conversations.

To normalise conversations about alcohol, programme board members felt that it was important to know from record-keeping who had raised the issue of alcohol previously with a service user and how it had been addressed. This was felt to be particularly important in health and social care settings where continuity of care is important.

Members also described their attempts to include alcohol consumption on patient record management systems as frustrating and largely unsuccessful. It was notable that this was an experience that was replicated in different health board areas by many different individuals and identified in evidence.[11,12,13,14,15,16] One of the barriers

to achieving this was the low priority given to these types of developments among all of the other digital developments which have to be made.

Recommendations

Short-term recommendations

- The Scottish Government should as an immediate measure consider removing the requirement for 80% of interventions to be delivered in priority settings**.**
- Public Health Scotland should strengthen available quantitative indicators on population alcohol consumption to describe high-risk patterns of consumption (including binge drinking)**,** and patterns of consumption among women, older adults and people with co-existing chronic health conditions.

Medium-term recommendations

- The Scottish Government should work with primary care leads to make conversations about alcohol a requirement for preventative health elements of national contract frameworks (e.g. dentistry, primary care and pharmacy).
- Public Health Scotland, in partnership with other stakeholders, should work with behaviour change experts to develop multicomponent strategies to support the normalisation of opportunistic conversations about alcohol in health and social care settings. Implications for delivery, such as the inclusion of other health-harming behaviours, should be considered.

Action area 2: Describing what conversations should look like in practice

The existing model of delivery was based on evidence available in the mid-2000s at the time of design. The programme used definitions of an Alcohol Brief Intervention and associated training and resources based on a relatively fixed approach. Abbreviations like 'ABI' can be interpreted to mean a fixed form of intervention that is unhelpfully inflexible from the point of view of the individual and the practitioner.[32] Programme board members reported that this inflexibility was experienced as pushback against an intervention that was not person centred, and an add on to an already busy schedule. This was particularly the case when trying to scale up or expand in existing settings identified by policy as priority settings. Members acknowledged that brief interventions may be delivered but not recorded, and that all recorded brief interventions are not the same.

The absence of the recognition for flexibility in policy and guidance was felt to present a barrier to achieving the ambition of mainstreaming and normalising conversations about alcohol, in line with available research.[33]

To move to an approach which is reflective of wider values of person-centredness, several of the key features of the approach require updating. These are discussed in the following sections.

1. Reorientate the Alcohol Brief Interventions concept towards conversations about alcohol

Multiple systematic reviews.[34] have highlighted evidence of the efficacy and effectiveness of alcohol screening and brief interventions in reducing self-reported alcohol consumption. However, an important limitation of research to date is that the only robust evidence is of impact on self-reported alcohol consumption[35] and there is good reason to doubt the validity of self-report in this case.[17]

Reviews do not cite any evidence that demonstrates the validity of self-report for hazardous or harmful drinkers in Alcohol Brief Intervention trials.[17,21] Where

examined, most studies find no impact on biomarkers of alcohol consumption, alcohol-related harms, or quality of life.[21] There are clear psychological processes (e.g. social desirability and reciprocity) that encourage conscious or unconscious false self-reporting of reduced consumption. [22]

Primary care settings have been the most comprehensively studied. A large UK-based randomised control trial in primary care trial reported no difference in self-reported hazardous and harmful drinking in the control group for the trial (who were provided with feedback) compared to those in the intervention groups who were provided with a 5-minute or 20-minute structured intervention. All three groups reported reduced consumption at follow-up.[36]

The null finding of this trial should not be interpreted as evidence of ineffectiveness, but rather as lack of evidence of effectiveness of the 5-to 20-minute interventions compared to the control condition of screening and feedback. There are a number of possible explanations for this null finding. First, it is possible that the detailed screening and feedback process in place for the control condition[37] may have worked in a similar way to the two interventions in leading to changes in self-reported alcohol consumption. Second, it may also be that actual alcohol consumption did not change at all and was falsely reported as reduced by members, or that alcohol consumption did reduce, but for reasons that were nothing to do with the intervention or control conditions, for example, wider economic conditions or a general effect of participating in the trial.

None of these evidence gaps change the ethical argument for ensuring that people are adequately informed about alcohol as a factor that may be impacting on the problem or issue that they are discussing with a service and providing support to reduce consumption. Rather, the weaknesses in the overall evidence base reinforce the idea that there is no one fixed way to have this conversation that has been proven over other ways to be effective.

2. Ensure clarity on the key features of conversations about alcohol

A mainstreamed approach should take account of the international evidence, which does not point to any one fixed set of content as effective, while broadly supporting a person-centred motivational approach.[22,26,34] This uncertainty increases the importance of learning from all the efforts in the Scottish Alcohol Brief Intervention programme to date. The programme was subject to several studies commissioned by NHS Health Scotland, some of which were published[9,10,11] and some of which were internal management documents. [13,14,15,16] Multiple studies were also independently funded.[12,32,46,38,39] Key points from these evaluations also point to valuable learning to inform the next phase of moving towards routine conversations about alcohol. These findings are summarised below.

Flexibility and pragmatism in adapting the model of Alcohol Brief Intervention is essential. Defining what is core and what is adaptable has been an important factor across a range of diverse settings.[9,10,11] Through discussion of various healthcare scenarios, programme board members concluded that it was appropriate and acceptable for a diverse range of people to start conversations about alcohol and that there was no 'one size fits all'.

Those who regularly delivered Alcohol Brief Interventions reported that it was important to consider the type of relationship and level of trust with the person in addition to the impact that alcohol was having on the person at that time. Programme board members felt that it was important those raising the issue had flexibility in terms of their approach. For example, in some settings raising the issue and personalised feedback are useful whilst in others more structured conversations with components of motivational interviewing are appropriate.

At the time of the previous programme, it was thought that there was no good evidence to support the delivery of follow-up sessions with an individual after the initial Alcohol Brief Intervention.[40] However, subsequent reviews have found that interventions delivered over multiple sessions are likely to be effective.[41] Going forward, in line with the desire to trust practitioner judgement and be person-centred,

the programme should avoid being prescriptive about the number of sessions over which conversations about alcohol might take place. This is in line with the views of the programme board.

3. Develop guidance on the use of screening tools

The purpose of screening is to explore with people patterns of alcohol consumption accurately, objectively and in a non-judgemental way. This is particularly important given the stigma associated with alcohol harm and, in particular, alcohol dependence. Programme board members described using a number of screening tools and some valued their use as conversation openers which allow people to recognise that they have a problem, the initial stage required before a brief intervention can be delivered.

Other programme board members described picking up on cues in the conversation to raise the issue of alcohol. In these types of situations, it was felt that a formal screening tool would jeopardise the conversation flow and the trust between the professional and the individual.

Studies from England among people who drink hazardously and harmfully found that they are less likely to assess their use of alcohol as problematic compared to someone with probable dependence.[42] A person-centred approach would focus on enabling the individual to understand how alcohol might be affecting their life (including health) and whether that matters to them or not. Person-centred means individuals have autonomy to decide to prioritise drinking over whatever benefits they might accrue from drinking less.

Furthermore, existing guidance needs to be reviewed and streamlined in light of emerging evidence suggesting that there may be some situations where formal screening may not be needed and may be at odds with a person-centred approach.[22,43] This is also true in antenatal settings, where the currently recommended screening tools are based on 1980s thinking about ‘denial’ which would now be considered stigmatising.[44,45]

4. Ensure clarity on what aspects of ABI can be applied to people with possible alcohol dependence

At the time of designing the original Scottish Alcohol Brief Intervention programme, Alcohol Brief Interventions were not considered appropriate for someone with alcohol dependence. While it remains true that a brief intervention may be inadequate as stand-alone support for many people with alcohol dependence, it is now thought that frontline staff can use the communication skills central to brief interventions to support individuals to recognise and seek help for their alcohol problem.[22,46,47]

Also, current thinking is that alcohol problems exist on a continuum and that drawing a line between those who are dependent and those who are not, is likely to be counterproductive.[48] Early identification of people with probable alcohol dependence and the use of skills such as active listening and motivational interviewing to support engagement with treatment or other support should be considered strategically as central to the next phase of delivery.

5. Develop a systematic approach to identifying and implementing effective digital interventions

Alcohol Brief Interventions also include interventions delivered electronically, such as through mobile applications or on websites. Digital interventions may be used independently or as a tool following a conversation about alcohol. Digitally delivered screening and brief interventions may be more economical to set up and have the potential to reach a large number of people, although their reach and effectiveness needs careful consideration.

Programme board members pointed to the impacts of the pandemic, the rapid shift to digital approaches across the public sector and the resulting lack of clarity about whether a conversation about alcohol in this new care context could be called an Alcohol Brief Intervention.

Programme board members identified that there were now a number of different applications available, although it was not clear which could or should be used and whether there was a need for applications to be developed locally.

The role and contribution of digital interventions to the delivery of Alcohol Brief Interventions in Scotland should be clearly set out and, where appropriate, economies of scale in developing digital interventions considered, taking digital exclusion and the potential for inequalities of access into account.

6. Ensure approaches are in place to adapt practice and research as the evidence base becomes more developed

Individuals have a right to be informed about how their alcohol consumption may be an underlying causal factor impacting the issue the issue they are presenting with.

Lack of evidence or conflicting evidence is different from suggesting that the intervention is ineffective. Given people's right to be informed and the responsibility of duty bearers to support people to achieve positive health and wellbeing and there is a need to continue to provide interventions.

However, this must be done in a way that enables practice to adapt to new and emerging evidence.

There is available evidence on what is likely to work best,[28,49] although the Gaume review needs to be updated. In addition, at least one feature of the current national approach (‘pros and cons’) has been found to be potentially counterproductive in motivating people to reduce their alcohol consumption[34,50] and should be removed from guidance materials.

Practice also needs to adapt to the changing needs and ways of structuring and providing services. The programme board members concluded that services that people access need to be able to evolve and change rapidly.

Efforts to implement person-centred conversations about alcohol in specific service settings can then start from a point of seeking to understand what current conversations look like, rather than coming with a pre-determined solution.[51]

Future practice can be informed by and through linking practice and research, contribute to the evidence base about the elements of effective conversations and, importantly, what does not work or is counterproductive. This should inform the systems of data collection which should be developed.

Recommendations

Short-term recommendations

- The Scottish Government should establish an expert advisory group to produce evidence-based policy briefings and provide ongoing strategic oversight to the revised policy approach.
- Public Health Scotland should undertake a revised review on elements of effective conversations including the role of any screening tools and support the translation of research into practice.
- The Scottish Government should ensure a pathway is in place to assess effectiveness of digital innovations in this space and enable roll out of impactful applications. It may want to consider the role of the existing Accelerated National Innovation Adoption (ANIA) pathway in this.

Medium-term recommendations

- Local areas should use techniques of continuous improvement to achieve the revised policy aims and objectives. The revised policy should recognise the importance of local innovation in achieving ambitions of integrating alcohol into wider wellbeing conversations and remaining fit for purpose into the future.

Action area 3: Reducing inequalities in alcohol-related harms

Alcohol harms are a complex public health problem, linked to the wider social, economic and political context and are unequally distributed across Scottish society.

The need for universal and targeted approaches

The programme board members looked at the opportunities and challenges of reducing inequalities in alcohol-related harm via conversations about alcohol in public-facing services. The board considered the results of the Triple I tool, a mathematical model developed by NHS Health Scotland which modelled the impact of health improvement interventions on population health and inequalities.[52] The model demonstrated that targeting of Alcohol Brief Interventions in our more deprived communities was necessary to contribute to any reduction in the inequality associated with alcohol-related harms.

Evidence from studies conducted in England contrasts with this conclusion on targeting. It found that people living in socioeconomically disadvantaged areas tend to access public services substantially more often than those living in more advantaged areas. As a result, they are more likely to have the opportunity to have a conversation about alcohol with a professional, where such conversations are embedded in routine practice. Even taking into consideration the difficulties faced by people living in areas of disadvantage in accessing services and in implementing strategies to reduce hazardous and harmful consumption, the studies in England concluded that inequalities are more likely than not to be reduced by widespread delivery of Alcohol Brief Interventions.[53,54]

Members reflected on the reasons for the growth in recorded Alcohol Brief Intervention delivery observed in the ‘wider’ settings and highlighted the breadth and diversity of settings contributing to this growth. These include several settings in which delivery is likely to result in reductions in inequalities if conversations about alcohol are effective in reducing consumption. These include commissioned specialist agencies who provide outreach, screening, brief intervention and support to

people who might benefit from additional help with alcohol problems, prison and community justice settings,[47] housing providers, youth homeless services,[18] and agencies of Department of Work and Pensions. It is worth reiterating, however, that mainstreaming conversations about alcohol also has the potential to reduce inequalities through broader system-wide effects that contribute to changing public perceptions about alcohol and alcohol policies.[17]

Place-based approaches will have an important role to play. The programme board members considered place-based approaches in a broad sense, ranging from geographical areas of socioeconomic deprivation to settings such as housing support, welfare rights and financial inclusion as well as health services such as primary or urgent care which may be more commonly accessed and trusted by people living in areas of socioeconomic disadvantage. Members reflected that the current policy guidance on Alcohol Brief Interventions encouraged the conduct of needs assessments and evaluations of impact.

A consultation of stakeholders conducted by NHS Health Scotland in 2018–19 found there was substantial variation in the extent to which local areas were able to deliver ABIs, with resourcing identified as a limiting factor (available on request). Delivery of ABIs may be better addressed as part of wider strategic planning cycles for health and social care, alcohol and drug partnerships and community planning. Doing so could bring opportunities to integrate evidence-informed conversations about alcohol into third sector and locally commissioned services as standard and benefit from statutory requirements to respond proportionately to inequalities in outcomes.

Members shared their experiences of developing targeted inequalities-sensitive approaches. Common themes were:

- Building on local connections and local knowledge.
- Working with people who were trusted by the population being targeted.
- Using the expertise generated in one setting to inform work in another in a form of continuous learning or improvement.
- Confidence to tailor the approach and conversation to the local context.

It is likely that even in a context where conversations are a routine expectation of public service provision, support will be needed to ensure implementation.

Features of conversations about alcohol that promote equity of outcome

The alcohol-harm paradox describes the situation where people in more disadvantaged communities experience greater levels of alcohol related harm at a population level compared to those in more advantaged communities even when rates of consumption are similar or lower.[55] Within the literature, there has been a dominance of research on individual-level risk behaviours to understand and explain the alcohol harm paradox, partly because of the dominance of behaviour change models in health improvement.[56] To better understand the context of trauma, stress, multiple complexities, and multiple health conditions which disproportionately affect people from deprived communities, programme board members felt that the current emphasis of the programme on a high volume of short conversations was insufficient to fully address inequalities in alcohol-related harms.

Members discussed the experience of 'deep end' practices, where longer, trauma-informed conversations were a critical means of addressing some of the inequalities in alcohol-related harms, however, these conversations needed to embody principles of trauma-informed approaches, creating safety, trust and empowerment. Such conversations tended to be longer and were reliant on trusted relationships between professionals and patients.

Programme board members thought that place-based factors, the lived experience of disadvantage, stigma, and wider economic and social factors were also important considerations when trying to address reducing inequalities associated with alcohol harms.

Developing Alcohol Brief Interventions to address underlying reasons behind alcohol consumption

The programme board discussed how higher levels of alcohol consumption may not occur in isolation, reporting it was commonly accepted good practice to tailor the conversation to the personal circumstances of the individual. This was particularly common among more experienced members and those working in wider settings who described that recognising and responding to the stigma of harmful alcohol use and some of the underlying drivers were central to raising the issue of alcohol in an appropriate and sensitive manner.

Emerging thinking suggests that discussions with the public about alcohol in services should be considered in the context of wider influences on alcohol consumption – as current norms and policy contexts impact the implementation and outcome of such conversations.[17,57,58]

The person-centred nature of the intervention was a valued dimension that could be strengthened in the next phase of the programme and related guidance, and training materials. This finding has implications for Scotland in terms of broadening the range of individuals who could have conversations about alcohol, broadening the types of settings in which these conversations can occur. It would also have implications on the types of material required to support training and the ongoing practice of speaking about how alcohol affects someone's life.

Considerations for implementation

One of the barriers to delivery has been the lack of evidence for different approaches and settings. This has been found to be a barrier to gaining the support of senior and strategic staff[12] and highlights the need for better evidence and better conversations about evidence in the future, including recognising potential systemic effects on population-level consumption of a large-scale programme.[17,33]

Successful implementation is likely to require planning, piloting and adaptation of models of delivery and intervention bespoke to specific teams and practice settings

rather than a predefined model.[10,11,49,52] This requires resourcing for scoping capacity building and evaluation at a local level.

Despite the extensive examples of innovation described by members of the board, evaluation of such innovation and the sharing of findings across practice and research communities interested in Alcohol Brief Interventions has been limited to date. This has likely held back practice development, implementation and the development of the evidence base in this field.

Recommendations

Short-term recommendations

- The Scottish Government should reflect the need for universal and targeted approaches in its revised policy approach.
- The Scottish Government should update policy guidance to move away from specific needs assessment for Alcohol Brief Interventions and towards an integrated approach with strategic commissioning plans of statutory agencies and partnerships.
- The Scottish Government should explore options for developing a specification template that can be made available to local partners. This would ensure that appropriately tailored conversations about alcohol are included in service specifications for locally commissioned support services (e.g. mental health support, welfare rights and housing support) in line with the outlined above and available evidence.

Medium-term recommendations

- Public Health Scotland should develop a plan to improve the quality and use of data relevant to reducing alcohol harm and inequalities in alcohol harm in Scotland.

Action area 4: Workforce development, training and health information resource requirements

Low levels of awareness and understanding about alcohol units and hazardous or harmful consumption

The programme board members described low levels of awareness about harms associated with alcohol and limited confidence in calculating units among the public. They highlighted that this situation was also mirrored in the workforce they were trying to train to provide interventions.

The provision of training for frontline staff was described as a constant challenge and one that members felt was under-resourced. The current approach did not consider workforce turnover. More sustainable approaches such as including training as part of workforce induction should be considered.

Updating the competency framework

To respond to the vision of person-centred, stigma-informed and trauma-aware conversations about alcohol, and current evidence, the existing competency framework needs to be reviewed and updated. The competency framework needs to be developed to support the learning needs of those working in wider settings.

Sustainable models of training delivery

As a consequence of not having a sustainable approach to training and workforce turnover, those involved in Alcohol Brief Intervention delivery experience considerable and ongoing demand for providing training and training materials. Support previously provided by NHS Health Scotland to manage training materials and ensure a supply of trainers has not been in place since 2015. Although the core training resource is available online, the choice of learning platform makes access challenging for those from non-NHS settings. There is a risk that the knowledge and

skills to have good conversations about alcohol will be lost and cannot be quickly recovered if the gap in training and coordination support continues. However, it is also important to learn from this finding and rapidly develop a longer-term, more efficient and sustainable approach to training provision.

In the medium to longer term, the most sustainable approach to embedding these conversations as part of routine delivery will be for them to be embedded in higher and postgraduate education and workplace training programmes for the relevant practitioner groups. This would allow ad-hoc bespoke training to be scaled down in settings where it would be expected that conversations should be routinely occurring.

This has happened to some degree in the past but has often been as an add-on to existing teaching and training, rather than as part of the core curriculum. Changing this in future will require securing buy-in from the accreditation bodies for professional education and integration alongside other relevant content like communication and consultation skills.

Health information material produced or sponsored by the alcohol industry

Some members raised concerns about the role of alcohol industry-sponsored agencies in the provision of information and resources. At a practitioner level, people reported using these resources because they felt there was no alternative available. All members were clear that this was not an acceptable position and that public services and third-sector agencies should not be promoting or using health information material developed by the industry or by organisations funded by the industry.

Members noted that materials from some of the same organisations had been found by researchers to be misleading about the common risks associated with alcohol. These included the association with cardiovascular disease,[59] underplaying the risks of cancer[60] and providing alternative explanations to introduce doubt about the links between alcohol consumption in pregnancy and fetal alcohol spectrum disorder.

Recommendations

Short-term recommendations

- The Scottish Government should explore options to ensure that learning resources developed by different areas are pooled and shared. This should be seen as an opportunity to create a dynamic toolkit or platform that includes notes on appropriate use and considers currency of included resources.

- The Scottish Government should explore options to provide direct support to local areas that have skilled trainers in place who are able to share learning and expertise with other areas. This would reduce the risk of losing knowledge and skills while working towards the creation of a sustainable learning system.

- The Scottish Government should explore options to support a managed network that functions as a community of practice. Additionally, this could provide a forum for local leadership to exchange learning and management of training resources.

Medium-term recommendations

- The Scottish Government should work with higher education policy leads, education providers and organisations leading on education standards and curricula to include core communication skills and alcohol and stigma awareness in their training programmes. These would include higher education institutions providing undergraduate and postgraduate education for health and social care professionals and practitioners, and equivalent bodies for workplace-based training.

- The Scottish Government should identify options for sustainable procurement of health information materials. Any procured materials should not be affiliated with the alcohol industry.

- Public Health Scotland should offer stakeholder support and guidance to support good practice in relation to identifying and managing conflicts of

interest. This includes interaction with the alcohol industry to protect independence of public health policies and health information materials from commercial and other vested interest and influence.

Action area 5: Reduce stigma by having conversations about alcohol

Stigma is a well-documented barrier to seeking help and engagement in care across a range of health conditions. The evidence base on stigma describes it operating on multiple levels: intrapersonal, interpersonal, organisational and structural.[61]

Programme board members reflected that within the brief intervention training materials, intrapersonal stigma and its effects were well described through the training and resources. Also reflected in the training materials, but more challenging to address in practice, were dimensions of interpersonal stigma. Examples of this in practice included trained individuals not raising the issue of alcohol because of not wanting to label someone as having a problem with alcohol and not wanting to cause offence.

The stigma related to the labels of problem alcohol use and alcohol dependence was well recognised and felt to be well reflected in current materials that support conversations. Programme board members pointed out that stigma can be cross-cutting, linked to more than just alcohol use. Examples were given about the stigma associated with financial hardship, poor mental health and gender. Addressing this requires a flexible, person-centred conversation. There is a growing body of evidence that describes how the stigma associated with multiple circumstances perpetuates socioeconomic disadvantage and individual stress.[62] Addressing stigma and its manifold effects is therefore a key dimension of reducing inequalities in health outcomes.

Programme board members were clear that any approach to reducing inequalities needs to address the experiences of, and practices that create, stigma. A multilevel approach to addressing stigma is recommended, including actions to shift the narrative and values at the intrapersonal, interpersonal, organisational and structural levels.[63]

Alcohol is part of the economy, society and culture in Scotland. Programme board members discussed their experiences of raising the issue of alcohol throughout their

careers. They felt that the links between alcohol consumption and common conditions – for example, cardiovascular health or diabetes – and the opportunities to improve health through reducing consumption were poorly understood. Members felt that part of the reason for this was that the public obtained most of their beliefs, perceptions and information about alcohol from the publicity and marketing activities that accompany alcohol.

Evidence from comparing industry and public health material confirms that the common negative consequences of alcohol consumption are not described in industry messages of 'responsible drinking'.[64] These framings further reinforce the false sense that individuals are wholly culpable for any alcohol problems they develop. Structural interventions that address the underlying reasons for alcohol consumption such as affordability, acceptability and availability may therefore have an opportunity to contribute to a shift in narrative and stigma at a population level. Recognition of the contribution of upstream interventions that challenge the pervasive normalisation of alcohol consumption could be a valuable element of future conversations about alcohol[17] supported by the programme board.

Recommendations

- The Scottish Government should ensure that the reviewed policy and associated materials to support implementation and delivery include components related to stigma and consider the consequences of stigma associated with multiple circumstances.

- The Scottish Government should consider how the framing and implementation of structural interventions to reduce alcohol harm (e.g. the price, availability, marketing and labelling) can also contribute to reducing the stigma associated with problem alcohol use.

Action area 6: Ensure conversations about alcohol are embedded as part of a wider comprehensive population-wide prevention strategy to promote health and reduce inequalities

Programme board members identified the normalisation of alcohol consumption in everyday life and a widespread lack of awareness of risks associated with alcohol as ongoing challenges to delivery. Programme board members were clear that a comprehensive strategy for reducing consumption could help mitigate the projected increase in the non-communicable disease burden in Scotland.

Programme board members emphasised the importance of addressing upstream economic factors such as pricing, availability and marketing (including labelling) in addition to the wider work that was happening around reducing poverty as key contributory factors and which they expected to work together synergistically to reduce inequalities.

Minimum Unit Pricing legislation was associated with an estimated reduction in deaths and hospitalisations wholly attributable to alcohol consumption in the four most socioeconomically deprived deciles in Scotland.[65]

Members reflected that among professionals and the public alike, the level of awareness of the links between alcohol and common health conditions or harms was generally low. Member participants who trained frontline staff to deliver Alcohol Brief Interventions reported that understanding the links between alcohol and particular conditions or situations was a critical component of raising the issue with people who might benefit from cutting down on alcohol consumption. This reflection aligns with evidence that a theory-informed training programme was able to overcome concerns about discussing alcohol with patients in primary care.[27]

Members who deliver interventions daily described how very few people are knowledgeable about alcohol units or able to accurately estimate the unit content of different drinks. Professionals who delivered interventions infrequently reported that

calculating total consumption in units could be difficult and time consuming. Time was spent asking the person to list their recent alcohol consumption and then approximate units were calculated. Some found it useful to have a drinks calculator or similar tool, but these were not always to hand. Our recommendations to explore digital options and provide clarity on when or at what point screening is or is not advisable could alleviate this challenge in practice.

As above, it may not always be necessary, especially at the start of a conversation about alcohol, to seek detailed information to enable calculation of total units being consumed. Nevertheless, people may find it easier to cut down on their alcohol consumption if they have a better understanding of the alcohol content of different products. Although information is on some labels, its size and location mean that people often are not aware of the unit contents of their drinks when asked by programme board members who deliver interventions.

Programme board members considered that population-focused and individually focused interventions should not be considered in isolation but as interdependent and part of a continuum. The World Health Organization European Region alcohol framework recommends a comprehensive policy approach, recognising that the success of a programme of brief interventions is dependent on creating a supportive environment for those wishing to cut down their consumption. This includes providing appropriate health information through labelling, as well as restricting marketing, implementing price controls and restricting availability.[7]

Recommendations

- The Scottish Government should maximise all available evidence-based approaches to reduce hazardous and harmful alcohol consumption including:
    - maintaining Minimum Unit Pricing of alcohol
    - enacting and enforcing comprehensive restrictions on exposure to alcohol advertising

    - enacting and enforcing restrictions on the physical availability of retailed alcohol.

- The Scottish Government should work across policy directorates to reflect the contribution that reducing hazardous and harmful alcohol consumption would have on wider population health outcomes.

Action area 7: Embedding learning at the heart of governance and accountability mechanisms

This is a complex area with emergent evidence. Learning must be at the heart of governance and accountability processes with a focus on adapting what we do in response.

Role of the performance target

Evaluations of the Alcohol Brief Intervention programme found that the priority given to the programme was generated by the existence of a national target. In line with this evidence, programme board members felt that target had been instrumental in getting Alcohol Brief Interventions on to the agenda of chief executives of NHS boards and making it a priority among the numerous priorities that arise. They were concerned that if the target was withdrawn, funding would be withdrawn and partners who had previously contributed to the programme would withdraw due to its perceived lack of importance.

However, feedback from programme board members reflected uncertainty about why the delivery framework for the programme had remained unchanged since its inception in 2008 where the need was to scale up delivery from a baseline of zero.

The current performance target, a Local Delivery Plan standard, requires that over 61,000 Alcohol Brief Interventions are recorded each year. That target is divided by NHS board based on adult population and further subdivided into priority and wider settings. Members were not clear on the rationale for the split between priority and wider settings, and this led to differences in how the programme was delivered and strategic priorities identified. There were differences in what was considered a priority setting. For example, some areas included sexual health but others did not. Some areas included interventions delivered by primary care link workers reporting but others counted these within wider settings reporting.

Programme board members described how the target had, in some settings, created an environment and culture where the focus is on recording numbers and reporting.

Many reported situations of conversations happening but not recorded because of the additional effort involved to report and the sense of burden placed on many to collect numbers that did not serve much use either to the consultation or to learning in the service.

Those involved in collating the numbers of Alcohol Brief Interventions described a situation where there were multiple different counting systems of varying quality. Some areas described using paper-based systems which were then sent to the coordinator at the end of each month. Reporting was easier where the screening tool and intervention could be recorded and extracted from an electronic patient management system. However, getting priority to include this development at a local level was challenging. A new challenge that some areas faced was getting access to these data for the purpose of reporting, which was not seen as a priority by the clinical teams who had to extract the data.

Public Health Scotland assessed the overall quality of data received as poor and difficult to quality assure.

Members were most concerned by the amount of time and effort that was invested in the collection of this information and the opportunity cost for those with the expertise who could instead be focused on scaling up the programme. This was of particular concern given that the data collected were, in most cases, incompatible with quality improvement or answering questions about what worked where or what should be different.

A further reflection from members of the programme board was that counting the number of interventions told us nothing about the experience of the person receiving one. For example, what did the person take from the conversation? Answering these types of questions was felt to be a more important indicator of success, particularly for an initiative that is mainstreamed. Understanding the proportion of people who recalled discussing alcohol with a practitioner, and in what settings that conversation had taken place, could provide useful information for improving reach, acceptability and communication and could be considerably less onerous than routine reporting by services.

If the objective was to mainstream and have conversations as normal, members reflected that working towards a set target number of interventions did not give a sense of how complete or incomplete coverage was.

Programme board members discussed the value of an outcome indicator. There was interest among members to explore approaches used in other parts of the UK where nationally run surveys include a question on whether a person was asked about alcohol and whether advice was received when they attended specific health or care settings. Programme board members felt that it was encouraging that a validated question already existed[66] and would be keen to use it as a good indicator of progress in mainstreaming conversations about alcohol into routine practice in ways that would be recalled by the public.

Programme board members thought the target would have been even more effective if there was greater clarity on whose responsibility it was to deliver on the target within local areas.[12] At an NHS board level, members reported that there is occasionally a lack of clarity about who is accountable for the delivery of the programme, although in most cases it sits with the Director of Public Health. There are complex relationships between NHS boards, Integration Joint Boards and Alcohol and Drug Partnerships, all of whom may also have responsibilities for the programme and have governance structures in place.

However, recognising that the target had delivered some benefits in terms of focusing attention and resources, members were cautious about the approach to change and the risks to changing targets in a complex landscape.

Evaluation considerations

The programme board spent time discussing what the purpose of evaluation would be in the context of a future mainstreamed programme. Main considerations include proportionality and the resource requirements to conduct an evaluation.

It will be important to try to understand the impact of future initiatives to embed conversations about alcohol as outlined in this report, that follow this new conceptual model and include novel stigma-informed approaches. Efficacy studies (in research

settings) are unlikely to be feasible, and effectiveness studies (in routine practice) are onerous to set up and would require independent research funding.

Consideration should be given to how implementation could be done in a way that enables robust study, for example, stepped implementation, pilots and involving researchers well prior to implementation. Further researchers should be supported to secure independent research funding to ensure that evidence from Scotland can contribute to knowledge at an international level.

Within the future programme, the board discussed that a key contribution of evaluation would be to help explain how a programme works. The members also discussed the RE-AIM (Reach, Effectiveness, Adoption, Implementation and Maintenance) framework[67] as a practical way to structure future evaluations. This framework could answer questions about the reach of innovative initiatives to mainstream conversations about alcohol, the level of adoption, maintenance over time, opportunity costs and likely value in a particular setting.

Other questions of public health importance include describing the system-level impacts on population understanding and attitudes to alcohol. These are not explicitly included in the RE-AIM framework but could be easily considered alongside it.

Longitudinal studies using linked health datasets may also offer the opportunity to examine whether patients who have had the opportunity to participate in conversations about alcohol suffer lower rates of alcohol harms than matched patients who do not. While Public Health Scotland has access to such datasets, such studies are time-consuming to design and conduct and would require significant staff resource.

Furthermore, issues with the accuracy of recording the delivery of such conversations in electronic patient records, the variability in practice, and limitations in recording of protected characteristics would considerably reduce the value of studies in some settings. However, if these issues could be improved, longitudinal studies using routine data could prove highly valuable and cost-effective.

Recommendations

Short-term recommendations

- The Scottish Government should clarify implementation and strategic roles, responsibilities and accountability.
- The Scottish Government should support local areas to reorientate information collection systems to focus on data which enables improvement in the effectiveness of interventions.
- The Scottish Government should reduce the burden of reporting and recording placed on local areas with a view to eventually replacing national reporting of the number of interventions with a validated outcome indicator.
- The Scottish Government should identify and assess options for an outcome indicator that can be reported at a national level and set out feasible options and requirements for local-level outcome reporting.
- The Scottish Government should encourage collaborative links between research and practice by setting clear priorities for research and supporting the provision of mutually beneficial ways of working, including research networks and learning events.

Medium-term recommendations

- The Scottish Government should explore options to develop an effective national learning platform that collates evidence-based practice and emergent learning to ensure effective collaborations between researchers and local areas.

References

[1] Office for National Statistics. Alcohol specific deaths in the UK registered in 2021; 2022. **www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/alcoholspecificdeathsintheuk/2021registrations** (accessed 23 May 2024).

[2] Public Health Scotland. Evaluating the impact of Minimum Unit Pricing in Scotland. Edinburgh: Public Health Scotland; 2023. **www.publichealthscotland.scot/media/20366/evaluating-the-impact-of-minimum-unit-pricing-for-alcohol-in-scotland-final-report.pdf** (accessed 23 May 2024)

[3] Scottish Government. The Scottish Health Survey – volume 1 main report. Edinburgh: Scottish Government; 2022.

[4] The Organisation for Economic Cooperation and Development. Preventing harmful alcohol use. **www.oecd.org/health/preventing-harmful-alcohol-use-6e4b4ffb-en.htm** (accessed 23 May 2024).

[5] Public Health Scotland. Scottish Burden of Disease study. Forecasting the future burden of disease: Incorporating the impact of demographic transition over the next 20 years. Edinburgh: Public Health Scotland; 2022. **https://publichealthscotland.scot/publications/scottish-burden-of-disease-study/scottish-burden-of-disease-study-21-september-2021/** (accessed 23 May 2024).

[6] Public Health Scotland. Alcohol consumption and harms dashboard. **https://scotland.shinyapps.io/phs-health-achd/** (accessed 24 May 2024).

[7] World Health Organization. Global alcohol action plan 2022–2030. Geneva: World Health Organization; 2024.

[8] World Health Organization. European framework for action on alcohol 2022–2025. Tel Aviv: World Health Organization; 2022.

[9] Scottish Government. Alcohol framework 2018: preventing harm. **www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/** (accessed 28 May 2024).

[10] Parkes T, Atherton I, Evans J et al. An evaluation to assess the implementation of NHS delivered Alcohol Brief Interventions: Final Report. NHS Health Scotland; 2011. **www.healthscotland.com/documents/5438.aspx** (accessed 24 May 2024).

[11] Stead M, Parkes T, Nicoll A et al. Delivery of alcohol brief interventions in community-based youth work settings: Exploring feasibility and acceptability in a qualitative study. BMC Public Health; 2017;17(1).

[12] Stead M, Eadie D, Mckell J et al. Process evaluation of alcohol brief interventions in wider settings (Young People and Social Work). Edinburgh: NHS Health Scotland; 2014. **www.healthscotland.com/documents/23021.aspx** (accessed 24 May 2024).

[13] Fitzgerald N, Platt L, Heywood S et al. Large-scale implementation of alcohol brief interventions in new settings in Scotland: a qualitative interview study of a national programme. BMC Public Health;2015;15(1):289. **https://pubmed.ncbi.nlm.nih.gov/25886312/** (accessed 28 May 2024).

[14] Fitzgerald N. Antenatal alcohol brief interventions: Current practice in rolling out ABIs in Scottish antenatal settings. Glasgow; 2009.

[15] McCluskey S. A&E alcohol brief interventions: current practice in rolling out ABIs in Scottish A&E Settings. Glasgow; 2009.

[16] McCluskey S, Fitzgerald N. Alcohol brief interventions in the accident and emergency department: key questions, relevant literature and current practice in Scottish A&E departments. Glasgow; 2009.

[17] Dowds J, Fitzgerald N. Antenatal alcohol brief interventions: key questions, relevant literature and current practice in Scotland. Glasgow; 2009.

[18] Fitzgerald N. Patients & Populations: a whole system perspective on optimising the value of brief interventions: INEBRIA Nick Heather Lecture. Edinburgh; 2022.

[19] Dowds J, McCluskey S. Getting the Measure: An evaluation of alcohol intervention (AI) training and resources for frontline staff working in the homelessness sector. Glasgow; 2011.

[20] Li J, Lovatt M, Eadie D et al. Public attitudes towards alcohol control policies in Scotland and England: Results from a mixed-methods study. Social Science & Medicine 2017;177:177–189. **https://pubmed.ncbi.nlm.nih.gov/28171817/** (accessed 28 May 2024).

[21] Public Health Scotland. Alcohol Brief Interventions 2019/20. Edinburgh: Public Health Scotland; 2020. **https://publichealthscotland.scot/publications/alcohol-brief-interventions/alcohol-brief-interventions-201920/** (accessed 28 May 2024).

[22] Scholin L, O'Donnell A, Fitzgerald NM. Financial incentives for alcohol brief interventions in primary care in Scotland: a mixed methods evaluation. Scottish Health Action on Alcohol Problems; 2017. **www.shaap.org.uk/images/remuneration-report-web.pdf** (accessed 30 May 2024).

[23] O'Donnell A, Haighton C, Chappel D et al. Impact of financial incentives on alcohol intervention delivery in primary care: a mixed-methods study. BMC Family Practice 2016;17(1):165. **http://bmcfampract.biomedcentral.com/articles/10.1186/s12875-016-0561-5** (accessed 30 May 2024).

[24] Rosário F, Santos MI, Angus K et al. Factors influencing the implementation of screening and brief interventions for alcohol use in primary care practices: a systematic review using the COM-B system and Theoretical Domains Framework. Implementations Science 2021.

https://implementationscience.biomedcentral.com/articles/10.1186/s13012-020-01073-0 (accessed 30 May 2024).

[25] Rosário F, Vasiljevic M, Pas L et al. Efficacy of a theory-driven program to implement alcohol screening and brief interventions in primary health-care: a cluster randomized controlled trial. Addiction 2022;117(6):1609–21. **https://pubmed.ncbi.nlm.nih.gov/34935229/** (accessed 30 May 2024).

[26] Fitzgerald N, Stewart D, Drinking interventions in pharmacies study. The Robert Gordon University; 2005. **https://dspace.stir.ac.uk/bitstream/1893/20425/1/AERC_FinalReport_0038.pdf** (accessed 30 May 2024).

[27] McAuley A, Goodall C, Ogden G et al. Delivering alcohol screening and alcohol brief interventions within general dental practice: rationale and overview of the evidence. Addiction science & clinical practice; 2012. **http://europepmc.org/abstract/PMC/PMC3480148** (accessed 30 May 2024).

[28] Rapley T, May C, Kaner EF. Still a difficult business? Negotiating alcohol-related problems in general practice consultations. Social Science & Medicine; 2006. 1;63(9):2418–28.

[29] Schölin L, Fitzgerald N. The conversation matters: a qualitative study exploring the implementation of screening and brief interventions in antenatal care in Scotland. BMC Pregnancy Childbirth 2019. **https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-019-2431-3** (accessed 30 May 2024).

[30] Orr KS, McAuley A, Graham L, McCoard S. Applying an alcohol brief intervention (ABI) model to the community justice setting: learning from a pilot project. Criminal Justice 2013. **http://crj.sagepub.com/cgi/doi/10.1177/1748895813509636** (accessed 30 May 2024).

[31] Fitzgerald N. Challenges and opportunities in alcohol screening and brief interventions in new settings: a narrative review of implementation initiatives. Addict Sci Clin Pract 2015;10(Suppl 2):O39. **http://ascpjournal.biomedcentral.com/articles/10.1186/1940-0640-10-S2-O39** (accessed 30 May 2024).

[32] Evans B, Kamon J, Turner WC. Lessons in implementation from a 5-year SBIRT effort using a mixed-methods approach. The Journal of Behavioral Health Services & Research 2023;50(4):431–51.

[33] Fitzgerald N, Platt L, Heywood S, McCambridge J. Large-scale implementation of alcohol brief interventions in new settings in Scotland: a qualitative interview study of a national programme. BMC Public Health 2015;15(1):289.

[34] Jonas DE, Garbutt JC, Amick HR, et al. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the US Preventive Services Task Force. Annals of Internal Medicine 2012;157(9):645–54.

[35] McCambridge J, Saitz R. Rethinking brief interventions for alcohol in general practice. British Medical Journal 2017;356.

[36] Newbury-Birch D, Coulton S, Bland M et al. Alcohol screening and brief interventions for offenders in the probation setting (SIPS Trial): a pragmatic multicentre cluster randomized controlled trial. Alcohol and Alcoholism 2014;49(5):540–8.

[37] Daeppen JB, Gaume J, Bady P et al. Brief alcohol intervention and alcohol assessment do not influence alcohol use in injured patients treated in the emergency department: a randomized controlled clinical trial. Addiction 2007;102(8):1224–33.

[38] Scholin L, O'Donnell A, Fitzgerald N. Financial incentives for alcohol brief interventions in primary care in Scotland – a mixed-methods study. Scottish Health Action on Alcohol Problems. Edinburgh; 2017.

[39] Fitzgerald N, Molloy H, MacDonald F, McCambridge J. Alcohol brief interventions practice following training for multidisciplinary health and social care teams: A qualitative interview study. Drug Alcohol Rev 2015;34(2):185–93. **www.ncbi.nlm.nih.gov/pubmed/25196713** (accessed 30 May 2024).

[40] Kaner EF, Beyer F, Dickinson HO, et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database Syst Rev 2018. **https://pubmed.ncbi.nlm.nih.gov/29476653/** (accessed 30 May 2024).

[41] Jonas DE, Garbutt JC, Amick HR et al. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the US Preventive Services Task Force. Annals of internal medicine 2012;157(9):645–54.

[42] Dunne J, Kimergård A, Brown J et al. Attempts to reduce alcohol intake and treatment needs among people with probable alcohol dependence in England: a general population survey. Addiction 2018;113(8):1430–8.

[43] McCambridge J, Rollnick S. Should brief interventions in primary care address alcohol problems more strongly? Addiction 2014;109(7):1054–8. **www.ncbi.nlm.nih.gov/pubmed/24433291** (accessed 28 May 2024).

[44] Fitzgerald N, Angus K, Schölin L et al. Why are we failing to identify drinking in pregnancy? A systematic critical review of antenatal alcohol screening. Unpublished. University of Stirling; 2023.

[45] Schölin L, Fitzgerald N. The conversation matters: A qualitative study exploring the implementation of alcohol screening and brief interventions in antenatal care in Scotland. BMC Pregnancy Childbirth 2019;19(1).

[46] Andréasson S, Finn S, Bakshi A-S. Barriers to treatment for alcohol dependence: a qualitative study. Addiction Science and Clinical Practice; 2013 **https://ascpjournal.biomedcentral.com/articles/10.1186/1940-0640-8-S1-A5** (accessed 28 May 2024).

[47] Finn SW, Hammarberg A, Andreasson S. Treatment for alcohol dependence in primary care compared to outpatient specialist treatment – a randomized controlled trial. Alcohol and Alcoholism 2018;53(4):376–85. **https://dx.doi.org/10.1093/alcalc/agx126** (accessed 28 May 2024).

[48] Morris J, Albery IP, Heather N, Moss AC. Continuum beliefs are associated with higher problem recognition than binary beliefs among harmful drinkers without addiction experience. Addictive Behaviors 2020;105:106292. **www.sciencedirect.com/science/article/abs/pii/S0306460319310020** (accessed 28 May 2024).

[49] Gaume J, McCambridge J, Bertholet N, Daeppen J-B. Mechanisms of action of brief alcohol interventions remain largely unknown - a narrative review. Frontiers in Psychiatry 2014;5:108. **https://pubmed.ncbi.nlm.nih.gov/25206342/** (accessed 28 May 2024).

[50] Bertholet N, Palfai T, Gaume J et al. Do brief alcohol motivational interventions work like we think they do? Alcohol Clinical and Experimental Research 2013;38(3):853–859. **www.ncbi.nlm.nih.gov/pubmed/24125097** (accessed 28 May 2024).

[51] Fitzgerald N. Challenges and opportunities in alcohol screening and brief interventions in new settings: a narrative review of implementation initiatives. Addiction Science & Clinical Practice 2015;10(Suppl 2):O39.

[52] Public Health Scotland. Triple I tools – informing interventions to reduce health inequalities (Triple I). Edinburgh: Public Health Scotland; 2019.

[53] Brown J, West R, Angus C et al. Comparison of brief interventions in primary care on smoking and excessive alcohol consumption: a population survey in England. British Journal General Practice 2016;66(642).

[54] Yang F, Angus C, Duarte A et al. Impact of socioeconomic differences on distributional cost-effectiveness analysis. Medical Decision Making 2020;40(5):606–

18. **https://journals.sagepub.com/doi/10.1177/0272989X20935883** (accessed 30 May 2024).

[55] Bloomfield K. Understanding the alcohol-harm paradox: what next? The Lancet Public Health, Volume 5, Issue 6, e300–e301.

[56] Boyd J, Sexton O, Angus C et al. Causal mechanisms proposed for the alcohol harm paradox – a systematic review. Addiction 2022;117(1):33–56.

[57] Holloway A, Donaghy E. Practices and attitudes of general practitioners in the delivery of alcohol brief interventions in Scotland. Scottish Health Action on Alcohol Problems; 2017. **www.shaap.org.uk/images/holloway-and-donaghy-report-final_print_version.pdf** (accessed 28 May 2024).

[58] McCambridge J. Reimagining brief interventions for alcohol: towards a paradigm fit for the twenty first century?: INEBRIA Nick Heather Lecture 2019. Addiction Science Clinical Practice 2021;16(1):1–10. **https://ascpjournal.biomedcentral.com/articles/10.1186/s13722-021-00250-w** (accessed 28 May 2024).

[59] Peake L, van Schalkwyk MC, Maani Hessari N, Petticrew M. Analysis of the accuracy and completeness of cardiovascular health information on alcohol industry-funded websites. European Journal of Public Health 2021;31(6):1197–204.

[60] Petticrew M, Maani Hessari N, Knai C, Weiderpass E. How alcohol industry organisations mislead the public about alcohol and cancer. Drug and Alcohol Review 2017;293–303.

[61] Rao D, Elshafei A, Nguyen M, Hatzenbuehler ML, Frey S, Go VF. A systematic review of multi-level stigma interventions: state of the science and future directions. BMC Medicine 2019;17:1–1

[62] Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. Am J Public Health 2013;103:813–21.

[63] Stangl AL, Earnshaw VA, Logie CH et al. The health stigma and discrimination framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. BMC Medicine 2019;17:31

[64] Maani Hessari N, Petticrew M. What does the alcohol industry mean by 'Responsible drinking'? A comparative analysis. Journal of Public Health 2018;40(1):90–97.

[65] Wyper GM, Mackay DF, Fraser C et al. Evaluating the impact of alcohol minimum unit pricing on deaths and hospitalisations in Scotland: a controlled interrupted time series study. The Lancet 2023;401(10385):1361–70.

[66] Kock L, Shahab L, Moore G et al. Protocol for expansion of an existing national monthly survey of smoking behaviour and alcohol use in England to Scotland and Wales: the Smoking and Alcohol Toolkit Study. Wellcome Open Research 2021;6.

[66] Holtrop JS, Estabrooks PA, Gaglio B, et al. Understanding and applying the RE-AIM framework: clarifications and resources. Journal of Clinical and Translational Science 2021;5(1):e126.

Appendix 1

Programme board membership

We would like to thank Elisabeth Smart, Consultant in Public Health for NHS Highland, for chairing Alcohol Brief Intervention programme board meetings, leading discussions of thematic analysis and developing the recommendations.

We would like to thank the members of the Alcohol Brief Intervention programme board for their expertise and insight in preparing this review:

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Maureen O'Neill Craig, Health Improvement Lead, NHS Greater Glasgow and Clyde (Invited Dec 2022).

Michaela Jones, National Recovery Community Development Officer, Scottish Recovery Consortium.

Graeme Callander, Policy & Public Affairs Lead (Scotland), With You.

Gary Meek, Scottish Alcohol Counselling Consortium representative and CEO of Glasgow Council on Alcohol.

Elinor Jayne, Director, Scottish Health Action on Alcohol Problems (SHAAP).

Dr Arlene Reynolds, Senior Professional Advisor in Public Health, Scottish Government (Invited Dec 2022).