

Brief Alcohol Intervention in Mental Health Services: Feasibility for Older Adults

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by

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Declaration

I confirm that the literature review, research report and critical appraisal contained within this thesis are my own work and have not been submitted for any other academic award.

Thesis Abstract

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Older people are at an increased risk of experiencing harmful effects from alcohol, particularly in conjunction with physical and mental health difficulties. Brief Alcohol Interventions (BI) aim to raise awareness of potential difficulties and enhance motivation to change drinking behaviour. There is a robust evidence base for using BI with adults drinking at hazardous/harmful levels. However, limited attention has been paid to how alcohol screening and BI can apply to older adult populations.

The systematic review examined the literature investigating the effectiveness of using BI with older adults in primary care and the quality of the evidence evaluated. Although variation in the delivery of the BI and sampled populations was evident, evidence suggested that BI can be effective in reducing alcohol consumption for older adults, but less effective for those drinking at heavier levels. However, the literature was found to be limited in quality and number and using BI with older people or within secondary care remains under researched.

A feasibility study of using alcohol screening and BI in mental health services for older people was developed. Community Psychiatric Nurses' (CPNs) experiences of trialling the BI and attitudes towards addressing alcohol use with older people were explored through qualitative interviews, along with perceived barriers and facilitators for implementation. Challenges in undertaking research with older adults were highlighted and no hazardous drinkers identified to complete the BI. An overarching theme of *anxiety about addressing alcohol* and a lack of confidence in being able to influence the drinking behaviour of older people were identified. Older people had little knowledge about alcohol and its potential risks and differences emerged as to whether CPNs felt it their responsibility to address this. Several barriers to implementation were identified and the results indicated that offering BI within mental health services for older people was not feasible. For implementation to become successful, training and ongoing support is essential; to highlight the risks of alcohol for older people and the role CPNs can play. Further clinical implications and areas of future research are discussed.

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What is the Strength of the Evidence for the Effectiveness of Brief Alcohol Interventions for Older Adults in Primary Care Settings? A Review

ABSTRACT

Purpose: Given the increasing number of older adults drinking alcohol at levels that exceed government recommended limits and the increased risk of alcohol-related harm in later life, a systematic review of the literature was undertaken to establish the effectiveness of Brief Alcohol Intervention (BI) in reducing alcohol consumption in older adults accessing primary care services.

Method: Systematic review methods were utilised to search, screen and critically appraise data extracted from peer reviewed published papers. The databases PsychInfo, Web of Science and SCOPUS were searched for papers relevant to the topic, yielding 12 quantitative papers suitable for inclusion in the review. Articles were assessed for their methodological rigour and the quality of evidence discussed, together with implications for practice.

Results: The quality of papers was extremely variable, with more robust papers describing more rigorous RCTs. Great variation in the format and delivery of BI and definitions of older adults and heavy drinking were found across the studies. The results of the three highest quality rated studies found evidence that BI is effective in reducing alcohol consumption for older adults drinking at hazardous/harmful levels but less effective for those drinking at heavier levels.

Conclusions: The literature on using BI with older adults in primary care is limited in quality and number. Although these findings are encouraging, further research is needed to expand the evidence base for using BI with the older adult population.

Key Words: Older adults, Hazardous drinking, Brief Intervention, Effectiveness, Alcohol reduction

INTRODUCTION

With an estimated 90% of adults in England drinking alcohol (Alcohol Harm Reduction Project, 2003) for many, alcohol has become part of daily life and alcoholic beverages are consumed and enjoyed at moderate levels. At present, the recommended safe limits for alcohol use stipulate that men and women should not exceed 21 and 14 units per week respectively (Royal Colleges, 1995). However, an increasing number of people are drinking in a way that may have adverse effects for their health and wellbeing, with 38% of men and 29% of women reporting drinking above these recommended guidelines (Alcohol Concern, 2010). Twenty three percent of the adult population or 7.1 million people have been classified as drinking in a hazardous or harmful way (Drummond et al., 2004). Hazardous drinking is defined as: ‘use of alcohol that will probably lead to harmful consequences’ whilst harmful drinking is: ‘a pattern of use which is directly causing damage to physical or psychological health’ (Raistrick, Heather & Godfrey, 2006). As such, the proportion of people in the UK consuming alcohol at these levels is placing an increased pressure on healthcare services. It is estimated that the cost of alcohol-related harm to the NHS in England is £2.7 billion, with 1,168,300 alcohol-related hospital admissions in 2010/2011, more than twice as many as in 2002/2003 (Statistics on Alcohol, 2012).

In addition, an estimated 22% of men and 11% of women over the age of 65 are exceeding the government recommended limits for alcohol consumption (General Household Survey, 2006) and with an ageing population, the number of older adults drinking alcohol is on the increase. Older adults are more vulnerable to the adverse effects of alcohol than those who are younger (O’Connell, Ai-Vryn, Cunningham & Lawlor, 2003), with age-related biological changes leading to a higher level of blood alcohol concentration and increased effects on the central nervous system. Older adults

are more likely to experience physical or mental health conditions that can be aggravated by alcohol, with an increased risk of adverse interaction between alcohol use and medications (Atkinson, 2002).

With alcohol use being prevalent in both adult and older adult populations, alcohol-related harm poses a major public health problem and both the Department of Health and the National Institute of Clinical Excellence (NICE, 2011) have recognised the need to address this problem and support those for whom harmful drinking may be causing social difficulties and/or physical and mental health problems. It is recognised by NICE (2011) that staff within the NHS should be able to identify harmful levels of alcohol use and assess the need for intervention, to enable them to support those who potentially misuse alcohol. In line with this, NICE (2010) stipulate that interventions should help people of all ages to become aware of the potential risks they are taking or harm they may be doing to themselves at an early stage, giving rise to the possibility of behaviour changes and prevention of further alcohol-related difficulties. As such, NICE recommend that both structured brief advice on alcohol and extended brief intervention, consisting of motivational interviewing or motivational enhancement therapy are offered within healthcare services (NICE 2010) and highlight the need for commissioners to ensure interventions are available to those of all ages who need it. However, this is yet to be fully implemented in many settings (Boland, Drummond & Kaner, 2008).

As a result of increased need and in line with clinical practice guidelines, brief alcohol interventions (BIs) have been widely used and cited within the substance misuse literature, with the aim of reducing alcohol consumption and alcohol-related difficulties. Throughout the literature and across clinical services, BIs vary in their approach and format and the term is often used to mean both ‘opportunistic’ interventions for those

not seeking help for an alcohol problem and ‘less intensive’ treatment for those seeking help (Raistrick et al., 2006). However, BIs can largely be defined as being short in duration and of low intensity (Babor & Higgins-Biddle, 2001), lasting between 5 and 60 minutes and consisting of no more than 5 sessions (Kaner et al, 2007). They typically focus on providing counselling and education and work to enhance motivation to change, with the most effective styles being based on techniques from motivational interviewing (Miller & Sanchez, 1994). BIs do not require extensive training but offer a style of engagement, providing information and suggested ways to change patterns of drinking, supported with written information.

Such interventions have been assessed for their efficacy with working-age adults and found to be effective in reducing alcohol consumption to low risk levels (Moyer, Finney, Swearingen & Vergun, 2002), and alcohol-related problems (Richmond, Heather, Wodak, Kehoe & Webster, 1995). As such, BIs have gained strong supporting evidence as psychosocial approaches for alcohol problems (Raistrick et al., 2006) and there is a wealth of evidence in favour of using them within primary care services.

Increased life expectancy and the prevalence of drinking in older adults have brought new challenges for healthcare services and patients, with increased risk of alcohol affecting physical and mental health. In light of this, recent years have seen an increasing recognition of the scale of the problem and the need for better identification and treatment for alcohol problems (Alcohol Harm Reduction Strategy, 2004), although both clinically and within the literature, less attention has been paid to the use of BIs with older adults. This is despite alcohol use being potentially harmful to this population, particularly in conjunction with physical or emotional illness (Blow & Barry, 2000).

The National Treatment Agency for Substance Misuse (Raistrick et al., 2006) provide a comprehensive review of the evidence base for all treatments available to those with alcohol-related problems, ranging from simple alcohol advice to intensive specialist treatments. A search of the literature identified six previous reviews in which the effectiveness of BIs for adult populations in primary care settings was considered (Ballesteros, Duffy, Querejeta, Arino & Gonzales-Pinto, 2004; Bertholet, Daeppen, Wietlisbach, Fleming & Burnand, 2005; Kahan, Wilson & Becker, 1995; Kaner et al., 2009; Poikolainen, 1999; Whitlock, Polen, Green, Orleans & Klein, 2004). However, none of these reviews focused on BIs for older adults and no previous reviews for this population have been identified. With this in mind and due to the clinical importance, the current paper aimed to systematically and critically review the literature on the effectiveness of BIs in reducing alcohol consumption in older adults accessing primary care services, with the intention to: 1) provide a descriptive overview of the recent literature and 2) establish whether BIs are effective in reducing alcohol consumption for older adults in primary care, based on a quality appraisal of the studies.

METHODOLOGY

A systematic review of the literature surrounding the use of BIs with older adults in primary care was conducted using the main electronic databases (PsychInfo, Web of Science and Scopus). In addition, the NHS Evidence database was searched, including the Cochrane Database of Systematic Reviews.

Identified articles were initially screened for relevance by scanning titles and abstracts and those deemed relevant were selected for further analysis against inclusion/exclusion criteria, described below. Where insufficient information was available within the abstract, articles were retrieved and read in their entirety to ensure relevance to the

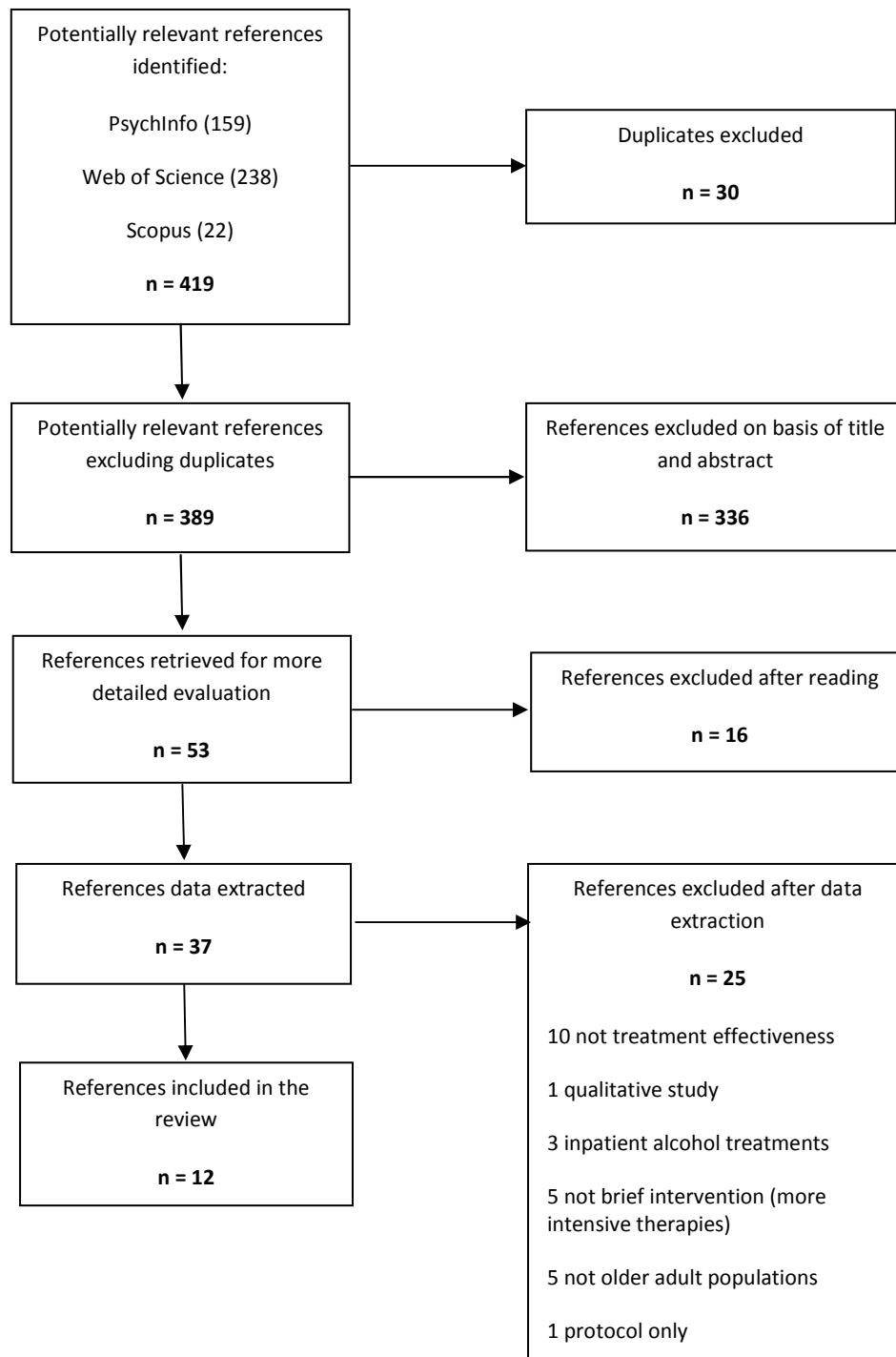
review question. Finally, the reference sections of relevant articles and previous reviews were hand searched to ensure all potential studies were identified.

Databases were searched using combinations of the search terms: *effectiveness, efficacy, brief intervention, early intervention, alcohol treatment, alcohol reduction, alcohol, problem drinking, hazardous drinking, risky drinking, older adults, elderly*.

Articles were combined in reference management software (Refworks) and duplicates removed. A systematic review of each relevant article was carried out using a Data Extraction Form (Appendix A).

Inclusion Criteria: Papers selected for inclusion were those aiming to evaluate the effectiveness of a BI for older adults in primary care settings. Although Randomised Controlled Trials (RCTs) were preferentially selected, multi-site and quasi-experimental designs were also included. Participants were older adults aged 50 years and over and did not have to be seeking treatment for difficulties related to alcohol use. Studies were included if they used a measurable outcome of alcohol consumption or a measure of clinical change. Studies looking at substance misuse were included only where a separate measure of alcohol consumption was used and results analysed independently of those for other substances. For the current review, BI was defined as being short in duration and of low intensity (Babor & Higgins-Biddle, 2001), consisting of no more than 5 sessions (Kaner et al., 2007). Studies were included where the intervention met these criteria.

Figure 1. Flow chart of paper selection



Exclusion criteria: Searches were limited to peer-reviewed journals, written in the English language. Articles were limited to older adult populations and studies of adult populations were considered only where a separate analysis of older adults was evident. As BIs began to emerge throughout the late 1980s (Nilsen, Kaner & Babor, 2008) and

no previous review with older adult populations was identified, searches spanned the period of January 1990 to March 2013, to ensure all relevant literature was examined.

From the initial searching, 37 articles were further examined for possible inclusion. Of these, 25 were deemed not appropriate and were removed on one or more grounds, as shown in Figure 1. One article outlined a study protocol (Coulton et al. 2008). The primary author was contacted via email to enquire whether this was due for publication, but this was not within the timescale of the current review.

In order to assess the methodological rigour of the studies, a quality assessment was completed using the Scottish Intercollegiate Guidelines Network (SIGN, 2011) guidelines for systematic review. These guidelines were selected as providing comprehensive methodological checklists for a range of study designs. The algorithm for classifying study design was consulted, to ensure the most appropriate checklist was adopted. The Methodology 2 Checklist for Controlled Trials, (SIGN, 2012) was selected (Appendix B), as being most appropriate for RCTs, whilst still being applicable to non-randomised studies, with the omission of some criteria. The 10 criteria were completed for each of the studies and scored as either positive or negative. Where studies did not provide sufficient information for a clear decision to be made, the criterion was marked as negative. Based on total scores (sum of the positive criteria), an overall rating was attributed of high, moderate or low quality. No studies were excluded due to their quality rating, as the quality assessment provided a framework through which to highlight strengths and weaknesses of each study and these were taken into account when making conclusions about the results.

RESULTS

Of the 419 articles initially identified, 37 were examined further. Twelve quantitative articles met inclusion criteria and were included in the current review (see Appendix C for a summary of the 12 reviewed articles). Of these, 6 were RCTs and 2 used a non-randomised controlled design. Four additional studies presented secondary analyses from two RCTs and were felt to add to the evidence base and as such, were selected for inclusion and discussion within the results. However, the 8 primary studies were included within the quality assessment, as shown in Table 1. Of the 8 primary studies, 7 were conducted within the USA and 1 in Denmark.

For the purposes of clarity, the results section has been separated into two parts: RCTs and non-randomised studies and subsequently structured according to type and duration of the BI used.

Randomised Controlled Trials (RCTs)

a) Minimal Brief Intervention

Of the six RCTs reviewed, three used a minimal BI, comprising 1-2 sessions (Copeland, Blow & Barry, 2003; Fleming, Manwell, Barry, Adams & Stauffacher, 1999; Gottlieb-Hansen, Becker, Nielsen, Gronbaek & Tolstrup, 2012). Sample sizes ranged from 158 to 772 with 1158 participants in total, aged 50 to 85. The majority of participants were male (N=713, 62%). All studies included older adults who were drinking above recommended weekly limits, with two defining this as more than 11 standard drinks for men and 8 for women. In one study (Gottlieb-Hansen et al., 2012) the sample was classified as ‘heavy’ drinkers, drinking more than 21 standard drinks for men and 14 for women per week. In this study, those drinking at a ‘dependent level’ were not excluded from the sample. All studies defined a standard drink (or one unit) as 12g of alcohol.

Intervention

The three RCTs using a minimal BI consisted of a maximum of two face-to-face sessions with a healthcare professional. Intervention sessions lasted 10-15 minutes in all studies, though one study asked participants to attend for two sessions, a month apart (Fleming et al., 1999). All 3 studies used a BI protocol, providing feedback on drinking behaviours, adverse effects of alcohol and a drinking agreement to reduce intake. Two studies (Copeland et al., 2003; Gottlieb-Hansen et al., 2012) described interventions using principles of Motivational Interviewing (Miller & Rollnick, 2002). Both Fleming et al. (1999) and Gottlieb-Hansen et al. (2012) included telephone booster sessions within one month of intervention. In two studies (Fleming et al., 1999; Copeland et al., 2003), control groups received general health advice booklets. In the third study, the control group received alcohol information leaflets (Gottlieb-Hansen et al., 2012).

Table 1. Assessment of methodological quality of included studies (SIGN, 2012)

	Schonfield	Osin	Moore	Gottlieb-Hansen	Gordon	Fleming	Fink	Copeland
Addresses an appropriate, clearly focused question	✓	✓	✓	✓	✓	✓	✓	✓
Randomised assignment to treatment groups	X	✓	✓	✓	✓	✓	X	✓
Adequate concealment method used	X	X	✓	✓	X	✓	X	X
Subjects and investigators are kept 'blind' about treatment allocation	X	X	✓	X	X	✓	X	X
Treatment and control groups similar at start of trial	X	✓	✓	✓	✓	✓	X	✓
Only difference between groups is the treatment under investigation	✓	✓	✓	✓	✓	✓	✓	✓
All relevant outcomes are measured in a standard, valid and reliable way	✓	✓	✓	✓	✓	✓	✓	✓
Percentage of dropouts from each treatment arm	-	IC 19%, ER 15%	BI 28%, CON 7%	BMI 19%, CON 21%	-	BI 9%, CON 6%	PR 6%, CR 7%, CON 7%	-
Intention to treat analysis	X	X	✓	✓	X	X	✓	X
Overall quality assessment of the study	Low	Moderate	High	High	Moderate	High	Low	Moderate

Outcome Measures

All three RCTs using a minimal BI used self-report measures of alcohol consumption at baseline assessment, focusing on average weekly consumption and number of episodes of ‘binge’¹ drinking. All studies used a validated alcohol measurement tool at baseline, though some variation was present. The CAGE questionnaire (Mayfield, McLeod & Hall, 1974), a 4-item alcohol assessment, was used across two studies (Fleming et al., 1999; Copeland et al., 2003), whilst Copeland et al., (2003), also used the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G, Blow et al., 1992), a 10-item questionnaire. In the Gottlieb-Hansen et al. (2012) study, questions 1-3 on the Alcohol Use Disorders Identification Test (AUDIT, Babor, Higgins-Biddle, Saunders & Monteiro, 2001) were used.

All three RCTs repeated measures of alcohol intake, most typically at 6 and 12 month follow-up. In the Fleming et al. (1999) study, this was done by patient interview where Gottlieb-Hansen et al. (2012) asked participants to complete an internet-based questionnaire. Copeland et al. (2003) also assessed changes in healthcare utilisation following intervention, assessing the number of inpatient and outpatient visits at 9 and 18 months post treatment.

Quality Assessment

The assessment of the quality of the three RCTs employing minimal BI is shown in Table 1. Both the Fleming et al. (1999) and Gottlieb-Hansen et al. (2012) studies were rated to be of high methodological quality, with steps taken to limit the risk of bias and ensure high internal validity. The Copeland et al. (2003) study was rated as moderate quality due to fewer of the methodological criteria being met.

¹ Defined as 4 or more drinks per occasion for men 2 or more times in the last 3 months or 3 or more drinks per occasion for women (Fleming *et al.*, 1999)

All three RCTs were multi-centre, using appropriate methods for random assignment to treatment conditions, minimising the risk of sample bias and influences of confounding variables. Due to the nature of the interventions, it was not feasible for physicians completing BI to be blind to treatment allocation. However, Fleming et al. (1999) took measures to ensure physicians were not informed which of their patients had been allocated to the control condition. In the Gottlieb-Hansen et al. (2012) study, the control group received alcohol information leaflets. All three studies followed participants up over a 12 month period, allowing longer term effects of the intervention to be investigated. The attrition rate in the Fleming et al. (1999) study was low with 92.4% of participants being followed up after 12 months. In Gottlieb-Hansen et al., (2012), the attrition rates for the intervention and control group were 19% and 21% respectively. An Intention to Treat (ITT) analysis was conducted to account for missing data. No details regarding participant attrition were reported within the Copeland et al., (2003) article and no ITT analysis was described.

Results

In the Fleming et al. (1999) study, significant differences in drinking levels emerged between the BI and control group 3 months after intervention, with alcohol use decreasing substantially in the BI group. These results were maintained at 12 month follow-up and indicated that those in the BI group reduced their weekly consumption by 36%, an average of 5 alcoholic drinks. In contrast, the control group reduced their weekly consumption by only 1 drink. These between-group differences were statistically significant ($p < .001$) and are of clinical significance. The proportion of people drinking at 'excessive' levels decreased by 52% in the BI group and levels of binge drinking declined by 47% 3 months post intervention. These reductions were also evident at 12 months, indicating the persistent effects of the intervention over time. In

contrast, the control group showed little improvement, with levels of 'excessive' drinking increasing from 30% at baseline to 35% at 3 month follow-up.

Gottlieb-Hansen et al. (2012) also found significant reductions in drinking levels between baseline, 6 and 12 month follow-up for the minimal BI group. However, similar reductions in drinking levels were found in the control group, in which participants received alcohol information leaflets. Therefore, no significant difference between the intervention and control group was evident with regard to drinking levels, with alcohol consumption among the women decreasing from a mean baseline level of 20.6 drinks per week to 14.1 drinks per week for those in the intervention group and to 15 drinks per week in the control group. Consumption among the older male participants reduced from 31.8 drinks to 24 drinks per week for the control group and 23 drinks per week for the intervention. Despite the slightly greater reductions in alcohol consumption following BI, this study did not find any evidence that a minimal BI was more effective than simple alcohol information for heavy drinking older adults.

Two studies also reported outcomes with regard to healthcare utilisation, with Fleming et al. (1999) finding that at 12 month follow-up, only 20 participants reported episodes of hospitalisation in the 6 months following the intervention, with a similar number having visited emergency departments, however, these changes were not statistically significant. In the study by Copeland et al. (2003) older adults who received BI used more outpatient medical services shortly afterwards. In the 9 month period following intervention, those who received BI used significantly more medical outpatient services than those in the control group.

In conclusion, the results from the two high quality RCTs (Fleming et al., 1999; Gottlieb-Hansen et al., 2012) provide evidence that minimal BIs were effective in

helping older people to reduce their alcohol intake and the risk of alcohol-related problems (Fleming et al., 1999). However, an intervention of this short duration was found to be less effective with those drinking at heavier levels (Gottlieb-Hansen et al., 2012). In addition, BI was thought to have raised awareness of health risks and alcohol use, increasing the likelihood that older people would seek out health advice and make greater use of healthcare services to do this (Copeland et al., 2003).

b) Brief Intervention of Longer Duration

Three multi-site RCTs examined BIs with older adults, comprising three or more sessions (Gordon et al., 2003; Moore et al., 2010; Oslin et al., 2006). Sample sizes ranged from 45 to 631, with a total of 1236 participants. All participants were aged 55 years or older, with 2 studies using 65 years as their lower age limit. The majority of participants (81%) were male. All studies included older adults who drank alcohol above recommended limits, defined as more than 12 drinks per week for women and more than 14-16 drinks a week for men. Two studies also considered episodes of binge drinking in determining eligibility and defined this as more than 3-4 drinks four or more times a week.

Intervention

All three studies used a BI, providing an alcohol education booklet including feedback on drinking behaviours and suggestions for reducing alcohol intake. The format for delivering the BI varied across studies, with Moore et al. (2010) offering one face-to-face session followed by 3 telephone sessions (2, 4 and 8 weeks following initial appointment), using motivational interviewing techniques. The control group received general health information. Oslin et al. (2006) compared a primary care based BI (termed integrated care), comprising three 20-30 minute face-to-face sessions, with an

‘enhanced specialty referral’ group, where participants were referred to specialist substance misuse services for treatment. Randomisation to treatment conditions took place following baseline assessment. Gordon et al. (2003) compared a one-session brief alcohol advice treatment (10-15 minutes duration) with a more intensive motivational enhancement intervention, during which participants received one 45-60 minute session and an additional two ‘booster’ sessions, lasting 10-15 minutes each. All sessions were with a member of the research team trained to deliver the intervention, with ‘booster’ sessions scheduled for two and four weeks following the initial session. In this study, a control group received treatment as usual.

Outcome Measures

All 3 RCTs with longer BIs used self-report measures of alcohol consumption at baseline, asking participants to report on the quantity and frequency of drinking in the 7 days prior to assessment. Two studies (Gordon et al., 2003; Moore et al., 2010) used the Time Line Follow Back (TLFB, Sobell & Sobell, 1995) procedure, a quantity/frequency instrument which assesses several aspects of alcohol consumption. Moore et al. (2010) also used the Co-morbidity Alcohol Risk Evaluation Tool (CARET) to identify and measure at-risk drinking both at baseline and follow-up, providing information regarding the proportion of people who met at-risk criteria. The SMAST-G (Blow et al., 1992) and the AUDIT (Babor et al., 2001) were also used at baseline assessment in the Gordon et al. (2003) and Oslin et al. (2006) studies respectively. All studies repeated measures at follow-up intervals between 3 and 12 months after intervention.

Quality Assessment

As shown in Table 1., the study by Moore et al. (2010) was rated high methodological quality, with both the Gordon et al. (2003) and Oslin et al. (2006) studies rated moderate quality.

Although all 3 studies were multi-centre and used appropriate randomisation methods, only one study (Moore et al., 2010) described keeping investigators blind to treatment allocation, with physicians only being made aware of patients allocated to the BI condition and not to the control group. In addition, research assistants completed baseline and follow-up assessments and were blind to treatment allocation. A further strength of this study was the large sample size, however attrition rate varied between the two conditions, with 28% in the BI group and 7% in the control group being lost at follow-up; an intention to treat analysis was adopted to account for missing data. In contrast, the Gordon et al. (2003) study had a small sample of only 45 older adults and although recruitment from multiple sites increased generalisability of results, both Gordon et al. (2003) and Oslin et al. (2006) reported high refusal rates, with as many as 75% of eligible older adults declining to take part. There was great variation across all 3 studies in the definition of older adults and the age of those participating.

With regard to control groups, Gordon et al., (2003) were the only study to include a treatment as usual control, although physicians were not discouraged from discussing alcohol with patients in standard care and some intervention may have been offered within usual practice. The control group in the Moore et al. (2010) study received information about low risk drinking limits, alongside other healthy lifestyle information. As Oslin et al. (2006) was a randomised comparative trial of two treatment modalities,

no treatment as usual group was included. Attrition rates were comparable between treatment groups, though analysis methods did not take account of any missing data.

Results

Moore et al. (2010) found reductions in alcohol consumption following BI, with a statistically significant difference between the groups at 12 month follow-up. However, the BI group were only drinking 1.3 drinks per week less than the control group and the clinical significance of this is questionable. Although the percentage of at-risk older adult drinkers also decreased in the BI group, similar reductions were found in the control group, who received information on recommended drinking behaviours. Differences between the groups did continue to favour the intervention group over time. Secondary analyses reported 39% of participants who received BI reduced their drinking within 2 weeks of the initial intervention session (Lin, Karno & Barry et al., 2010).

In a further secondary analysis of data from the Moore *et al.* (2010) study, Lin, Karno & Tang et al. (2010) found that the follow-up phone calls were moderately efficacious in reducing risky alcohol use over a short term period following initial intervention. Completing all 3 calls increased the odds of achieving 'not-at risk' drinking levels at 3 months by more than 5 times when compared to completing no phone calls. The effectiveness of this element of the intervention however was not pervasive over time and these improvements were not evident after 12 months.

When comparing BI in primary care to referral for treatment by a specialist substance misuse service, Oslin et al. (2006) found a greater percentage engagement in treatment for BI (65%) compared to only 38% treatment uptake in specialist treatment services. Measures of drinking declined following both BI and specialist treatment, with an

average decline in alcohol quantity of 35% and drinking frequency of 45%. Eighteen percent of those who received BI in primary care and 23% of those who received referral to specialist services reduced their drinking from at-risk levels to 7 or fewer drinks per week. As such, significant effects of time were noted, with a significant reduction in quantity and frequency of drinking found for all participants at both 3 and 6 month periods. However, the reduction in weekly alcohol consumption did not significantly differ between the two treatment modalities 6 month post intervention, indicating that BI for older adults in primary care was as effective as referral and treatment received within specialist substance misuse services.

A further site-specific secondary analysis of the data in the Oslin et al. (2006) study, supported the finding that BI treatment provided to the older adults within primary care resulted in a larger uptake and better engagement (Lee et al., 2009) than specialist service treatment. In this analysis, 93% of participants assigned to BI accessed treatment, compared to only 35% of those referred to specialist services. Those in the primary care BI group also received services and help to reduce their drinking sooner than those referred elsewhere.

Further secondary analyses examined the longer term effects of intervention (Zanjani et al., 2008) again indicating the effectiveness of both brief and specialist intervention models, with significant reduction in drinking 12 months following completion, with two thirds of the sample no longer meeting criteria for at-risk drinking. Although those drinking at higher levels showed heavier binge drinking at baseline, they appeared to equally benefit from both the brief and specialist interventions to reduce their drinking when compared to those drinking at lower levels.

Similarly, Gordon et al. (2003) found a reduction in alcohol consumption in two treatment groups (brief advice and motivational enhancement therapy) and for those receiving standard care at 6 and 12 months. When compared with the results of an adult population, similar effects of both brief advice and motivational enhancement therapy for older adults and the younger group were evident. Both models of intervention resulted in a reduction in alcohol consumption for participants and although the greatest improvements were seen after 6 months, sustainable improvements were still evident over the 12 month follow-up period.

The results from the high quality RCT (Moore et al., 2010) provide evidence that a BI of longer duration is effective in reducing alcohol consumption in older adults in primary care services, with differences still evident 12 months after intervention. However, BI did not reduce the proportion of at-risk or heavy older adult drinkers.

Non-randomised Clinical Trials

Two multi-centre trials included within the current review examined BIs (Fink, Elliott, Tsai & Beck, 2005; Schonfield et al., 2010) for alcohol consumption in older adults. Sample sizes were 665 and 244 participants respectively. All participants were aged 50 or older and there was a slightly higher percentage of female participants recruited across both studies. In the Fink et al. (2005) study, each of the 3 sites was randomly assigned to offer only one of these treatment conditions. The Schonfield et al. (2010) study examined BI for a range of substances, including alcohol, illicit substances and prescription medications. However, for the purposes of the current review, the BI for alcohol is described and these results discussed.

Intervention

In line with BIs, both studies used an intervention based on providing written information to participants, relating to the risks of alcohol and reasons to reduce their intake. Delivery of the intervention differed between the studies, with Fink et al. (2005) using a computerised screening and education program designed specifically for older adult populations (Computerised Alcohol-Related Problems Survey CARPS, Fink et al., 2002). In contrast, Schonfield et al. (2010) offered 1-5 sessions of BI, which used motivational interviewing techniques to elicit changes in drinking behaviour. The BI was compared to a 16 session relapse-prevention intervention.

In the Fink et al. (2005) study, prior to meeting with the physician, participants in both treatment conditions received a CARPS 'report' informing them about their alcohol use and providing them with personalised written information. The two treatment conditions differed in that in the first, both the patient and their physician received the report (combined-report condition) and in the second (patient-report condition) patients received their report but their physician did not. In the control group, participants continued to receive care from their physician as usual, but no report or alcohol education was offered.

Outcome Measures

The CARP survey, used by Fink et al. (2005) is a self administered computerised questionnaire, measuring quantity and frequency of alcohol use, drinking behaviours and possible dependency. The CARP was completed as a screening measure at baseline and again 12 months later, with reductions in hazardous and harmful drinking and maintenance of non-hazardous drinking as the primary outcome measures. Quantity and frequency of alcohol use were measured in Schonfield et al. (2010) using the initial 3

questions on the AUDIT (Babor et al., 2001). Where drinking had occurred in the past year, the 10-item Short Michigan Alcoholism Screening Test- Geriatric Version (SMAST-G, Blow et al., 1992) was then completed. Alcohol consumption measures were completed at baseline, post intervention and at 30 and 90 days post discharge.

Quality Assessment

Both studies (Fink et al., 2005; Schonfield et al., 2010) were rated as low methodological quality, as shown in Table 1. As neither of the studies were randomised controlled trials, several criteria were not met. Although in the Fink et al. (2005) study, each of the three research sites were randomly allocated to one of the three treatment conditions, no randomisation of participants occurred at an individual level. As allocation to treatment group was not randomised in either of the studies, group membership may reflect selection bias and the internal validity of the findings may be compromised by confounding factors. Both studies were conducted across multiple sites with large sample sizes increasing the generalisability of the results. The participant cut-off age differed across the two studies with Fink et al. (2005) including adults over the age of 65 and Schonfield et al. (2010) including those over the age of 50 years. Fink et al. (2005) reported a high refusal rate to participate, with 42% of eligible participants declining to take part. However, attrition rates between baseline and follow-up were low with little difference across the intervention conditions. In addition, Fink et al. (2005) included a treatment as usual control group. High attrition rates were reported in the Schonfield et al. (2010) study and precluded the longer term effects of intervention at 90 days post treatment from being examined.

Results

In the Fink et al. (2005) study, the primary outcome was ‘change in drinking classification’ at 12 month follow-up, from harmful to hazardous or non-hazardous drinking. An ordered logistic regression was used to model for this, with covariate-adjusted results reported as being more accurate for the size of sample. Using a multivariate-adjusted odds ratio, both interventions (patient-report and combined-report) were associated with greater odds of lower risk drinking at 12 month follow-up than usual care. The patient-report intervention significantly reduced harmful drinking at follow-up from an expected 21% in usual care, to 16% of people being classified as harmful drinkers following participation in this intervention arm. This intervention group also increased the number of non-hazardous older adult drinkers from the 52% expected in usual care to 58%. Relative to usual care, older adults in the combined-report condition reduced their drinking by 1.14 drinks per week, a statistically significant change. There was no evidence that the patient-report intervention significantly differed from the usual care group in their changes to drinking between baseline and follow-up. Similar estimates were obtained from unadjusted results.

Of the 3497 screened in Schonfield et al. (2010), 556 participants (16.8%) screened positive for alcohol misuse, at baseline assessment. Of these, 244 went on to receive BI or brief relapse-prevention treatment. Only 114 participants had data available at baseline, discharge and follow-up and were included within the analysis. Due to this level of attrition, the number of older adult participants who received follow-up at 90 days was too few for analysis to be completed. Scores on the SMAST-G significantly reduced at discharge, indicating that BI did lead to a significant decrease in alcohol severity. However, these scores did not remain significantly different from discharge to

30 day follow-up, indicating that the improvement seen at discharge was not maintained in the months following treatment completion.

DISCUSSION

Older adults are known to be more vulnerable to the adverse effects of alcohol than those who are younger, with an increased risk to physical and mental health even when consumption is at low levels. Brief alcohol interventions (BI) were found to be effective in reducing alcohol consumption to low risk levels in adult populations, although less is known about the effectiveness of BI with older adults. The aim of the current review was to systematically examine the strength of the evidence for the effectiveness of BI for older people accessing primary care services and provides the first review focusing on this population. Examination of the literature identified considerable variation in the methodological quality of the studies reviewed, with only 3 studies deemed to be of high quality (Fleming et al., 1999; Gottlieb-Hansen et al., 2012; Moore et al., 2010). It is the findings of these three rigorous RCTs that will be discussed, as providing the highest quality evidence. Within these studies, both a minimal BI comprising only one or two sessions (Fleming et al., 1999) and a BI of longer duration (Moore et al., 2010) were shown to be effective in reducing alcohol consumption in older adult hazardous and harmful drinkers, with improvements being maintained in the longer term. However, BI was not found to be effective in reducing the proportion of older people classified as drinking at at-risk levels. Minimal brief intervention was also found to be less effective for older heavy drinkers, with only a slightly greater reduction in drinking than simple alcohol information (Gottlieb-Hansen et al., 2012). In both the Moore et al. (2010) and Gottlieb-Hansen et al. (2012) study, reductions in alcohol use were also evident in the control conditions, a finding commonly reported in studies of BIs with adult populations (Kaner et al., 2009). Several reasons have been suggested in the

literature for the evident changes in alcohol use seen in control groups. Both Moore et al. (2010) and Gottlieb-Hansen et al. (2012) provided participants in the control groups with alcohol information leaflets, thereby providing a minimal intervention. It has also been suggested that the assessment process and focusing on alcohol during screening may have a positive impact on patients (Gottlieb-Hansen et al., 2012; Kaner et al., 2009). As such, encouraging clinicians to enquire about alcohol use and provide brief, minimal intervention in the form of simple clinician advice is likely to lead to positive reductions in alcohol use among older people drinking above recommended levels.

Within the 8 primary studies reviewed, there was substantial heterogeneity between the trials, with regard to the population, screening measures, baseline alcohol consumption, the content and format of interventions and control groups. Great variation in the definitions of heavy drinking was also found, as were differences in the definition of older adults, with the age at which participants were considered to be older adults and included in studies varying between 50 and 65 years of age. This heterogeneity makes synthesis and comparability of findings difficult and although may account for the differences in results noted, may also limit the reliability and generalisability of both individual studies and the findings of the current review. This finding of the current review supports that of previous reviews of BI with adults of working-age, where vast variation in BI definitions and formats has been noted (Kaner *et al.*, 2009; Raistrick et al., 2006). As previously discussed, the term BI is used to describe both ‘opportunistic’ interventions for those not seeking help or ‘minimal’ treatments for individuals seeking help for alcohol-related difficulties (Raistrick et al., 2006). As such, it is essential that studies evaluating the effectiveness of BI are clear in their definition and description of the content and type of intervention used, to ensure studies of BI can be compared in a valid and reliable way. As it is still not clear precisely which elements of BIs are most

effective in reducing alcohol consumption (Kaner, 2010), this variation in definition, content and delivery may make this even more difficult to establish. In light of the methodological limitations of some reviewed studies, further research is needed to broaden and further strengthen the evidence base for using BIs with older adult populations. Future research should seek to address the methodological differences and difficulties evident in the current evidence base and described previously; by more clearly defining the populations being studied and the brief intervention being offered. The variation in screening instruments used throughout the studies may reflect the paucity of specific instruments available and validated for use with older people and as such, further research is needed to establish which measures are most suitable to assess alcohol consumption in this population. In addition, clarity is needed in defining the age at which individuals are considered to be older adults, as this term is often used to define a large age range and differences within this age group are likely. Within the UK, older adults are often defined with a lower age of 60 or 65 years and NHS services are often set up to reflect this. However, the studies included in the current review were conducted outside of the UK and this may account for the variation in definition noted. Given the increased vulnerability to the effects of alcohol in later life, these effects are likely to become greater as a person ages. As such, it is important for the term older adults to be more clearly defined, to ensure similar groups of people are being compared within research studies and the effectiveness of BI for adults at different stages of their later life can be established.

Drinking alcohol at levels above recommended limits was prevalent within the older adult samples studied and as discussed previously, adults in later life are more vulnerable to the adverse effects of alcohol (Atkinson, 2002; O'Connell et al., 2003). Multiple risk factors, co-morbid physical and mental health conditions and taking

multiple medications are common amongst older adults (Moore et al., 2010) with as many as 75% of older adult participants reporting having at least one health condition potentially exacerbated by alcohol use (Fink et al., 2005). With this in mind, a primary clinical implication of the current review is the importance of screening for alcohol use in older adults accessing healthcare services within the UK. Screening for the possible presence of hazardous or harmful alcohol use would ensure that where alcohol-related difficulties are present, these can be identified and BI provided and tailored to address individual need. As many older adults regularly see a health professional within primary care services, this could provide an opportunity to identify and work to support older adults drinking at risky levels (Fleming et al., 1999) without more intensive, specialist alcohol interventions being required.

Although positive effects of BIs for older adults were evident, this area remains under-researched and the current evidence base remains small. A paucity of research was found with regard to BI and older adults, demonstrated by the relatively small number of controlled trials found for the current review. It was also noted that the majority of studies were conducted within the USA and applicability to UK older adult populations and healthcare systems may be limited. One study currently being conducted within the UK is of relevance and interest to the current review. Coulton et al. (2008) are conducting a multicentre RCT, investigating the effectiveness of a stepped care intervention, incorporating BI, for older adults drinking at hazardous levels. As this will provide the first trial of its kind in the UK and both the effectiveness and cost-effectiveness will be evaluated, the outcomes of this study will be of great interest and an addition to the evidence base.

In addition, several barriers to implementing screening and BI within clinical practice were discussed within articles, with a large proportion of eligible participants and those

identified as hazardous drinkers declining to participate in either screening or treatment. However, non-treatment seeking older adults were more likely to engage in alcohol intervention delivered within primary care than following referral to more specialist substance misuse services (Oslin et al., 2006) indicating that this method of intervention may be more accessible and acceptable to older people. Additional future research should seek to ascertain how easily and effectively BIs can be incorporated into routine practice within primary care services, whilst ensuring they are relevant and acceptable to older people.

The findings of the current review indicate that the literature on using brief alcohol interventions with older adults in primary care is limited in quality and number. Within the small evidence base, BI was shown to be effective in reducing alcohol consumption in older hazardous/harmful drinkers to levels safer for their health. Although these findings are encouraging, they come from only a handful of studies and further research is needed to add to and expand the evidence base for using BI with the older adult population.

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* denotes references which form the basis of this review

Abstract

Background: Due to age-related changes and an increased incidence of health conditions, alcohol has the potential to be harmful to older people, particularly in conjunction with mental health difficulties. Brief Alcohol Interventions (BI) aim to raise awareness of alcohol-related difficulties and enhance motivation to change drinking behaviour. BIs have strong supporting evidence as psychosocial approaches for hazardous/ harmful drinking in adult populations and may provide an effective way of identifying and addressing hazardous drinking within older adult mental health services.

Aims: To explore the feasibility of using alcohol screening and BI within mental health services for older people.

Method: A BI booklet was developed for the older adult population, before seven CPNs piloted using the Alcohol Use Disorders Identification Test (AUDIT) and BI with their patients. CPNs' experiences and attitudes towards asking about alcohol consumption, along with perceived barriers and facilitators for implementation, were explored through qualitative interviews.

Results: Several challenges in undertaking research with older adults were highlighted and within the sample of 15 older adults who completed the AUDIT, no hazardous/harmful drinkers were identified to complete the BI. Thematic analysis of the interview data indicated several barriers to implementing alcohol screening and BI and the results found this not to be feasible. An overarching theme of *anxiety about addressing alcohol* and a lack of confidence in being able to influence the drinking behaviour of older people were identified. Older people had little knowledge about alcohol and its potential risks and differences emerged as to whether CPNs felt it their responsibility to address this.

Conclusions & Implications: Routinely screening for alcohol use and offering BI was not found to be feasible within mental health services for older people. In order for implementation to become successful, addressing problematic alcohol consumption must be seen as a priority for services. Training and support are needed to highlight the risks of alcohol for older people, the role CPNs can play and the positive effects of BI. CPNs must also acquire knowledge and skills, to increase confidence in talking about alcohol with older people and offering BI.

Introduction

With an ageing population in the UK, the number of older adults drinking alcohol is on the increase and a ‘silent epidemic’ may be evolving (O’Connell *et al.*, 2003). As the cohort of ‘baby-boomers’ reaches the age of 65, there is a substantial and growing number of older adults misusing alcohol (Blow & Barry, 2012) and consuming more than previous older generations (NHS Health Scotland, 2006). A continuum of alcohol consumption ranges from abstinence or non-problematic drinking, to alcohol misuse or problem drinking. Within alcohol misuse, three levels (hazardous, harmful and dependent) are used to describe a person’s current drinking pattern and individuals may move between these levels over time (Raistrick *et al.*, 2006). Hazardous drinking is defined as: ‘use of alcohol that will probably lead to harmful consequences’ whilst harmful drinking is: ‘a pattern of use which is directly causing damage to physical or psychological health’ (Raistrick *et al.*, 2006). It is estimated that 22% of men and 11% of women over the age of 65 exceed the government recommended limits set for alcohol consumption (The UK General Household Survey, 2006) and are likely to be drinking at levels classified as ‘hazardous’ or ‘harmful’. At present, the recommended safe limits stipulate for men and women of any age, not to exceed 21 and 14 units per week, respectively (Royal Colleges, 1995.) However, older adults are more vulnerable to the adverse effects of alcohol than those who are younger and difficulties arise in applying recommended limits to this population (O’Connell *et al.*, 2003). At present, no age adjusted guidelines for ‘safe’ alcohol use exist in the UK.

An increased vulnerability to alcohol arises in older people following age-related changes in body mass, body water and metabolism which lead to a higher level of blood alcohol concentration and increased effects on the central nervous system (Atkinson, 2002). As such, older drinkers need smaller quantities of alcohol than younger adult

drinkers to create the same effects on: their subjective experience of intoxication; their motor coordination; and their memory (Atkinson, 2002). Older adults are also more likely to experience physical or mental health conditions that can be aggravated by alcohol, with an increased risk of adverse interaction with medications. As such, the presentation of alcohol-related problems in older adults more frequently takes the form of biomedical complications, than the social and behavioural problems more typically seen in younger drinkers (Royal College of Psychiatrists, 2011).

Despite the estimated prevalence of hazardous and harmful levels of alcohol use in older adults, there is a risk that rates of problem drinking² in this population are underestimated, with alcohol-related problems often being under recognised and unaddressed (Blow & Barry, 2012). O’Connell *et al.* (2003) provided several reasons why problem drinking continues to go undetected: older adults may be less likely to disclose their drinking; healthcare professionals may be less suspicious about alcohol consumption when assessing older people, or may perceive drinking as understandable in the context of poor health, rather than something of a problem. This is something O’Connell *et al.* (2003) described as leading to ‘therapeutic nihilism’; the presentation of problem drinking may be atypical and the effects masked by co-morbid physical or psychiatric illnesses. Health professionals may misinterpret the signs of problem drinking (e.g. memory problems, falls, poor sleep) as solely a result of ageing (Prigerson, 2001) or may have the misguided opinion that older people should not be advised to give up established habits, because it is either ‘too late’ or not worth the effort (Pennington *et al.*, 2000).

² The term problem drinking is used here to refer to hazardous and harmful levels of alcohol use. Problem drinking is also often termed alcohol misuse within the literature.

Older adults are more likely to drink alcohol to self-medicate or to temporarily alleviate symptoms of negative affect (Atkinson, 2002), making those with mental health problems vulnerable to consuming harmful amounts. Depression, anxiety and cognitive disorders are the most common mental health problems to co-exist with problematic drinking in older adults, with depression being linked to increased alcohol intake (Blow & Barry, 2000). In addition, 11-33% of older drinkers develop problem drinking within the later stages of life, suggesting that the ageing process itself may be a causative factor (Dar, 2006) and alcohol consumption may increase in the context of life changes, with a number of factors playing an important role at this stage of life. These factors may be emotional and social; such as bereavement, loss of occupation or social status and reduced self-esteem. Other difficulties may be more medical, with older people experiencing physical disabilities, chronic pain or reduced coping skills (Dar, 2006; O'Connell *et al.*, 2003). Those with lower physical and emotional functioning are more likely to experience serious consequences of drinking alcohol, even when consumption is at low levels (Blow & Barry, 2000).

Despite this, there is little literature on older adults with concurrent mental health difficulties and problem drinking and little is known about how the prevalence of such dual diagnoses varies with age (Prigerson *et al.*, 2001). It is known from the literature in adults of working age, that those with mental health difficulties are more sensitive to adverse effects of alcohol, even at moderate levels (Nehlin *et al.*, 2012) and concomitant problem drinking and mental health difficulties are associated with poorer treatment outcomes, with worsening psychiatric symptoms, poor medication adherence and poor social outcomes (Department of Health, 2002.)

Within the ageing population, a higher number of hazardous and harmful drinkers exist than those drinking at dependent levels and it is important to identify those who may

benefit from simple intervention methods to assist them in modifying their alcohol consumption (Atkinson, 2002). Older adults have been found to be least well informed about alcohol units (Dar, 2006) and, as many people do not recognise the potential risks of their alcohol use on their health and do not seek care (Clark *et al.*, 2008), alcohol screening and interventions should extend wider than specialist alcohol services (Mulia *et al.*, 2011). Nurses may be integral to the success of screening individuals for problem drinking, as they often spend the greatest amount of time in direct patient contact (Vadlamudi *et al.*, 2008).

Despite the importance of assessing the level of alcohol consumption in those accessing healthcare services, there is evidence to suggest that health professionals do not feel confident or competent in addressing problem drinking with their clients. In a study with nurses in primary care, Lock *et al.* (2002) found that alcohol was seen as an emotive topic that was difficult to address and a lack of experience was given as a reason for not prioritising the issue during clinical assessment. As such, the effectiveness of training staff to administer alcohol screening and interventions in primary care and mental health services has been highlighted as an important area of future research (Raistrick, *et al.*, 2006).

Psychological treatments, with some evidence of effectiveness for problem drinking in adults of all ages, include psycho-education, counselling and motivational interviewing (O'Connell *et al.*, 2003). Within this, brief alcohol interventions (BI) have been widely used, primarily within primary care services but also within a range of other settings. BIs are directed at hazardous and harmful drinkers who are not typically seeking help for an alcohol problem but may have been identified by opportunistic screening (Raistrick *et al.*, 2006). They provide counselling and education to enhance motivation to change. BIs focus on a style of conversation to catalyse change, by encouraging

responsibility and self-efficacy to address drinking, whilst providing evidence that personal change is possible (Boland *et al.*, 2008). Where more serious alcohol-related difficulties are identified (such as dependency), screening and BI can facilitate referral to more specialist services (Babor & Higgins-Biddle, 2001). BIs have strong supporting evidence as psychosocial approaches for hazardous or harmful drinking (Raistrick *et al.*, 2006) and there is a wealth of evidence in favour of using BI within primary care with adults of working age to reduce alcohol consumption to safe levels (Kaner *et al.*, 2009; Ballesteros *et al.*, 2004; Bertholet *et al.*, 2005.) Less attention has been paid to the use of BIs with older adults and this remains an under-researched area. However, trials conducted within primary care have shown BIs to be effective in changing the drinking behaviour of older problem drinkers (Fleming *et al.*, 1999; Gottlieb-Hansen *et al.*, 2012) with longer term reductions in alcohol consumption evident (Fleming *et al.*, 1999).

There is however, a scarcity of research on older adults with both mental health difficulties and problem drinking: those thought to be the most vulnerable to developing alcohol-related problems even at low levels of consumption. Little is known about either the prevalence of the problem or the applicability of BI packages to this client group. Following the effectiveness of BI for adults drinking at hazardous and harmful levels within primary care and the growing support for using BI with older adults in primary care settings, the need for further research in using BI in UK mental health services and with the older adult population has been highlighted (Boland *et al.*, 2008). As longevity continues to increase, the salience of the problem of older drinkers with physical and/or mental health problems will likely present an increasing demand on health services (Prigerson *et al.*, 2001). Health professionals in all settings should be assessing for the role of alcohol in the presentation of older people with physical, psychological and social difficulties (O'Connell *et al.*, 2003). Alcohol use and problem

drinking have the potential to be more harmful to older adults, particularly in conjunction with physical or mental health difficulties (Blow & Barry, 2000) due to the age-related changes, an increased incidence of health conditions and medication use. As BI is aimed at this lower level but potentially harmful drinking in non-treatment seeking people and aims to raise awareness of potential or actual alcohol-related difficulties (Raistrick *et al.*, 2006), screening and BI may provide an effective way of uncovering and addressing hazardous drinking within older adult mental health services. However, this remains an under-researched area and the feasibility and applicability of using alcohol screening and opportunistic BI in this setting is yet to be explored.

Research Aims

The aims of the current research were:

1. To estimate the prevalence of drinking at any level in a mental health service for older adults.
2. To develop a package of a BI for Community Psychiatric Nurses to use in working with their older adult clients identified to be drinking at hazardous or harmful levels, following a brief training session.
3. To pilot using an alcohol screening questionnaire and brief alcohol intervention package within the routine clinical practice of older adult CPNs and to explore feasibility and CPN experiences of using the intervention package, addressing:
 - a. Facilitators and barriers to using the BI package with this client group.
 - b. Confidence and competence to work with older adult patients who drink alcohol at hazardous or harmful levels

- c. Acceptability of the brief alcohol intervention package
- 4. To trial the use of simple pre-treatment and follow-up measures of drinking levels with older adult patients who report hazardous or harmful levels of alcohol use.

Method

Research Design

The research was a feasibility study, combining a quantitative self-report questionnaire design with qualitative analysis of semi-structured interviews, using thematic analysis. Thematic analysis was selected due to its transparent and rigorous methodological structure, as outlined in Braun & Clarke (2006). As thematic analysis is not bound to a pre-existing theoretical framework, this approach provided the greatest flexibility, ensuring data could be captured into a rich and detailed, yet complex account. The theoretical freedom allowed the study to be firmly grounded within the data. Although thematic analysis provided a method for identifying, analysing and reporting themes within the data, it also allowed interpretations to be made from various aspects of the research topic (Boyatzis, 1998).

Participants

The study comprised two groups of participants: Older Adult Community Psychiatric Nurses (CPNs) and patients accessing Older Adult Mental Health Services.

Staff Group Participants

CPNs were eligible to participate if they were employed in the mental health teams in which the research was being conducted and were willing to trial the Alcohol Use

Disorders Identification Test (AUDIT, Saunders *et al.*, 1993) and the brief alcohol intervention (BI) with patients on their caseload. CPNs also had to be willing to complete an individual interview and have the agreement of their team leader to participate during work hours.

Client Group Participants

Older adult patients (aged 60 years or older) were invited to participate if they had a routine appointment with a participating CPN during the trial period. Patients were eligible to participate in the BI stage of the study where a score above the cut-off for ‘hazardous’ (use of alcohol that is likely to lead to harmful consequences) or ‘harmful’ (a pattern of alcohol use which is directly causing damage to physical or psychological health) drinking (scores between 7 and 19) were reached on the AUDIT (Raistrick *et al.*, 2006.)

Patients were excluded from participating at either stage where a profound cognitive impairment or mental health difficulty precluded them from giving informed consent or if they were known to be using illicit substances in addition to alcohol. Patients were excluded from the BI phase if they were identified as drinking within ‘safe’ levels or at a ‘dependent’ level (scores above 20 on the AUDIT), due to BI targeting less severe levels of drinking.

Client Group Measures and Materials

Demographics

Demographic information was collected via patient self-report (Appendix F). Patients were asked about their age, gender, ethnicity, employment and marital status, to allow the characteristics of the sample to be described.

Alcohol Screening

Alcohol consumption was measured using the Alcohol Use Disorders Identification Test (AUDIT, Saunders *et al.* 1993), (Appendix G). It has been widely used within healthcare settings to identify individuals who may benefit from intervention to reduce their consumption and avoid harmful consequences of their drinking (Babor *et al.* 2001). Ten questions ask about recent alcohol use, dependence symptoms and alcohol-related problems. Some questions may be skipped if respondents report abstaining from alcohol or drinking infrequently (Babor *et al.*, 2001). Items are rated on a five-point Likert scale from ‘Never’ (scored 0) to ‘More than 4 times per week’ (scored 4). Scores for each item are summed to produce a scale total. Total scores of 8 and above are considered indicators of ‘hazardous’ or ‘harmful’ alcohol use (8 – 15 medium level of alcohol use, 16+ high levels of problems, 20+ warrants further evaluation for alcohol dependence). A cut-off point of 7 is suggested (Babor *et al.*, 2001) for older adults aged 65+, due to the differing effects of alcohol, increasing the sensitivity of the measure for this population. The AUDIT has been shown to perform well at detecting hazardous older adult drinkers, with 67% sensitivity and 95% specificity (Góómez *et al.*, 2006); a similar level to that found in younger populations.

Measures of Alcohol Use

Patients engaged in the BI stage were asked to complete the following self-reported drinking outcomes:

- Drinks per Drinking Day (Appendix H): number of drinks (units of alcohol) per drinking day and % of days abstinent.
- Drink Diaries (Appendix I): monitoring the type of drink consumed, number of drinks and number of units per day.

CPN Measures and Materials

Brief Intervention Booklet (Appendix I):

A brief psychosocial intervention booklet, '*How to help you change your drinking*,' was developed by the researcher, based on guidance from the National Treatment Agency for Substance Misuse (Raistrick *et al.*, 2006) and materials used with adult populations. Information was adapted and feedback sought from CPNs, to ensure it was relevant to the needs of older adults with mental health difficulties and appropriate for use in clinical practice. BIs (delivered within one session by non-alcohol specialist health professionals) can be effective in reducing alcohol consumption from hazardous/harmful levels to low-risk levels in adult populations (Moyer *et al.*, 2002) primarily by enhancing motivation to address the problem. The intervention in the current study provided a style of engagement, incorporating components of the FRAMES acronym (Miller & Sanchez, 1994): structured and personalised *feedback* on risk and harm; emphasis on personal *responsibility* to change; clear *advice* to make a change in drinking; a *menu* of strategies for changing behaviour; delivered in an *empathic*, non-judgemental way; and an attempt to increase confidence to change behaviour (*self-efficacy*).

The BI booklet included: definitions of alcohol use; risks for older adults of drinking at hazardous or harmful levels and the benefits of reducing alcohol consumption to low risk levels (for physical and mental health); reasons for drinking; information about alcohol units and how to measure consumption; interactions between alcohol and medications; recommended limits for consumption; tips to reduce alcohol intake; and setting goals to change drinking behaviour.

Training Session & Manual

The training session with the participating CPNs covered the importance of asking patients about their alcohol use and the rationale and aims for using alcohol screening and BI. An overview of the Stages of Change Model (Prochaska & DiClemente, 1984) was incorporated and how this may apply to patients. The session covered how to administer the AUDIT and the BI materials, including how to feed AUDIT scores back to patients and how to proceed, dependent on the level of drinking indicated. Time was allocated to going through the BI, to ensure the CPNs understood and felt confident using it. Time was also given to training the CPNs in the procedure for gaining informed consent and ensuring they understood all ethical considerations relevant to trialling the intervention. The importance of confidentiality and the procedure for storing information was also discussed. The training manual provided written information on administering the AUDIT and BI, to which the CPNs could refer back.

Interviews with CPNs

A research interview schedule (Appendix J) was used as a guide during the interviews. The schedule contained open-ended questions to explore the CPNs' attitudes and experiences of using alcohol screening and BI and their views about implementation.

Staff Attitudes to Working with Alcohol Use

The Short Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ, Cartwright, 1980) (Appendix K) is a 10-item questionnaire used to measure professionals' attitudes about providing care to those with alcohol use disorders. Each of the 10 items are scored between 1 (strongly disagree) and 7 (strongly agree). Items are paired and summed to give five measures of role adequacy, role legitimacy, motivation, task specific self-esteem and work satisfaction. CPNs were asked to

complete the questions in relation to working with older adults who drink at hazardous or harmful levels.

Procedure

Stage 1: Development of the BI

The BI package was developed by the researcher, with CPNs' suggestions incorporated, as described previously.

Stage 2: Recruitment of CPN Participants

The researcher and collaborating Clinical Psychologist contacted Team Leaders of the approached teams to discuss the study and obtain agreement for staff to participate. Where agreement was given, the researcher attended a team meeting to explain the research to the CPNs. Participant Information Sheets (PIS) (Appendix L) were sent via email to the team leader and forwarded to CPNs a minimum of 24 hours before the meeting. During the meetings, CPNs were asked to express an interest in participating and to either provide written consent (Appendix M) at the time or to contact the researcher if they decided to participate following the meeting. In these latter instances, the researcher met with CPNs to obtain written consent prior to the training session.

Stage 3: Trialling the AUDIT and BI

Three training sessions were run by the researcher (one at each team base) and lasted 45-60 minutes, as described previously.

A flowchart depicting the pathway for patient participants is shown in Figure 2. Over the 8-week recruitment period, all patients seen by a participating CPN, who met inclusion criteria, were invited to participate in the study. Potential participants were

identified by the CPN, based on their caseload during the trial period and those who had a scheduled appointment. Where a patient met the inclusion criteria, the CPN sent the Participant Information Sheet (PIS) about the research to their home address a minimum of 24 hours before their appointment, as stipulated by the NHS Research Ethics Committee. During the appointment, the CPN went through the PIS (Appendix N) with the patient and after time to understand the information, asked them to provide written consent (Appendix O) to participate. Those who did not consent had no further involvement. Where individuals were seen regularly by a CPN, the PIS was often discussed in one appointment and consent gained in the subsequent visit.

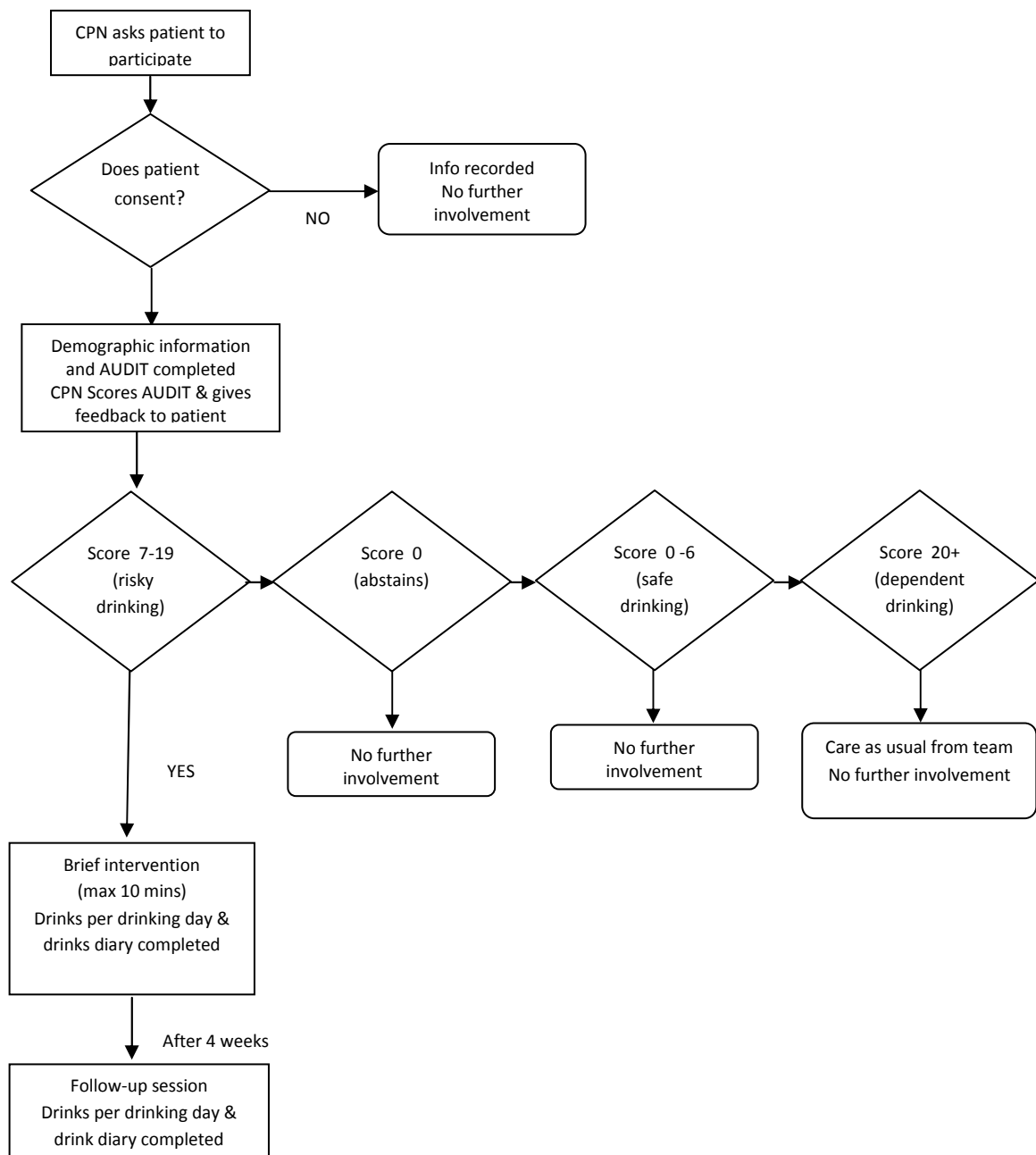
Those who consented to take part were asked to complete the Demographic Information Sheet and the screening questionnaire (AUDIT) about their recent alcohol use. The CPN administered the AUDIT questions verbally and scored them immediately, before providing feedback to the patient:

Abstainers & Safe Drinkers (Scores of 0 – 6): feedback was given that their drinking remained within safe limits and the individual was encouraged to keep their drinking at this level.

Hazardous & Harmful Drinkers (Scores of 7 – 19): feedback was given about their level of drinking and the BI was then delivered opportunistically in the same session.

Dependent Drinkers (scores of 20 and above): individuals identified as possible dependent drinkers received care as usual from the assessing CPN, as per the service procedures and risk management policy, with referral to specialist services where necessary.

Figure 2. Procedure for patient participants



Delivering the Brief Intervention

The CPN asked the patient to complete the measure of Drinks per Drinking Day, before the BI package was used with the patient, taking a maximum of 10 – 15 minutes. Patients were then asked to complete a Drinks Diary and to continue this at home until the follow-up appointment. The CPN arranged a review appointment for 4 weeks after

the initial session, at which the Drinks per Drinking Day was repeated and the Drinks Diary reviewed.

The researcher remained in contact with participating CPNs throughout the recruitment and trial period. This was done by email and telephone and the researcher visited each team base either on a weekly basis or at an agreed time to meet with CPNs, to keep updated on the progress of the research and to support any difficulties or concerns.

Stage 4: Feedback and Evaluation

The researcher conducted individual semi-structured interviews with each CPN who participated in piloting the BI package. Interviews lasted 30 – 45 minutes and were audio recorded. At the beginning of the interviews CPNs were asked to complete the SAAPPQ.

Ethical Considerations

Ethical approval was obtained from the local NHS Research Ethics Committee and the host Trust's Research and Development department. Each potential participant (both CPNs and patients) was given a PIS to enable them to give informed consent and had a minimum of 24 hours to consider this. All participants were free to choose not to take part and patients were reassured that their clinical care would not be affected by their decision. Data were linked to the participant's name by an ID number, to ensure it could be removed should they wish to withdraw. It was discussed with CPNs that patients may experience a low level of distress being asked about their alcohol consumption. All CPNs were experienced in discussing sensitive topic areas and in working with emotional distress. As participation took place within their accessing mental health services, if an individual became distressed due to participation in the research, they continued to receive care from the CPN. Where any risks were identified or a level of

distress thought to be of concern, CPNs worked within their service and NHS Trust policies for the management of risk, although the need for this did not arise.

Transcription

Transcription was completed by the researcher and an individual experienced in transcribing for qualitative research. During the transcription process, all identifying details were changed to ensure participant anonymity. A confidentiality statement was signed by the transcriber (Appendix P) and consent for this gained from CPNs.

Data Analysis

Data for the AUDIT was analysed descriptively, to give an indicator of the prevalence of drinking at each level, within the older adult sample. Scores on the SAAPPQ were analysed using descriptive statistics, to provide a measure of CPNs' attitudes toward working with older adult problem drinkers. Descriptive analyses were planned to report the number of patients who completed and returned their Drinks Diary and the Drinks per Drinking Day Scores compared, to give an indication as to whether patients made any changes to their drinking.

Interviews

As stipulated by Braun and Clarke (2006), researchers must ensure they are explicit in their epistemological assumptions (Appendix Q) and how these underpin the methodological decisions within the research and analytic process. Consistent with this, a number of questions were considered prior to the analysis commencing. A rich thematic description of the entire dataset was aimed for, to allow the reader to get a sense of the most predominant and important themes. An inductive thematic analysis was undertaken, with the themes remaining strongly linked to the data. Themes were

identified at a semantic level; within the explicit and surface level of meaning, before progressing with the analytic process from description to interpretation. This method provided a way to theorise the significance of the patterns within the data, their broader meanings and implications. The phases of thematic analysis (Table 2.) as outlined by Braun & Clarke (2006), were adhered to in conducting the analysis.

Quality Issues

Several measures were employed to ensure methodological quality. Reliability of the study was ensured by being transparent and explicit about the methodological and analytical procedures employed, to enable replication. To improve the validity of the results, a proportion of transcripts were read and independently coded by the research supervisor and emerging themes discussed. As a minimum standard, themes were to be present in at least two of the seven interviews, to ensure they were not specific to one person.

<i>Phase</i>	<i>Description of the process</i>
1. Familiarising yourself with the data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table 2. Phases of thematic analysis

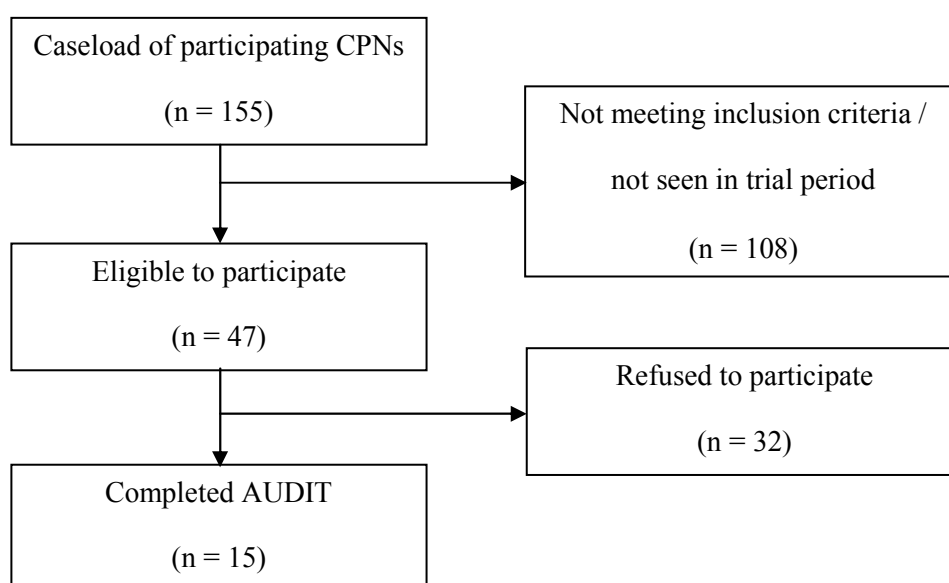
Taken from Braun & Clarke (2006) P87.

Results

Patient Sample Characteristics

A total of 47 patients met the inclusion criteria and were invited to participate in the research (Figure 3). Sixty eight percent declined to participate. The total sample size was 15 older adult participants: 67% female and 93% White British (7% Black Caribbean). The mean age of participants was 77 years (range = 66-88). Within the patient sample, 36% described themselves as married and living with a spouse and 43% were widowed (7% single, 14% divorced). All participants were retired from any paid or voluntary employment.

Figure 3. Patient participant flowchart



Alcohol Use Disorders Identification Test (AUDIT)

Three patient participants (20%) scored 0 on the AUDIT, indicating that they were abstinent from alcohol at the time of assessment. Scores for all 15 participants were below 7, with a mean score of 1.53 (SD 1.13), indicating low risk drinking. Nine

participants (60%) reported drinking monthly or less, with two (13%) reporting drinking 2-4 times per month and one (7%) drinking 2-3 times per week.

Due to the low scores on the AUDIT, none of the patient sample were indicated to be drinking alcohol at hazardous or harmful levels and as such, did not meet criteria to continue to the BI stage and no pre-treatment or follow-up measures of drinking levels were completed.

CPN Sample Characteristics

Nine CPN participants were recruited from 3 teams within one NHS Trust. The sample was 78% female and experience of working as a CPN ranged from 1 to 24 years. None of the CPNs had previous experience of using the AUDIT or BI within their clinical practice. Two CPNs withdrew from the research prior to beginning the 8-week feasibility trial, due to competing clinical commitments.

Short Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ)

Seven CPNs completed the SAAPPQ and questions were asked in respect of working with older adult problem drinkers. The mean scores in all domains (see Table 3.) were indicative of positive attitudes (score > 3.5) toward working with older adult drinkers. The positive scores on all components of the SAAPPQ indicated that the CPNs perceived themselves as having the skills to help older adults to change their drinking (role adequacy) and saw it as part of their role to do so (role legitimacy). They also indicated they had the motivation and self-esteem to work with older adult problem drinkers and expected a high degree of work satisfaction in doing so.

Table 3. Mean (and standard deviation) SAAPPQ Scores (n=7)

<i>SAAPPQ Component</i>	<i>Mean Score</i>	<i>Standard Deviation (SD)</i>
Role Adequacy	10.14	1.07
Role Legitimacy	10.43	1.99
Motivation	10.71	1.60
Task-specific Self-esteem	11.29	1.70
Work Satisfaction	8.71	1.25

Thematic Analysis of CPN interviews

Six themes, each with subthemes were identified across the dataset for all seven CPNs interviewed (Appendix T).

1 - Anxiety about addressing alcohol

Anxiety about addressing alcohol use with older adults was the most prominent and overarching theme that came out of the interview data. The anxiety underpinned several aspects of working with alcohol use and four subthemes were identified: ‘Alcohol as private and sensitive’; ‘dealing with disclosure’; ‘knowledge and confidence’; and ‘ability to influence change.’

Alcohol as private and sensitive

CPN participants spoke of finding it difficult to talk to older adults about their alcohol use, largely because they viewed it to be a private and sensitive topic area. Participants had a reluctance to explore these personal aspects and did not feel they always had the right to ask such personal information, although this appeared to be easier once a therapeutic relationship was established.

'I felt a bit uncomfortable urm .. I think because it was something outside my .. Even though our assessment asks about drinking urm, for some reason I think it's something we don't really like to discuss... I think people look at it as being that's their personal life and they don't always urm you know enquire in to it.' **Helen (L55)**

'A lot of this stuff is difficult to get into because to access that information means someone trusting you enough to be able to open up that relationship with them..... the alcohol issue that can be a private area for a lot of people.' **Brian (L85)**

Many were concerned that asking about alcohol would cause offence to older people and it would appear they were being judgemental. The CPNs spoke of this being a particular concern due to the age of the patients with whom they work, as older adults were thought to more likely feel offended by the question than younger adults. This created a further anxiety about broaching the subject of alcohol, because negative reactions were often anticipated.

'I think the issue is about asking older people. Erm I suppose the fact that you're asking looks like you're saying it's a problem if you tell me you do drink... And obviously with older people you don't want to put them in that position that you're being impertinent, you know.' **Angela (L213, 217)**

'I felt that there were some people that felt insulted....., just that sense of urm talking about drink as if there's this like, I don't know, a stigma as such.' **Jane (L66)**

Within the negative reactions discussed, the CPNs expected older adults would become defensive when asked about alcohol or would simply deny any difficulties.

'I am sure if you got into more and more detail then perhaps they start to get more defensive.' **Brian (L150)**

'There are things like denial, I think denial is going to be your big one, it's like with cigarettes isn't it, it's only a couple a day, and the same with drinking because they don't want to address that. So that's one of the issues.' **Emily (L188)**

However, there was some acknowledgement that this may stem from their own anxieties and in reality, patients may not mind being asked.

'They weren't surprised about being asked about alcohol use, urm, I got the impression overall they felt it was a reasonable thing to be asking urm. I don't know for us I suppose it just seems a bit, a bit difficult, uncomfortable' **Helen (L66)**

Dealing with disclosure

A further anxiety that participants spoke of was a concern about what asking about alcohol may open up for their patients and what they may disclose. CPNs appeared reluctant to ask about alcohol for fear of not knowing what to do with the information and concern they would have to act on what they had been told. This was talked about as something that could negatively impact on therapeutic rapport.

'Well if somebody was saying that they were drinking obviously quite a lot of alcohol and they were obviously on anti depressants and all these sort of things. I would need to take that information further and discuss it with other people. That might cause difficulties with our therapeutic relationship with the client and that sort of thing.' **Emily (L105)**

'I suppose with the driving in particular, if you've asked about alcohol intake and they say yes we go to the pub every lunchtime, have a few pints and then we drive home again, then obviously it, it can lead to other risk factors...and what do I do with that information.' **Angela (L254)**

Knowledge and confidence

Knowledge and confidence were talked of as being closely linked, with feeling knowledgeable underpinning confidence. A lack of knowledge about alcohol again linked back to anxiety; with a lack of confidence in knowing how to proceed and deal with disclosure, or CPNs not having a good enough knowledge themselves to advise patients.

'Some people may feel a lack of confidence, if they don't work with alcohol or what if they ask this, what if they ask that and I think that's about that person's individual lack of knowledge maybe around alcohol and causes' **Jane (L345)**

'Well they should be fairly confident but there probably are some clinicians who don't necessarily know an awful lot about it themselves. It does assume that knowledge doesn't it, which may or may not be present.' **Brian (L428)**

Ability to influence change

Participants appeared to feel that changing older adult drinking behaviour would be difficult and there was an anxiety and lack of confidence in their own ability to influence this.

'I am not naïve enough to think I can go in there and say this is what you need to do, having been in nursing a long time I know that's not going to happen. And I think you are, there are going to be difficulties there is no doubt about that.' **Emily (L181)**

'But maybe equally you also know that there's something that's just not going to work and that's not being pre-judgemental I think it's from experience that you just know.' **Mary (L312)**

The difficulties of changing behaviour were discussed within the context of mental health and the reasons older adults may be drinking. Alcohol was seen as serving a purpose for older people and CPNs appeared to feel it would be harder to change in their patients than younger populations, primarily due to drinking behaviours being more longstanding in later life. Assumptions were also made that older people would not wish to make any changes.

If you have got somebody who has been drinking a long, long time they are not going to want to change that, because they obviously get things from that. But that doesn't mean to say you don't try. **Emily (L183)**

'And I think some people use it as a coping mechanism and it's difficult to get them to replace it with something else sometimes.' **Helen (L40)**

Despite this, there was a sense of optimism for some that they would try to work with their patients in this way.

'If [alcohol is] having a negative effect and it's making you tired or erm... If you can look at the negative effects of it, and if people want to change, then they just need that little bit of help to switch to something else or keep the routine of going to the pub but having something else to drink.' **Angela (L399)**

2 - Generational attitudes

In all interviews the CPNs spoke of the attitudes and understanding they felt their patients had of alcohol and its associated risks, with many reporting they did not think older people saw alcohol as potentially problematic. Alcohol was thought to be something older people saw as being beneficial or good for them. This seemed specific to the older generation and these longstanding attitudes compounded the CPNs' lack of

confidence that older people would be willing or able to change their drinking behaviour.

'I think there is a lot of this urm you know a glass of wine or whatever it was they say keeps you well and that, I think they probably hold on to a lot of those old sayings....Because I guess the way it was looked at when they were younger... I guess they continue to think that.' **Helen (L111)**

'Alcohol is seen as having a sherry to celebrate....good for your nerves, it's medicine.' **Steve (L165)**

The CPNs generally talked about older people having little understanding of the risks alcohol may pose to their physical and mental health, with alcohol units and safe limits being poorly understood.

'They wouldn't have any idea, you can tell they have no idea about units and safe drinking and so on. There is a big gap actually in the older person group as to what they know about alcohol and its effects and urm what they ought to know.' **Brian (L271)**

'I'm still not sure how much the message gets through.....that how much they drink might impact on their general well being and health or even their mental health.' **Mary (L211)**

Due to this lack of knowledge, the CPNs felt that when asked about their alcohol consumption, older adults were likely to either underestimate the amount they drink...

'Either people pride themselves on just not drinking at all or yes they drink and everything becomes approximated, ah one or two, one or two tots of whisky, which you know is going to be more than one or two tots.' **Brian (L269)**

...or under report how much they consumed.

'I think you have to dig a bit more because the first thing they'll say, oh just maybe once a week I'll have a drink at home, oh and then I go out on a Friday, oh and then we always have... So it builds up but you sort of keep going and is that all [the alcohol] you have...' **Angela (L123)**

3 - Is it our responsibility?

A theme that was identified across the interviews was whether the CPNs felt it their responsibility to address alcohol use with their patients. The role alcohol played in the lives of many of their older adult patients was recognised and the potential difficulties of alcohol in later life and in the context of mental health difficulties were acknowledged.

'It is a problem we encounter working with older persons and many older persons do drink.' **Steve (L6)**

'I think when you look at possible you know mental health problems that err sort of chronic drinking can cause, the evidence is massive you know...and with depression as well alcohol is an anti-depressant obviously so yeah there are a lot of issues.' **Helen (L90)**

Asking about alcohol was seen as part of their role as mental health professionals and within their responsibility.

'It's got to fit in with it anyway because if you are looking at somebody's mental health, alcohol intake is going to be affecting that... You can't say no I am not, that's not me, I am not going to be looking at that bit because it's part of your assessment process and

part of how that person is presenting. So you can't not look at it, is what I am saying.'

Emily (L327)

'It's everyone's responsibility really. Urm and working in mental health we know really that alcohol is often abused.' **Helen (L205)**

However, they commonly reported that alcohol was not explored during their assessments and there was a discrepancy between their recognition of the need to address it and their current practice. This was discussed as being an area of their clinical work that could be improved on.

'It's certainly something that we don't urm, address or talk about with older persons urm.' **Emily (159)**

'Again I think that would be a good idea, because it's not something that's done routinely at the minute. But we keep going on about it and we all know about how significant a factor it really is....we have only really touched the tip of the iceberg.'

Brian (L192)

Despite feeling it was their responsibility to ask about alcohol, the CPNs were divided as to whether they felt it their responsibility to address alcohol-related difficulties when they were identified. Some talked about referring to other services and it seemed that once a need was identified, intervening may not be part of their role but something separate. However, this again may relate to the CPNs feeling they did not have the skills or knowledge to undertake a level of intervention themselves.

'If we really felt that something like this should be used or urm they might need extra help, to be honest I think we probably would refer them to other services. Urm because I think it would be sort of quite ...quite a separate thing in a way to what we do. So we

would assess but ..I am not sure how much our intervention would be about alcohol to be honest.’ **Helen (L384)**

Some participants did feel that offering some minimal intervention could become part of their role and this could fit with the work they do with some patients.

‘There will be certainly for some that if it’s not been done anywhere else then someone’s got to do it somewhere.’ **Angela (L380)**

‘And I know you can’t ignore issues that are within our reach of managing, so I think with this I would be comfortable on my case load with that level of intervention’ **Jane (L404)**

Personal beliefs

The CPNs’ own attitudes towards alcohol appeared to influence whether or not they saw it as important to ask about. Their own beliefs, personal drinking behaviours and views of ‘normal’ drinking in part impacted on their judgements of their patients’ drinking and whether or not they felt it their responsibility to intervene.

‘I suppose it’s just your own culture and your own... It’s like the Margo and Jerry of the Good Life, you know, that was just the way people would always come home from work and have a gin and tonic, that was the social norm.’ **Angela (L144)**

‘I am not saying you know ignore people who have clearly got a drinking problem but just what we consider to be normal amounts of drinking... also the amount of stress that everyone knows that nurses are under as well I think sometimes we drink more than we probably should (laughs), so I think all those things affect us not wanting to [address it]...’ **Helen (L236)**

There was also a sense that drinking needed to be extreme before it was viewed as problematic or something they felt a responsibility to address.

'I think the concern would be if someone's a dangerous drinker drinking at dangerous levels urm and posing a risk to themselves or other people perhaps that's the time to refer on to specialist services and to go and explore other avenues really' **Steve (L303)**

'You're not really interested unless people have significant memory problems or its sort of recent drinking you're not really, it's not what we're looking for' **Mary (L94)**

4 - Implementation

Across the interviews, participants spoke about whether they saw screening and brief intervention as something that could be integrated into their clinical work. All CPNs talked of expecting barriers and obstacles to doing this, but offered possible ways to move toward implementation.

Barriers

Barriers were perceived at three levels of the system: an organisational and managerial level, the CPNs' own work pressures and the complexity of the client group. Service level changes were discussed as being needed, although difficulties within this were anticipated.

'Well it might be difficult because it's like everything in the NHS, the problem is everything goes up and down a chain urm, we are very much at the grass roots level so by the time things get to us its gone through lots of different layers. Something like this is a very good idea I think, but quite how you then get it implemented and off the ground is really a different matter.' **Brian (L365)**

This notion of bureaucratic barriers was particularly evident where changes to assessment documentation would be required.

'You would find yourself (laughs lightly) having to wade through the bureaucracy just to get any kind of change to the assessment documentation...but getting that change is going to be very difficult.' **Brian (L369)**

Under pressure

Across the dataset, the CPNs spoke about their workload and feeling 'under pressure.' Concerns were raised that implementing alcohol screening would be seen as just another thing they were being asked to do within an already heavy workload and this may be met with negative attitudes and resistance among team members.

'I guess you would get a bit of resistance, people saying it's going to add a lot of time on etc. I think people don't like change do they.... I think people are likely to say they have got enough to do as it is' **Helen (L186)**

'I think there could be some barriers about people feel they have got enough to do already. I think that could be an issue.' **Emily (L471)**

Complex client group

Participants spoke about the complexity of the older adult client group and difficulties they felt would arise in successfully addressing alcohol use with them. All CPNs spoke of cognitive impairment making intervention difficult. In addition, it seemed that patients were often seen in a crisis, making a thorough assessment difficult and CPN involvement was often at the time of a patient being acutely unwell.

'So you are battling against memory problems...that can get in the way of the effectiveness and the consistency I think of the treatment.' **Jane (L312)**

'I suppose a lot would depend on how unwell they were because if you're seeing people that are quite unwell, they haven't really got the concentration.' **Angela (L278)**

Ways forward

Although perceived difficulties were evident, participants also spoke optimistically about ways to overcome these and facilitate implementation. Many of the subthemes appeared to link with overcoming the anxieties CPNs felt and increasing their confidence to ask about and address alcohol use.

Increasing awareness

Increasing the awareness and understanding of CPNs emerged as a key part of successful implementation across the interviews, primarily as to why alcohol should be addressed with older adults. Training and health promotion were discussed as being key ways to do this.

'If you were going to be introducing something like this you would have to promote it, so somebody you know talking to us about urm .. you know well the effects of alcohol and things like that. But why we are targeting this particular age group as well.' **Helen (L247)**

'For it to work you need to do some training on the awareness, because that's obviously, that flagged it up for me... We had done this and therefore you have got the confidence then to go and use that.' **Emily (L341)**

Having a support system was also talked about as being important if implementing alcohol work into their practice. The need for peer support was discussed, as was the need for additional support from someone with more specialist knowledge, should questions or difficulties arise.

'As long as you had the ongoing ...support, somebody to be able to discuss things with if you have got some issues that came up... that would be really important....and certainly I guess somebody from the alcohol team would be useful.' **Emily (L412, 427)**

A clear pathway

There was concern that if the AUDIT and BI did not form part of the core assessment, clinicians would overlook them or choose not to do it, perhaps in the interest of saving time or because it was not something they felt confident to do. As such, the need for a clear pathway was talked about, for CPNs to be clear what they were being asked to do and for resources to be easily available.

'I think it would have to be on the actual [assessment] form. Because there's so many questions we have to ask that really if it's not on there it'll get missed off or just a clinician will think well it's, that's just an add-on, that's a bolt-on that I will use at my discretion.' **Angela (L161)**

5 - Evaluation of tools

Throughout the interviews, participants spoke about the alcohol screening questionnaire and the BI materials used as part of the current research.

Screening

Highlights problems

The AUDIT was talked about in terms of helping the CPNs to highlight a potential problem or where alcohol may be exacerbating someone's mental health difficulties. Asking about alcohol in this way seemed to open up a difficult conversation and having a 'tool' to do this encouraged confidence to talk to about alcohol. It seemed that having some additional questions would generally be welcomed.

'In certain peoples' cases it will highlight they have got a problem when they didn't think they did, and I think they are the ones we can really perhaps target and help.'

Brian (L199)

'I think, because what happened was it did raise discussion and talking about drinking.'

Emily (L47)

Routine Vs. selective

This subtheme refers to how the CPNs felt the AUDIT could be used within their clinical practice. There seemed to be a differing opinion amongst the CPNs as to how to screen for alcohol use and perhaps what the real function of the AUDIT would be. Some spoke positively about using it routinely and felt this would be of benefit within an assessment phase.

'I think it would be handy having a few more extended questions maybe within the assessment that we do, not just 'do you drink alcohol yes or no' kind of thing' **Jane (L393)**

'I personally think it would be good to introduce it or incorporate it as part of the assessment.' **Brian (L204)**

Others spoke of using the AUDIT on a more selective basis and perhaps only where concerns about alcohol were identified by other means, such as if *'there were lots of empty bottles about'* (Mary), or family members raised concerns. In this sense, some CPNs felt the AUDIT would add additional information where alcohol use was already known about, rather than as a way to identify potentially harmful drinking.

'I think if they were drinking more and above the recommended daily guidelines and it was having a discernible effect on their mental health or wellbeing it would be useful to actually have the survey to do a more formal rigorous assessment in terms of what their habits actually were so yeah I think I think as an adjunct it would be helpful....it's there on the shelf if you require it.' **Steve (L128)**

Brief Intervention (BI)

Educational

The BI booklet was generally spoken of positively by the CPNs and they spoke about the information being educational and of benefit for their patients; helping to increase the awareness and knowledge of older people about the potential risks of alcohol use to their health.

'People weren't aware how much a unit was and said oh that's interesting, so it raised that discussion about drinking and effects and things. And led on to whether you realised that if you did, this could affect your medication. So it added that sort of dimension to it, sort of an educational thing, which was quite a nice thing to do.' **Emily (L49)**

'It tells them everything really up to date that they need to know.... the way it's written is quite easy to understand, it's like sort of user friendly, it doesn't sort of panic people or frighten people.' **Helen (L141, 159)**

Choose when to use

Although positive about the BI, participants spoke about needing to be selective about who to use it with and it appeared that several factors may be involved in making this decision. Participants spoke of needing a good therapeutic relationship with their patient before introducing something of this nature, as well as the timing of intervention being important. This perhaps also stemmed from an anxiety in the CPNs about how this information may be received and not wanting to appear judgemental.

'I would choose my time with it I think timing's everything and I think it's often not what you say but how you say it uh....I think again it depends on the relationship you have with the person.' **Steve (L224)**

Additional resource in toolkit

Participants talked about the BI booklet as being a good additional resource for them to draw on when needed. It appeared that there was little of this nature available for CPNs to use and they generally spoke positively about the information it provided and the benefits it would have for their own clinical work. Many spoke of being willing to use the BI in their future practice.

'I mean it's useful to have something of that nature as a practitioner, to be able to do something practical rather than thinking well I'm a failure I don't know what to do, I've got a problem I don't know what to do with it.' **Steve (L184)**

'I think that's good to have in your tool kit, I think it's quite good to have something you can pull out...' Mary (L150)

6 - Barriers to research with older adults

Participants spoke of their experiences of taking part in the research and their initial interest and enthusiasm.

'I liked the idea of it and I thought all along it was a good idea to try and have a go at something like this because there is very little, to my knowledge, there is very little in the way of this type of work being done.' **Brian (L7)**

Despite this, all CPNs spoke of difficulties they experienced in recruiting older adults and these were primarily related to the complex nature of the client group. Several factors were discussed across the interviews as impacting on a person's suitability or willingness to participate. The most common and significant barrier to recruitment was the limited number of people the CPNs felt had the capacity to give consent.

'That's what made the number of people eligible for me to send out the information to, that was the biggest factor because we get referred so many organic clients as opposed to so many functional clients.' **Angela (L67)**

Once CPNs had identified patients as being suitable to participate, they frequently found that older adults declined to take part.

'People would just decline as well, urm I think some people you know who have got depression and things like that; I think because of motivation they just didn't want to.'
Helen (L9)

Many CPNs described their patients to be suspicious and wary of the research and this was seen as an uncertainty about being asked to participate, rather than a reluctance to talk about alcohol.

'When I went out to talk to people about it there were issues about who was going to be looking at it, urm, and that was quite a big one..., so that was quite an issue.' **Emily (L19)**

'I think it's, you know, that category of people, people of the older generation if you like, or older persons, generally are quite suspicious of paperwork, form filling, or signing.' **Brian (L59)**

The results from both the trial of the brief alcohol intervention (BI) and the themes identified within the interview data indicated that implementing alcohol screening and BI into mental health services for older adults was not feasible. In addition, due to the small sample of older adults recruited to the research, it was not possible for Aim 1 of the study to be addressed and the prevalence of drinking within older adults accessing the service to be estimated.

Discussion

The current study aimed to explore the feasibility of using alcohol screening and brief alcohol intervention (BI) within mental health services for older people. A BI booklet was developed for the older adult population, before seven CPNs piloted using the AUDIT and BI with their patients. Several challenges in undertaking research with older adults were highlighted and within the small sample of fifteen patients who consented to participate, no 'hazardous' or 'harmful' drinkers were identified to continue further than the screening stage to complete the brief intervention. Further exploration of the CPNs' experiences and attitudes toward asking about alcohol consumption was undertaken through qualitative interviews, exploring potential barriers and / or facilitators for alcohol screening and BI implementation. An inductive thematic analysis identified six themes within the data. The overarching theme was an anxiety about addressing alcohol use with older people, often because of anticipating negative reactions to being asked about drinking alcohol. CPNs also spoke of the little knowledge older people had about alcohol and differences emerged as to whether they felt it their responsibility to address this. In contrast to the interview responses, results of the SAAPPQ indicated that CPNs held positive attitudes toward working with older adult drinkers. As several barriers to implementation were identified both during the trial period and within the interview data, the results of the current study indicated that using alcohol screening and BI within mental health services for older people was not feasible.

Discussion of the Results

The results of the current study are discussed in relation to existing literature and the contribution the research makes to the evidence base.

Within the small patient sample, no hazardous or harmful drinkers were identified. In deciding who to approach to participate, the CPNs appeared to ‘pre-screen’ their patients for capacity to consent and level of illness. Based on this, each CPN only identified a small percentage of their caseload they felt were suitable to approach. The CPNs may not have felt confident in their clinical judgement about capacity and so were more likely to be cautious and rule a patient out if they were uncertain. Although capacity was reported by the CPNs to be the biggest barrier to recruitment, they also appeared to base their decision to approach a patient on other factors, such as their therapeutic relationship or the anticipated response of the older person to being asked to take part. They may also have been more likely to approach those who they suspected did not drink alcohol, to avoid expected defensive responses. The research also had a high refusal rate, with older people being suspicious and wary about participating. High refusal rates have also been found in alcohol BI studies with older adults in primary care (Gordon *et al.*, 2003). These difficulties in the research process and the recruitment of older adults to participate in the current research may have been a contributory factor in not identifying older adults drinking at hazardous or harmful levels.

Despite SAAPPQ scores to the contrary, anxiety about discussing alcohol with older people and a lack of confidence to do this was the predominant, overarching theme identified within the interviews. All seven CPNs spoke of finding alcohol a particularly difficult topic to raise with older people. This anxiety and reluctance to ask patients about alcohol presented a potential barrier to implementation and has been highlighted elsewhere, particularly among GPs (Nilsen *et al.*, 2008; Johnson *et al.*, 2010). The major theme of anxiety supports previous findings, with concern about appearing impertinent to patients being evident throughout the current interviews. The CPNs appeared to feel a heightened anxiety about talking about alcohol with older adults, a

generation they described as reluctant to share personal information. Despite CPNs anticipating negative reactions from patients, there is evidence to suggest such anxieties are not founded, with patients often expecting to be asked about their alcohol use by health professionals (Johnson *et al.*, 2010) and in favour of screening and being offered guidance (Miller *et al.*, 2006). Similar responses were experienced by some CPNs in the current study when they asked older people about their drinking, perhaps challenging any ageist attitudes they may have held.

The questionnaire (SAAPPQ) scores indicated that the CPNs felt they had the skills, motivation and confidence to help older adults change their drinking, although this was in contrast to the interview themes. This discrepancy may have resulted from differences in how the questions were asked, thereby affecting the way the CPNs responded, with the format of the SAAPPQ encouraging them to respond with more ‘professional’ answers. CPNs may not have recognised their own uncertainty about addressing alcohol until this was discussed in the interviews and this therefore provided a more honest and in-depth account of their attitudes and experiences.

Anxiety was closely linked with knowledge about alcohol and its associated risks. It appeared that the CPNs who were more confident to ask about alcohol were those who described having a working knowledge of alcohol units and safe limits. The lack of knowledge about alcohol, frequently reported by CPNs, may reflect the complexities of defining levels of drinking. Problem drinking is often ‘ill-defined, multifaceted and surrounded by arbitrary notions such as social drinking and safe limits’ (Kaner *et al.*, 2006) making it difficult for health professionals to establish the boundaries between ‘safe’ or ‘unsafe’ drinking. In part due to this, health professionals are also likely to disagree about the point at which drinking becomes a problem (Nilsen, 2008) and this was evident in the interviews.

The CPNs spoke about their own attitudes toward alcohol use and this impacted on the likelihood of them discussing alcohol with their patients. This again adds evidence to previous findings in which GPs saw problem drinking as being something that differed from or exceeded their own alcohol use (Kaner *et al.*, 2006). This was described as ‘bench-marking’. The CPNs in the current research were more likely to see alcohol as harmful and worthy of attention when it was at more extreme levels and they often defined the benchmark as ‘dependent’ drinking or with obvious effects on physical or mental health. Low levels of drinking, which may be much like the clinician’s own, are likely to be overlooked without adequate knowledge and appropriate screening methods. This highlights the need for clinicians to be aware of the differential effects of alcohol on older and younger people and to assess drinking against agreed standards, such as the AUDIT.

The CPNs in the current study felt their older adult patients had little understanding about alcohol and were unaware of the potential risks to their health. Older people were seen as having less understanding than younger people about alcohol and held on to ‘old-fashioned’ beliefs about its benefits. The CPNs particularly reported older people to have little knowledge of alcohol units and recommended limits, a finding confirmed elsewhere in the literature (Dar, 2006). This lack of knowledge, given the concomitant risk of increasing age and mental health difficulties highlights the importance of screening for alcohol use, to identify possible risks and increase alcohol awareness among patients and their carers. This would allow older people to make informed choices about whether to reduce their drinking to safer levels within a supportive environment.

Behaviour change in older people was seen by the CPNs as challenging and they felt little confidence in being able to help patients to reduce their alcohol consumption. This

presented another potential barrier to implementation and the uncertainty appeared to be compounded in the older adult group, with the age of patients bringing unique challenges. Drinking was described as something individuals had done all their lives, leading to a view of entrenched behaviours that would be more difficult to change than in younger people. Again, ageist attitudes were evident as CPNs assumed patients would not wish to change their drinking behaviour. Alcohol was described as providing older people with something they found beneficial and CPNs were reluctant to interfere with this. The evidence however, shows that older adults drinking at hazardous and harmful levels are able to reduce their alcohol intake and can engage well with BI (Fleming et al., 1999; Gottlieb-Hansen *et al.*, 2012).

The findings of the current research, therefore, indicated that implementation of alcohol screening and BI into mental health services for older people was not feasible and many reasons for this were evident. A number of barriers to identifying older adults drinking at hazardous or harmful levels were found within the research process, such that the CPNs felt only a small percentage of their caseloads were suitable to approach to participate and many older people declined to take part. In addition, the themes identified within the interview data pointed to several barriers to discussing alcohol use with older adults, primarily because alcohol was seen as a sensitive issue for older people and CPNs were anxious they would receive negative reactions should they ask about alcohol use. The CPNs also appeared to lack confidence in being able to help older people to change their drinking behaviour.

Clinical Implications

The barriers to implementation identified within the current research would need to be overcome for BI to be successfully introduced to mental health services for older

people. The primary clinical implication is that clinicians working with older people need to feel confident in their abilities to ask about alcohol use with patients. Nilsen (2008) described motivation to address alcohol issues as a key factor in successful implementation of BI and viewed this as resulting from an interaction between characteristics of the health professional (personal beliefs and drinking behaviours), the relationship they have with their patients and the setting in which this occurs.

Providing training to CPNs working within older adult mental health services will be a key part of making implementation feasible, to raise awareness of the potential impact of alcohol. As a higher percentage of people drink at 'hazardous' or 'harmful' levels than at 'dependent' levels in later life (Atkinson, 2002), it will be important to emphasise to CPNs that BI is most effective with this lower level but potentially harmful drinking in non-treatment seeking people (Raistrick *et al.*, 2006). As alcohol difficulties will not be the primary presenting problem and may not always be obvious, educating CPNs about the role they can play, the purpose of offering routine screening and the benefits (for physical and mental health) of using BI opportunistically will be important to change their ageist attitudes and improve their motivation to work with drinking behaviours. Nehlin *et al.* (2012) found that a 3-hour training session was sufficient to improve knowledge and therapeutic attitudes toward working with problem drinkers among mental health professionals. However, education will not be sufficient without CPNs acquiring the skills and confidence to use screening and BI within their clinical practice. As such, it is essential that ongoing specialist alcohol advice and support are available to older adult teams starting to incorporate alcohol work into their practice. It is unlikely that training alone would lead to cultural changes within organisations so that alcohol use in older people is seen as something important for health professionals to ask about and address, as the current research highlighted the

need for CPNs to have a specialist to ask questions and refer difficulties when they arise. Being able to seek this additional advice when needed is also likely to reduce anxieties about having to act on information disclosed.

The current research indicated that a brief intervention, developed for use with older people, was acceptable to CPNs, who in turn felt it would be beneficial to older adults. The clear pathway and having the tools in their therapeutic ‘toolkit’ appeared to ease their anxieties. Health professionals therefore need to feel they have factual information and practical materials to hand before they are willing to tackle alcohol-related issues.

It has been speculated that being asked about alcohol and knowing drinking behaviour is being monitored by a health professional, may provoke an individual to contemplate their alcohol consumption and reduce their alcohol intake (Nilsen *et al.*, 2008), highlighting the potential benefits of simply opening up the conversation about alcohol with older adults. As CPNs often see patients regularly and conduct holistic assessments, incorporating alcohol screening may provide an opportunity for these conversations to be held with older people. For this to be successful however, alcohol screening must be seen as a priority for mental health professionals and organisational barriers must be overcome. Several organisational barriers were evident in the current study, with service managers being reluctant to free up CPNs to participate and bureaucratic changes expected to be difficult. Without support at all levels of the organisation, changes in CPNs’ attitudes and practice are unlikely to happen, particularly within services for older adults, where ageist attitudes may be inherent.

Limitations and Future Research

Whilst the current sample of CPNs was sufficient for a feasibility study of this nature, the small sample is acknowledged. The CPNs were recruited from three teams within a

county-wide mental health service, which increases the applicability of the findings beyond one team and their specific way of working. All CPNs who participated did so on a voluntary basis and the results of this study are dependent on a small self-selected sample of CPNs. It is possible that these participating CPNs were particularly motivated to work with alcohol issues and may not be representative of all health professionals working with older people. This needs to be held in mind when considering whether implementation of screening and BI can be feasible, as others may hold more ageist attitudes and may be less motivated to change their clinical practice to incorporate what they perceive as a sensitive issue for older adults.

Various challenges of undertaking research within the setting of older adult mental health services were experienced, with the primary limitation being the small sample of older adults and the limited experiences the CPNs gained in using alcohol screening and BI. Difficulties with recruitment and obtaining consent were a particular challenge and perhaps reflected the complexities of research with this client group, something noted in other studies with older people (Hall *et al.*, 2009). In addition, it may be that those drinking at hazardous or harmful levels disproportionately opted out of participating in the research or were not approached to do so by the CPNs, due to their anxieties and lack of confidence to ask about alcohol use. Due to no hazardous or harmful drinkers being identified among the small patient sample, it was not possible to estimate the prevalence of alcohol use among older adults accessing the service or trial pre-treatment and follow-up measures of drinking levels as intended and this is a limitation of the current study.

Within the literature, research has recently moved away from rigorous RCTS, to evaluating BI with more heterogeneous populations, in the 'real world' (Nilsen, 2008). Kaner (2010) described needing to work in partnership with healthcare professionals to

understand their views clearly and to find mutual ways of embedding BI into practice, whilst Broyles *et al.* (2012) highlighted the importance of engaging health professionals in discussions early on for implementation to be successful. The current research was undertaken within the clinical practice of the CPNs, involving them at the development stage of the BI, to obtain their feedback on the applicability to their clinical work and these are strengths of the research design. The individual interviews provided rich qualitative data and the transparency of the research process, together with the systematic application of thematic analysis methods (Braun & Clarke, 2006) are additional strengths of this study.

At present, much of the BI research has focused on working age adults and primary care services and little implementation research has been conducted within the UK (Boland *et al.*, 2008). The current research, to our knowledge, provides one of the first feasibility studies of using alcohol screening and BI within mental health services for older people. As secondary care services have been identified as potential settings for BI and more research needed to establish feasibility and acceptability (Johnson *et al.*, 2010), the current research adds an important contribution to the evidence base.

However, as many challenges and barriers were encountered during the current study and implementing alcohol screening and BI was not found to be feasible, future research is needed to consider how these can be overcome to translate research into practice. Although no hazardous /harmful older adult drinkers were identified, all CPN participants could identify people with whom they work who do consume alcohol and may fall within this category of ‘increased risk’ to health. Future research is needed to investigate the prevalence of problem drinking in a larger sample and establish whether screening and BI can be effectively implemented within mental health services for older people. For this to be done successfully, a study of BI must be conducted from within

the teams, in order to overcome the research barriers. Future research should also assess the applicability of measures of alcohol consumption, such as drink diaries with this client group, to monitor alcohol use and any changes that may occur as a result of BI.

Conclusions

Alcohol screening and brief intervention are a set of clinical strategies for identifying and managing unhealthy alcohol use (Broyles *et al.*, 2012). The results of the current research indicated that routinely screening for alcohol use and offering opportunistic BI to those drinking at hazardous or harmful levels was not feasible within mental health services for older people. No hazardous or harmful drinkers were identified to complete the BI and all CPNs reported anxieties and a lack of confidence to address alcohol use with older people. Several barriers to implementation were identified at an organisational and managerial level, within the CPNs' own work pressures and the complexity of the older adult client group. However, after participating in the research, the CPNs recognised the importance of asking about alcohol consumption and acknowledged this to be an under focused on area of clinical practice. In addition, many saw alcohol screening as part of their clinical role and BI as something they could begin to offer. If BI is to be implemented successfully, training must be available to highlight: the potential impact alcohol may have for older people (physical, social and mental health); the proactive role they can play; and the positive effects of BI on changing drinking behaviour in an older adult client group. Training must also provide CPNs with knowledge and skills, to enable them to feel confident and competent to open up the conversation about alcohol with older people and to offer BI. Ongoing support will be essential for CPNs to feel they can ask questions as they learn, as training alone is unlikely to be sufficient to maintain implementation and organisational change in the longer term.

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Critical Appraisal

Development of Ideas

At the start of this research process I did not have a clear idea of a research area I wanted to investigate but when the area of alcohol use with older people was presented at the Course Research Fair, I was drawn to the idea of carrying out research with the older adult population. I was struck by the small amount of research there was in this area, particularly with the ageing population and the recent growth in interest both within the literature and the media. The many directions in which this research could be taken excited me, and I was keen to see how the research could be developed.

Planning the Research

Following an initial meeting with my research supervisor, during which many ideas for a research area were brainstormed, I was pleased to hear a Clinical Psychologist in the Mental Health Services for Older People was also keen to develop a project within the service. I was aware of the need to develop a project that would incorporate my own interests but also be something that was useful for the services in which it would be undertaken and something that would be feasible and achievable within the time constraints of the doctoral thesis. Initially the focus was on investigating the effectiveness of a brief alcohol intervention with older people with mental health difficulties, but after familiarising myself with the research literature, it became evident that there were large gaps within this field and considering effectiveness may be jumping a step too far. As discussions progressed with my supervisors, we realised that little was known about the drinking behaviours of older people accessing the mental health services and this was not readily addressed by clinical staff. It also became clear that the brief intervention literature focused on adults of working age, with much of the

information aimed at younger people, who we felt were perhaps a different type of drinker. Reading around the literature I became aware of the potentially different nature of alcohol use in older people, with the majority drinking at home alone and often to help them cope with the many life events experienced in later life. This really captured my interest, especially considering the likely interaction between alcohol and mental health difficulties. In addition, developing a brief intervention package suitable for older people and exploring how this and alcohol screening could be used within clinical practice was felt to be of clinical utility for the teams involved and offered something that was not present within the current literature.

Ethics and Approvals

Before submitting an application to the ethics committee and local Trust Research and Development (R&D), I was required to have consent in principle from the service in which I hoped to conduct the research project and a process of gaining approval from the mental health services for older people was embarked on. This was initially met with a number of hurdles as concerns were raised about the time commitment the CPNs would have to make to the research. At this stage, they did not support the research. This obviously felt like a major hurdle early on in the research process, but after some further clarification of what would be required of the CPNs and the potential that participation may enhance their clinical skills, approval to go ahead was granted. However, within the time taken to prepare for ethics submission, the management structure had changed and new committees existed in place of the ones that had given approval. Although re-approval was granted, this led to unexpected delays in being able to begin recruitment and I saw firsthand the complexities of undertaking research within the constraints of the NHS and at a time when services were being restructured.

Once I had received consent in principle from the targeted service, I was able to continue with my applications for ethical approval. The Research Ethics Committee initially requested clarification on some items, most of which were straightforward to provide. In order for a favourable opinion to be granted, the committee required all participants in the study to have a minimum of 24 hours to consider whether they wished to participate. Whilst I acknowledged the importance of this criterion, this also created practical and clinical difficulties, as it was likely that many patients would only be seen once within the trial period and this would not allow the required 24 hours, without additional appointments being arranged. As the initial stage was for patients to complete an alcohol screening questionnaire and we envisaged that this would be the only involvement for the majority of participants, an argument for not allowing 24 hours to consider this and using implicit consent could have been put forward. However, this would then have meant allowing 24 hours for those going on to the Brief Intervention stage to consider whether they wished to do so. Although this would have upheld the ethical procedure, this created a new dilemma, as the strongest evidence for brief alcohol interventions are when carried out opportunistically and directly following feedback to a patient about their score on the screening measure. Allowing time to consider consent at this stage would not have followed the methodology on which the evidence base is built. After much discussion with my supervisors, we decided that sending participant information to patients ahead of their appointment with the CPN would be the best way to proceed and a favourable ethical opinion and R&D approval was granted. I recognise that I learnt a great deal during these stages about the procedures involved and the systemic forces in play within clinical research.

Developing the Brief Intervention

Compiling the information and developing the brief intervention booklet was a part of the research process I particularly enjoyed and I felt it was important to create a resource that would be beneficial and acceptable for older people. I was mindful that the information needed to be accurate and up-to-date, but was also keen to ensure it did not become too lengthy or overwhelming. Receiving feedback and suggestions from both supervisors and the CPNs, who knew their client group so well, was invaluable.

Recruitment of CPNs

The initial stage of recruitment was to recruit CPNs to participate in the study. This meant contacting team leaders, to explain the research to them and see if they would be willing for members of their team to be involved. I was encouraged by the reaction of the team leaders I approached as they were interested in the idea and willing for me to go along to meetings to recruit CPN participants. I received a warm welcome within each of the teams and was struck by how much discussion talking about alcohol generated. This reinforced for me the importance of investigating this area of research. Although initially apprehensive about building links with teams with whom I had no personal or professional relationship, I was encouraged and motivated by their interest in the topic area and felt confident that the research was of real clinical interest. At times these meetings and the subsequent training sessions were difficult to arrange, due to teams only meeting monthly and the clinical commitments of the clinicians. This resulted in the trial periods of the screening and brief intervention being staggered over several months and as such, data collection took longer than I initially anticipated. In hindsight, however, this was beneficial to me as a researcher, as focusing on one or two teams at a time allowed me to keep in close contact with them and allocate more of my

time to visiting team bases. This enabled me to keep up to date with the progress of the research and also support CPNs during their participation. It was during these visits that positive relationships were maintained and some interesting discussions held with the CPNs, about their experiences, the difficulties they were encountering and the potential reasons for these. I also became aware of the complexities of conducting research in teams I was not embedded within and the competing demands the CPNs are faced with in their clinical work. During these conversations, I became aware of the impact of current NHS changes on the teams involved in the research, with CPNs feeling under pressure and with high workloads. During the recruitment period, the services were undergoing a period of management restructure and service redesign and it may be that this contributed to the difficulties in undertaking the research and the perceived barriers to implementing alcohol screening and brief intervention. Throughout the development and undertaking of the research, I was conscious of the importance of not overburdening the CPNs and the need for their clinical work to remain their primary focus. I was grateful to them for their time and commitment to the project.

The training sessions were an enjoyable part of the research process and generated a lot of discussion about alcohol use amongst patients. However, the duration of the session had to be shorter than initially planned, as stipulated within the management approval. As such, there was a lot of information to be covered within this short session. This is something that I and perhaps the CPNs found frustrating at times, as it appeared that a balance had to be struck between allowing enough time to explain the research process and the amount of time spent focusing on the theory and importance of alcohol issues, initial alcohol screening and brief interventions. It felt that much of the discussion had to be cut short and some CPNs commented afterwards that a longer training session would have been beneficial. This is definitely something I would look to revise were I

to design this research again, although this would require managerial support and for addressing alcohol to be seen as a priority within the organisation.

Data Collection

Further challenges were met within the data collection phase, primarily with regard to the recruitment of patients to participate. In designing the research, it was anticipated that CPNs would use the AUDIT with all patients on their caseload during the 8 week trial period, providing they had the capacity to consent and were willing to participate. In reality, recruiting patients became much more difficult than this. The CPNs appeared to 'pre-screen' their patients for suitability to participate and each looked at their own caseload to make clinical judgements about whether someone had the mental capacity to consent to participate. For many, this along with patients being acutely unwell, meant only a small percentage of their caseload were considered as being appropriate to invite to participate. In addition, many patients who were approached, declined to participate and I perhaps did not anticipate just how high the refusal rate would be. Some CPNs felt these factors perhaps reflected the changing nature of the service, with more patients on their caseload having dementia or being referred during a crisis than ever before. I also wondered if there was a level of anxiety amongst the CPNs about having to make the clinical judgement with regard to capacity and so they were more likely to be cautious and rule a patient out where they were uncertain. Having completed the research and in light of the themes that emerged, it seems obvious now that these difficulties would be encountered in research within this setting. However, in part given the little research done in this area, the extent of these difficulties were not anticipated by myself or supervisors during the planning stages of the research.

During the data collection period, I discussed these difficulties with my supervisors and considered whether changes could be made to the methodology to increase the participation rate. I was concerned about the lack of uptake and the very small sample size achieved and was mindful of the requirements and time pressures of meeting the thesis deadline. However, when considering this, it felt important that the real difficulties and complexities of conducting research in the 'real world' with this client group were captured and that these findings were an important part of the feasibility study and as such, the original procedure was adhered to. This also reassured me that the correct decision had been made not to embark on an effectiveness study prior to further exploring and understanding feasibility issues.

Although concerned about what the small sample size may mean for my results, I also felt a level of frustration that CPNs did not have much opportunity to trial using the brief intervention booklet within their clinical practice. Anecdotally, all the CPNs I spoke to during the research, both those who participated and others who did not, talked of current patients who drank alcohol regularly and in ways that they felt impacted on their mental health. However, due to the difficulties already discussed, I was not able to capture this data in any formal way within the research.

Conducting the individual interviews with the CPNs was one of the most enjoyable parts of the research for me and I felt the CPNs gave an honest and thorough account of their experiences, giving real insight into the way they work and the pressures and difficulties they are faced with. Given the difficulties with recruitment, the interviews gave me the opportunity to really explore these and how they felt they could be overcome. In talking with the CPNs, I was surprised and impressed with the protectiveness they felt towards their older adult patients and the strong concerns they had that their patients would respond negatively towards them if they asked about

alcohol. I was also surprised by the level of anxiety talking about alcohol with older people created. Although the CPNs assess for many personal things within their assessments and are trained and experienced in talking about sensitive subjects, alcohol was altogether a sensitive topic that was hard to question their patients about. I was surprised by just how taboo a subject alcohol remains, particularly with the older generation. I feel that my clinical training provided me with the skills needed to carry out rich and detailed interviews, allowing me to actively listen to what the participants were telling me and being sensitive to this in determining the direction the interview should take and the questions to ask. However, I was also very mindful and aware of the differences of conducting research and clinical interviews and was aware that my role in this was one of researcher and not clinician.

Data Analysis

When the analysis process began and I started to immerse myself within the data, it initially felt overwhelming and I was concerned about doing a 'good enough' analysis and getting it 'right.' I was anxious to make sure the themes reflected the data from which they came and the progression from descriptive codes to themes was initially difficult and took some time. Whilst the analysis was at times overwhelming and I found it frustrating to find bits that did not fit or contradicted something else, seeing the thematic map develop into its final form was both rewarding and satisfying. Discussing the emerging themes with my research supervisor was invaluable, both to inform the development of the thematic map, but also to ensure the quality of the analysis. Although completing an inductive thematic analysis, in which meaning was derived from the data and I strived to ensure this was the case, I remained mindful throughout the analytical stages, that no analysis can truly be free from the bias of the researcher. The process of thematic analysis was both an enjoyable and challenging process.

Learning Outcomes

In conducting this research, I feel I have learned a great deal of knowledge, skills and experience about the research process and have enjoyed developing the project from an initial idea through to completion. Although the process has not been without its challenges, I feel that this has given me a realistic view of conducting research within ‘real world’ clinical settings and the careful balance between research demands and clinical commitments that is required in doing this. I have also gained invaluable skills in qualitative research, from undertaking qualitative interviews, the process of transcription and thematic analysis. I feel that this has prepared me well for undertaking research in the future and within my practice as a Clinical Psychologist.

I have learnt how difficult it can be to recruit older people to participate in research and if I was to design the project again, I would look for ways to overcome some of the research barriers encountered. This may be by having a research nurse within the teams to obtain consent from patients, rather than requiring CPNs to do this. I would look to raise the importance of implementing alcohol screening and BI with senior managers and encourage them to trial incorporating routine screening within the work of their clinicians, allowing the research barriers to be overcome and the prevalence of drinking in older people to be established. Additional training and ongoing support for CPNs, perhaps from a research nurse, would be important to address the barriers found in this research; increasing CPNs’ confidence to ask older people about their alcohol consumption and to help them reduce the amount they drink if necessary.

Appendix A: Data Extraction Form

Article Number:	
Title:	
Author (1 st only):	
Publication Date:	Place of publication:
Journal:	
Keywords / Definitions	
Aims:	
Sampling / Participants: <i>(age range, who was studied, recruitment method, response rate)</i>	
Study Type / Design: <i>(randomisation, control groups)</i>	
Outcomes and Measures: <i>(validated measures, time points, self report or clinician rated)</i>	
Intervention: <i>(type and delivery of intervention, control group)</i>	
Analysis: <i>(statistical methods, power calculation, Intention-to-treat)</i>	
Findings:	
Controls/ Validity / Reliability:	
Conclusions: <i>(implications & recommendations)</i>	
Additional Comments:	

Appendix B: Quality Assessment Criteria

 SIGN	<i>Methodology Checklist 2: Controlled Trials</i>	
Study identification		
Section 1: Internal validity		
<i>In a well conducted RCT study...</i>	In this study this criterion is	
The study addresses an appropriate and clearly focused question.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
The assignment of subjects to treatment groups is randomised	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
An adequate concealment method is used	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
Subjects and investigators are kept 'blind' about treatment allocation	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
The treatment and control groups are similar at the start of the trial	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
The only difference between groups is the treatment under investigation	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable

All relevant outcomes are measured in a standard, valid and reliable way	Well covered	Not addressed
	Adequately addressed	Not reported
	Poorly addressed	Not applicable
What percentage of the individuals or clusters recruited into each treatment arm of the study dropped out before the study was completed?		
All the subjects are analysed in the groups to which they were randomly allocated (often referred to as intention to treat analysis)	Well covered	Not addressed
	Adequately addressed	Not reported
	Poorly addressed	Not applicable
Where the study is carried out at more than one site, results are comparable for all sites	Well covered	Not addressed
	Adequately addressed	Not reported
	Poorly addressed	Not applicable
SECTION 2: OVERALL ASSESSMENT OF THE STUDY		
How well was the study done to minimise bias? Code ++, +, or –		
Taking into account clinical considerations, your evaluation of the methodology used, and the statistical power of the study, are you certain that the overall effect is due to the study intervention?		
Are the results of this study directly applicable to the patient group targeted by this guideline?		

Appendix C: Summary Characteristics of the Studies included in the Review

<i>Author (s) and ID</i>	<i>Methodology</i>	<i>Sampling/Participants</i>	<i>Analysis/Measures</i>	<i>Key findings</i>	<i>Reliability/Limitations</i>
1: Gottlieb Hansen et al (2012)	Multicentre RCT 1026 heavy drinkers approached, 75% agreed participation. Treatment: opportunistic BMI < 10 minutes, motivational interviewing (MI), 2 alcohol leaflets, information about local alcohol treatment and a 4-week telephone booster session, lasting < 5 minutes. Control group received the same alcohol leaflets	772 heavy drinkers. 51% male, 50-65 yrs, median age 59yrs. Average baseline consumption: Men – 32 drinks per week, women – 21 drinks per week 391 allocated to BMI 381 allocated to control	Power analysis: 100 Ppts in each group gives 80% power to detect a significant difference with $p=0.05$. Screening tools: questions asking consumption each day & AUDIT questions 3-10. Outcome measures at 6 & 12 month follow-up: self-reported drinking and consumption, using an internet based questionnaire 87% of those enrolled had follow-up data at 6mths, 80% had follow-up data at 12 mths.	No sig differences between groups for baseline characteristics The difference in number of drinks per week favoured the intervention but no sig difference (95%CI: -2.15 to 0.23) No sig difference between BMI and simple information on alcohol intake or alcohol related problems. From baseline to 6 & 12 mth follow-up consumption declined sig in both the intervention and control group by approx 7 drinks per week.	No pure control group due to ethical consideration: received a minimal intervention. Randomised allocation to treatment and control groups (sealed envelope method) Blinding was not feasible for clinicians or Ppts. Study did not exclude dependent drinkers, who do not always respond well to brief interventions. Intention to treat analysis
2: Moore et al (2010)	Multicentre RCT Random assignment to intervention (310) or control group (321) Control group: general health advice booklet Intervention: each Ppt given a personalised report and drink diary at baseline visit (15-20mins). Reports outlined alcohol related risks. Oral and written advice given using alcohol education booklet. Follow up phone calls at 2, 4, 8 weeks with additional feedback and counselling using MI techniques.	Alcohol screening completed via telephone (Comorbidity Alcohol Risk Evaluation Tool, CARET) 631Ppts (55 yrs +) identified and enrolled through primary care providers; Age: 55-89 yrs. 71% male Average baseline consumption: >14 drinks in past 7 days, >1/3 drank more than 4 drinks in a day.	Power calculations: 250 Ppts per group to give 80% power to detect an effect size of 0.2 with alpha level of 0.05 Measures completed at baseline, 3 and 23 mth follow-up Alcohol consumption: CARET, 7-day alcohol time-line follow back (TLFB) Outcomes: % of Ppts meeting at-risk criteria on CARET, number of risks identified on CARET, number of drinks consumed per week (TLFB) and heavy drinking in past 7 days.	Intention to treat analysis: 555 (88%) completed 3mth follow-up. 521 (83%) completed 12mth follow-up % of at risk drinkers, amount of drinking and heavy drinking declined in both groups from baseline to 3mth follow-up and was sustained at 12mth. Between group difference of 1.3 drinks observed at 12 mths may not be clinically meaningful. Amount of drinking reduced by 30-40% in both groups At 3mths, fewer Ppts in BI group were at risk drinkers, and reported less heavy drinking,	Randomised allocation using a sealed opaque envelope method using a computer generated set of random numbers, stratified by age and gender. Differential attrition rate between the groups No pure control group, all Ppts received some information on low risk drinking limits
3: Lin, Karno & Tang	Multicentre RCT	Alcohol screening completed	Secondary analyses of data	19.7% completed 0 follow up calls, 30%	Largely male sample, affects

et al (2010) <i>Secondary analyses of data from Moore et al (2010)</i>	Random assignment to intervention (310) or control group (321) Control group: general health advice booklet Intervention: As outlined in Moore et al (2010) Health educator phone calls: each Ppt in intervention group received 3 follow up phone calls at 2, 4 and 8 weeks to review and discuss risks associated with drinking, using MI techniques. Intentions to reduce alcohol use explored and Ppts encouraged to develop a drinking agreement – reviewed in subsequent telephone calls. Calls lasted 20 – 40 mins.	via telephone (Comorbidity Alcohol Risk Evaluation Tool, CARET) 310 Ppts (55 yrs +) randomly assigned to the intervention group Intervention related variables: number of health educator phone calls completed (0-3), a dichotomous variable (no calls vs at least one call) and 3 categories of calls (0 calls, 1-2 calls, 3 calls).	from RCT. Frequencies & percentages used to describe risk outcomes at 3 and 12 months. Mixed-effects logistic regression: to study the association of completing health educator calls with achieving not at-risk outcome at 3 and 12 months. Average age of sample: 68.7 yrs, 76.7% male.	completed 1 or 2 calls, 50.3% completed all 3 calls. Risk outcomes: 212 Ppts had risk scores for both 3 and 12 month follow up. 74.5% had the same risk outcome at both time points (77 remained not at risk, 81 remained at risk for both periods). Completing at least 1 follow up call was associated with not at-risk outcomes at 3 mths but not 12 mths. Completing all 3 calls increased the odds of achieving not at-risk outcome at 3 mths by more than 5 times compared to completing no calls – magnitude of effect not seen at 12 months.	generalisability of results to more diverse groups. Health educator calls were one component of a larger intervention. Impact of the telephone calls may be influenced by other parts of the intervention. Follow-up data at 3 and 12 months not available for all 310 Ppts.
4: Lin, Karno & Barry et al (2010) <i>Secondary analyses of data from Moore et al (2010)</i>	Multicentre RCT Random assignment to intervention (310) or control group (321) Control group: general health advice booklet Intervention: As outlined in Moore et al. (2010)	RCT sample as described in Moore et al. (2010) Sample for secondary analyses: Ppts randomised to intervention group who completed the first health educator telephone call 2 weeks after enrolment (239 Ppts).	Secondary analyses of data from RCT. Sample divided into 2 groups: 38.9% who reduced drinking by first phone call, 61.1% who had not reduced drinking. Outcomes: reductions in the number of alcoholic drinks consumed Average age of sample: 68.7 yrs, 72.4% male.	At first telephone call, 93 Ppts (38.9%) had reduced drinking from baseline report. Older at-risk drinkers who had already reduced drinking by the first follow up call were more concerned about their risk status and more likely to have read through the educational booklet than those who did not reduce drinking.	Largely male sample – affects generalisability of results. Not all Ppts completed the first follow up telephone call: may introduce bias if differences between groups present. Information regarding reductions in drinking relied on self-report, possible bias and over-estimates of alcohol reduction.
5: Schonfield et al (2010)	Multicentre quasi-experimental Ppts recruited from 4 sites Brief Intervention: 1-5 sessions. Used a health promotion workbook inc: identification of future goals, education about older adults and alcohol, medication interactions, consequences of	3497 older Ppts screened, mean age 75 yrs. 69% were female. Of the 3497, 9.7% were referred because of alcohol problems. 68.8% were current drinkers and 18.2% consumed more than 3	Quantity and frequency of alcohol use measured using AUDIT questions 1-3 and Short Michigan Alcoholism Screening Test – Geriatric Version (SMAST-G)	Descriptive statistics for sample characteristics and repeated measures ANOVA to investigate changes following intervention. Of those referred for alcohol problems, 80% screened positive on the SMAST-G.	Screening was useful in identifying 'hidden' cases.

	drinking. Counsellors used MI to elicit change. Brief treatment: 16 session relapse prevention; cognitive behavioural and self-management. Ppts followed up at 30 and 90 days post discharge.	drinks per day.			
6: Lee et al (2009) <i>Secondary analyses of data from Oslin et al (2006)</i>	A site-specific secondary data analysis from a larger multi-site RCT. Intervention: as outlined in Oslin et al (2006)	34 at-risk drinkers randomised to integrated care or enhanced specialty referral (as described by Oslin et al 2006).	Secondary analyses of data from RCT. Outcomes: changes in the number of drinks per week, number of binge drinking episodes in past 3 months and changes in SMAST-G scores.	Scores on the SMAST-G sig decreased for 102 Ppts who had both screening and discharge scores $p < .001$ and SMAST-G scores differed across time. Means between screening and discharge were sig different but not from discharge to 30 day follow-up.	Small sample size for analyses No control group: comparison of two treatment groups
7: Zanjani et al (2008) <i>Secondary analyses of data from Oslin et al (2006)</i>	Multicentre RCT, random assignment to integrated care or enhanced specialty referral Intervention: as outlined in Oslin et al (2006).	Investigation focuses only on at-risk drinkers: those exceeding recommended drinking limits 258 older at-risk drinkers were examined: 56% identified as problem drinkers on SMAST-G	Secondary analyses of data from RCT. Outcomes: quantity and frequency of alcohol use within 7 days, number of binge drinking episodes within 3 month period and at-risk drinking status	Over time all at-risk drinkers showed a sig. Reduction in drinking. Sig. Reduction in average weekly consumption at 3,6,12 months for both problem and non-problem drinkers Sig. Reduction in drinking at 12 months, 2/3 no longer met at risk drinking criteria	Male only sample limits generalisability of results No control group: comparison of two treatment groups
8: Oslin et al (2006)	Multicentre RCT Random assignment to Integrated care (280) or enhanced specialty referral (280) Integrated Care: standardised intervention of three 20-30min BI sessions, included information on reasons for drinking, reasons to cut down and drinking agreement in a workbook.	Non treatment seeking older adults, all with at risk alcohol use 560 Ppts aged 65 and older, all had primary care appointments at one of the study sites. 92% were male, mean age was 72yrs.	Primary outcomes: quantity and frequency of alcohol use 7 days before each assessment. Number of binge drinking episodes 3 mths before assessment. Outcomes measured at baseline, 3 and 6mths during telephone or face to face interviews.	No sig differences between the groups on demographic variables at baseline. Greater engagement in care in the integrated care (65%) vs enhanced specialty referral (38%) Integrated: 120 Ppts (43%) received at least one brief intervention session. Enhanced: 24 (9%) had the recommended 3 intervention sessions. Drinking measures declined in both	Research staff were not blind as to the Ppts treatment assignment. Research carried out in 9 primary care settings Majority of the sample were male, limiting generalisability of findings to female older adults. Minimal uptake of interventions from Ppts

	Enhanced Specialty Referral: included referral to substance abuse services	At baseline, Ppts drank on average 17.9 drinks per week.			models from baseline to 6mth follow-up. Average quantity reduced by 35% and frequency of binge drinking declined by 45%. But no between group differences in drinking at 6mths. In total 21% reduced their drinking	Large percentage of people refused screening or random assignment for treatment (560 of 23,356 initially screened) just 2.4% Comparison of two treatment groups – no treatment as usual group
9: Fink et al (2005)	Computerised Alcohol Related Problems Survey (CARPS): a validated screening and education program, for older people in primary care. 1 primary care group practice with 3 different sites. Each site randomly assigned to one of two experimental conditions or control: Combined report:: Ppts and physicians received reports of alcohol use and risks, Ppts received individual educational information. Patient report: Ppts received reports but not physicians. Individual educational information received, Control group: usual care	23 physicians and 665 Ppts aged 65+ Patients identified from practice databases, contacted by telephone to assess eligibility: 65+, had consumed at least 1 alcoholic drink in past 3 mths. 1227 patients approached, 711 (58%) agreed, 665 had follow-up data.	Primary outcome measures: reductions in hazardous drinking and maintenance of non-hazardous drinking – measured using CARPs at baseline and 12mths later CARPS: self-administered survey, 10 mins to complete Change in drinking classification at follow-up	Providing personalised reports reduced harmful drinking and increased non-hazardous drinking over 12mths. Those in the patient report intervention reduced harmful drinking 23%. Providing information to physicians is effective in reducing alcohol consumption but no more effective than reports only to patients. 8% of those in usual care became hazardous drinkers over the 12mth period.	Low attrition rate between baseline and follow-up (8%)	
10: Gordon et al (2003)	RCT evaluating 2 types of brief intervention Brief advice (BA): one 10-15min session focusing on feedback to Ppt, implications of drinking and advice to reduce. Motivational Enhancement (ME): longer, more frequent sessions, focusing on feedback, consequences and goal setting. Initial 45-60min session, two 10-15min booster sessions 2 and 6 wks later. Control: Standard Care (SC) Baseline Assessment: alcohol consumption using TLFB	Recruited from a convenience sample, via GP waiting rooms in 12 primary care sites. Older people aged > 65yrs, hazardous drinkers identified as scores >8 on the AUDIT or >16 drinks per week for men and >12 drinks per week for women. 13,438 Ppts surveyed of which 2702 were elderly, aged 66yrs +. 180 (7%) met criteria for	SMART-G, AUDIT used at baseline TLFB used to measure quantity and frequency of drinking at baseline and follow up	No sig differences in demographic variables between the 3 groups at baseline. Each intervention arm showed decreases in alcohol consumption over time. TLFB measures of consumption: improvement for each intervention and SC at 6 and 12mth follow-up: sig decreases over time. Elderly and non-elderly Ppts had similar effects of the brief interventions and SC over time. Elderly: a sig reduction in alcohol use over time but no sig differences between	Comparing elderly and non-elderly Ppts. Elderly were demographically different to non-elderly at baseline. 75% refusal rate from the elderly Ppts. Small sample size and predominantly male older adults, may affect ease of generalising findings to wider samples.	

	All Ppts assessed at 1, 3 and 9 mths by phone and at 6 and 12mths in person	hazardous drinking. 45 (25%) agreed to take part and were randomised: SC 12, BA 15, ME 18. 87% Ppts were male		the two interventions and SC.	
11: Copeland et al (2003)	Randomised Clinical Trial. 1 session brief intervention, based on behavioural self control training (BSCT) and a BI workbook with information on: feedback on drinking, strategies for reduction and alcohol reduction contract. Session provided motivation and skills to encourage change Control condition: general health advice booklet	At risk drinkers, aged 55+ 105 Ppts in control group 100 Ppts in intervention group Average baseline consumption: 21.25 drinks per week	CAGE, SMAST-G used to assess alcohol use and alcohol related problems. Measures of healthcare utilisation: number of inpatient and outpatient appointments	No baseline differences between the groups. The effect of intervention on short term medical outpatient care was significant. At 9 month follow-up Ppts in the intervention group used more medical outpatient services than the control group Brief intervention's educational and motivational components may have increased awareness of health risks in Ppts and encouraged them to seek help.	No information about attrition given. Mainly male sample of veterans – affect generalisability of results to female sample.
12: Fleming et al (1999)	RCT in 24 community based primary care practices. 43 physicians conducted interventions across sites Ppts randomised to BI group (87) or control group (71) Intervention: general health booklet and BI workbook - feedback on health behaviours, reasons for drinking and adverse effects, drinking agreement and drink diary. Two 10-15 minute visits with the physician 1 mth apart (BI session and reinforcement session) Follow-up phone call 2 wks after each visit. 3, 6, 12 mth follow-up via phone for both groups. Control group: general health booklet	6073 initially screened, 656 screened positive and invited to participate in face-to-face interview (396) 158 Ppts were eligible and randomised Ppts aged 65+, attending scheduled appointments with participating physicians. 105 men, 53 women, most were 'young old' aged 65-75yrs. Ppts in both groups consumed on average 16-17 drinks per week at baseline	Initial screening using CAGE Baseline research interview: TLFB used to gather information on 7 day alcohol use. Primary outcome measures: changes in alcohol use, health status measures and use of health care services. Alcohol use: mean number of drinks in past 7 days, number of binge-drinking episodes in past 28 days, excessive drinking in past 7 days: measured by Ppt interview and family member corroboration.	Intervention group: 72 completed both physician visits No sig differences between groups on baseline characteristics. Sig differences emerged within 3 mths of intervention; average weekly alcohol use decreased by 40% in intervention group and only 6% in control group. At 12 mths, intervention group reduced its baseline weekly alcohol consumption by 36% (5 fewer drinks per week). Alcohol use in the control group was less consistent.	Physician Ppts paid a fee of \$250 for participating. Patient Ppts paid a fee of \$70 for participating Blinding: physicians and staff were not told which of their patients were randomised to the control group. Low attrition rate: 92.4% completed 12 mth follow-up

Appendix D: Instructions to Authors

Instructions for Authors

INTRODUCTION

Submission of a paper to *Addiction Research and Theory* will be taken to imply that it represents original work not previously published, that it is not being considered elsewhere for publication, and that if accepted for publication it will not be published elsewhere in the same form, in any language, without the consent of editor and publisher. It is a condition of the acceptance by the editor of a typescript for publication that the publisher automatically acquires the copyright of the typescript throughout the world.

SUBMISSION OF MANUSCRIPTS

All submissions should be made online at the *Addiction Research and Theory's* [Manuscript Central site](#). New users should first create an account. Once a user is logged onto the site, submissions should be made via the Author Centre.

Each paper will be read by at least two referees.

FORMAT OF MANUSCRIPTS

Manuscripts should be typed in double spacing with wide margins. Please upload an anonymous main document and a separate title page with author information.

Title page: This should contain the title of the paper, a short running title, the name and full postal address of each author and an indication of which author will be responsible for correspondence, reprints and proofs. Abbreviations in the title should be avoided.

Abstract: This should not exceed 250 words and should be presented on a separate sheet, summarising the significant coverage and findings.

Key words: Abstracts should be accompanied by up to six key words or phrases that between them characterise the contents of the paper. These will be used for indexing and data retrieval purposes.

TEXT HEADINGS

All headings in the text should be set over to the left-hand margin, and the text should begin on the next line. Type first level (sectional) headings all in capitals. For second and third level headings, only the first letter of the first word should be a capital. Underline third level headings.

For example:

FIRST LEVEL TEXT HEADINGS

Second level text headings

Third level text headings

REFERENCES

Style, statistical reporting, and reference citations should conform to the American Psychological Association's guidelines, from the *APA Publication Manual*, fifth edition.

To conform with the *APA Publication Manual*, fifth edition, references should be alphabetized at the end of the manuscript text, in the following formats:

Kozlowski, L. T., Henningfield, J. E., & Brigham, J. (2001). *Cigarettes, nicotine, and health*. Thousand Oaks, CA: Sage Publications.

Weinstein, N. (2001). Smokers' recognition of their vulnerability to harm. In P. Slovic (Ed.), *Smoking: Risk, perception, & policy* (pp. 81-96). Thousand Oaks, CA: Sage Publications.

Perkins, K. A., Donny, E., & Caggiula, A. R. (1999). Sex differences in nicotine effects and self-administration: review of human and animal evidence. *Nicotine & Tobacco Research*, 1, 301-315.

FIGURES

All figures should be numbered with consecutive Arabic numerals, have descriptive captions and be mentioned in the text. Figures should be kept separate from the text but an approximate position for each should be indicated in the margin. It is the author's responsibility to obtain permission for any reproduction from other sources.

Preparation: Figures must be of a high enough standard for direct reproduction. They should be prepared in black (india) ink on white card or tracing paper, with all the lettering and symbols included. Axes of graphs should be properly labelled and appropriate units given. Photographs intended for halftone reproduction must be high quality glossy originals of maximum contrast. Redrawing or retouching of unsuitable figures will be charged to authors.

Size: Figures should be planned so that they reduce to 10.5cm column width. The preferred width of submitted drawings is 16-21cm, with capital lettering 4mm high, for reduction by one-half. Photographs for halftone reproduction should be approximately twice the desired size.

Captions: A list of figure captions should be typed on a separate sheet and included in the typescript.

TABLES

Tables should be clearly typed with double spacing. Number tables with consecutive arabic numerals and give each a clear descriptive heading. Avoid the use of vertical rules in tables. Table footnotes should be typed below the table, designated by superior lower-case letters.

PROOFS

Authors will receive proofs (including figures) by air mail for correction, which *must* be returned within 48 hours of receipt. Authors' alterations in excess of 10% of the original composition cost will be charged to authors.

Appendix E: Correspondence with Research Ethics Committee


Health Research Authority

NRES Committee East Midlands - Nottingham 2
 The Old Chapel
 Royal Standard Place
 Nottingham
 NG1 6FS
 Telephone: 0115 8839428
 Facsimile: 0115 9123300

29 March 2012

Mrs Rachel Bard
 Trainee Clinical Psychologist
 Leicestershire Partnership NHS Trust
 Doctorate in Clinical Psychology,
 University of Leicester,
 104 Regent Road, Leicester
 LE1 7LT

Dear Mrs Bard

Study Title: Brief Alcohol Intervention in Mental Health Services:
Feasibility for Older Adults

REC reference: 12/EM/0101

The Research Ethics Committee reviewed the above application at the meeting held on 26 March 2012. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
REC application	97191/295776/1/390	21 February 2012
Investigator CV	Rachel Bard	13 February 2012
Investigator CV	Marilyn Margaret Christie	06 February 2012
Participant Consent Form: CPN	2	13 February 2012
Participant Consent Form: Patient	2	13 February 2012
Participant Information Sheet: CPN	2	13 February 2012
Participant Information Sheet: Patient	2	13 February 2012
Questionnaire: Alcohol Use Disorders Identification Test		
Questionnaire: Short Alcohol and Alcohol Problems Perception		
Sample Diary/Patient Card	1	13 February 2012
Sample Diary/Patient Card	1	13 February 2012
Other: Example Brief Alcohol Intervention Manual	1	13 February 2012
Questionnaire: Demographic Information (Patients)	1	13 February 2012
Protocol	4	09 February 2012
Interview Schedules/Topic Guides	1	13 February 2012

A Research Ethics Committee established by the Health Research Authority

Provisional opinion

- You were asked whether there was the possibility that CPNs could feel pressured into being involved in the study as their own managers will be recruiting them. You informed the committee that recruitment would be done this way as you did not want to be making the first contact with participants about this study. You will be attending staff meetings with CPNs who have had the study explained to them by their manager and will find out who is interested in participating. They will have at least 24 hours to decide whether to be involved.
- The committee queried whether CPNs will get the relevant consent taking training if they are expected to take consent. You informed the committee that you will be conducting CPN training sessions and consent taking will be included if necessary however you anticipate that some CPNs will already have consent training.
- It was queried why clients of CPNs do not get 24 hours to decide whether to be involved in the study. You informed the committee that you would like to include all of the screening for the study in one clinical appointment so that multiple appointments do not need to be made. If participants do want longer to decide, this is possible and recruitment can be delayed until the next clinical visit. The committee queried whether it would be feasible for CPNs to send out information via post before the visit. You informed the committee that it could be sent out with the routine clinical appointment letter. You added that you intend on doing the recruitment over eight weeks so clients may only be seen once during that time so sending the information with the clinic letter is a better option than recruiting over two clinic appointments.
- The committee enquired whether it was necessary to ask participants to state ethnicity. You informed the committee that the study is being conducted in [redacted] which has a very diverse ethnicity. You would like to ask ethnicity to find the demographics of the participants they are working with rather than to find any links with alcohol consumption.
- The committee mentioned that the validated World Health Organisation guide to low risk drinking contains many American terms such as 'retarded babies' that participants may find offensive. You stated that this is just a guide you are using to tailor a guide specifically aimed at adults aged 65+. The American terms will be removed.

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Vice Chair.

Further information or clarification required

1. Researchers must ensure that the CPNs taking consent from clients have undergone appropriate training in taking consent for research studies to allow them to undertake this role. The CPN information sheet states they will be asked to attend

a 30 minute training session. If the training session is to include consent taking training it will take longer than 30 minutes. The participant information sheet should be updated to reflect this.

2. Confirmation is required that the clients of GPNs will get 24 hours to decide whether to be involved in the study or not. This can be done either by providing the information for the study at one appointment and taking consent the next time the client attends an appointment or by sending out the study information with the routine clinic appointment letter and consenting at the next appointment.
3. The participant information sheet needs to contain the relevant PALS contact number
4. The participant information sheet needs to state that the study has been reviewed by has been reviewed by the East Midlands – Nottingham 2 Research Ethics Committee
5. The consent form for GPNs should have the section about medical notes being accessed removed as it is not necessary.
6. The committee require a copy of the low risk drinking guide after it has been tailored by the researchers to be specifically aimed at participants aged 65+
7. The demographic information sheet should include an 'Other' tick box for ethnicity section and an 'Other' tick box for the employment section.

If you would find it helpful to discuss any of the matters raised above or seek further clarification you are welcome to contact the committee co-ordinator:

Heather Harrison
0115 8839421
Heather.harrison@notspct.nhs.uk

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 27 July 2012.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

12/EM/0101

Please quote this number on all correspondence

Yours sincerely



Dr Simon Roe
Vice-Chair

Email: heather.harrison@nottscc.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

NRES Committee East Midlands - Nottingham 2

Attendance at Committee meeting on 26 March 2012

Committee Members:

Name	Profession	Present	Absent
Ms Gill Bumpfrey	Clinical Trials Pharmacist	Yes	
Miss Shamim Byrns	Consultant Gynaecologist/Obstetrician	No	
Dr Frances Game	Consultant Physician	Yes	
Dr Martin Hewitt	Consultant Paediatric Oncologist	No	
Mrs Sheila Hodgson	Clinical Trials Pharmacist	Yes	
Mr Asim Latif	Research Pharmacist	Yes	
Mrs Linca Reynolds	Occupational Therapist	Yes	
Dr Simon Roe	Consultant Nephrologist	Yes	
Dr John Shaw	Lay Member	No	
Miss Catherine Shenton	Lay Member	Yes	
Mrs Sally Ann Smith	Retired Audit Manager	Yes	
Mr Glen Swanwick	Lay Member	Yes	
Miss Alison Thorpe	Research Technician / part time PhD	Yes	
Ms Margaret Vince	Translator	Yes	

Also in attendance:

Name	Position (or reason for attending)
Miss Heather Harrison	Committee co-ordinator
Ms Patricia Rastbury	Trust CLRN

Mrs Rachel Bard
Trainee Clinical Psychologist
Doctorate in Clinical Psychology
University of Leicester
104 Regent Road, Leicester
LE1 7LT

13th May 2012

Dr Simon Roe
Vice-Chair
NRES Committee East Midlands – Nottingham 2
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Dear Dr Simon Roe

Study Title: **Brief Alcohol Intervention in Mental Health Services: Feasibility for Older Adults**

REC reference: **12/EM/0101**

Many thanks for your response following my application which was reviewed by the committee on 26 March 2012.

Please find attached the revised documentation (with revised version numbers and dates) with regard to the following changes:

Item 1: The research team will ensure that CPNs taking consent from clients undergo appropriate training in consent for research studies. All CPNs who will be invited to participate in the research are highly experienced clinicians, some of whom are likely to have been involved in previous research. Consent training will be included within the training session that each participating CPN will be asked to attend. Information and guidelines will be provided in written form for each CPN to take away with them. An additional 10 – 15 minutes will be added to the training session duration in order to include consent issues. The attached participant information sheet has been updated to reflect the change of timing for the training session.

Item 2: Prior to their arranged appointment with the CPN, each client will receive information regarding the research study, sent in the post from a member of the clinical team. This will ensure they are informed of the ongoing research study, in which all clients are being asked about their alcohol use, and will allow a minimum of 24 hours for them to read the information before being asked to consent to participate.

When the client attends for their appointment, the CPN will review the information sent in the post, going through the participant information sheet and consent form, prior to asking for consent. All clients will be given time to ask any questions they have before being asked to consent.

Item 3: The participant information sheet for client participants has been amended to include the PALS contact telephone number.

Item 4: The two participant information sheets (for both CPNs and client participants) have been updated to state that the study has been reviewed by the East Midlands – Nottingham 2 Research Ethics Committee.

Item 5: The consent form for CPNs has been amended to remove the section about medical notes being accessed.

Item 6: Developing and tailoring the Brief Alcohol Intervention package (low risk drinking guide) for use with older adults, constitutes the initial phase of the research study. The procedure has been designed in this way to allow the materials to be developed with input from the CPNs recruited to the study, to ensure the information is appropriate and relevant to the older adult clients and the services in which it is aimed. Following this initial stage of the research, a copy of the tailored materials will be made available to the committee.

Item 7: 'Other' boxes have been added to both the ethnicity question and the employment question on the demographic information sheet.

Yours Sincerely

Rachel Bard
Trainee Clinical Psychologist

Enclosures: revised

*Client & CPN Participant Information Sheets (Version 3, 30th April 2012),
Consent form for CPN participants (Version 3, 30th April 2012),
Demographic Information Sheet (Version 2, 30th April 2012).*

NRES Committee East Midlands - Nottingham 2

The Old Chapel
 Royal Standard Place
 Nottingham
 NG1 6FS

Telephone: 0115 3838437
 Facsimile: 0115 3830204

18 May 2012

Mrs Rachel Bard
 Trainee Clinical Psychologist
 Leicestershire Partnership NHS Trust
 Doctorate in Clinical Psychology,
 University of Leicester,
 104 Regent Road, Leicester
 LE1 7LT

Dear Mrs Bard

Study title: Brief Alcohol Intervention in Mental Health Services:
 Feasibility for Older Adults
REC reference: 12/EM/101

Thank you for your letter of 13 May 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
REC application	97191/29577 6/1/200	21 February 2012
Investigator CV	Rachel Bard	13 February 2012
Investigator CV	Marilyn Margaret Christie	06 February 2012

Participant Consent Form: Patient	2	13 February 2012
Questionnaire: Alcohol Use Disorders Identification Test		
Questionnaire: Short Alcohol and Alcohol Problems Perception		
Sample Diary/Patient Card	1	13 February 2012
Sample Diary/Patient Card	1	13 February 2012
Other: Example Brief Alcohol Intervention Motivational Manual	1	13 February 2012
Protocol	4	09 February 2012
Interview Schedules/Topic Guides	1	13 February 2012
Questionnaire: Demographic Information Sheet (Patients)	2	30 April 2012
Participant Consent Form: CPNs	3	30 April 2012
Participant Consent Form: Patients	3	30 April 2012
Participant Consent Form: CPN	3	30 April 2012
Response to Request for Further Information		13 May 2012

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document '*After ethical review – guidance for researchers*' gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/EM/0101	Please quote this number on all correspondence
------------	--

With the Committee's best wishes for the success of this project

Yours sincerely


Dr Simon Roe
Vice Chair

Email: stephen.briggs@nnots.nhs.uk

Enclosures: *After ethical review – guidance for researchers*

Mrs Rachel Bard
Trainee Clinical Psychologist
Doctorate in Clinical Psychology
University of Leicester
104 Regent Road, Leicester
LE1 7LT

Dr Simon Roe
Vice-Chair
NRES Committee East Midlands – Nottingham 2
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Dear Dr Simon Roe

Study Title: **Brief Alcohol Intervention in Mental Health Services: Feasibility for Older Adults**

REC reference: **12/EM/0101**

Following request from the committee, please find enclosed a copy of the Brief Alcohol Intervention booklet, for your information. I am enclosing this as an example of the research materials being used in the above named study. This is in line with the following point from my previous correspondence and according to the committee's requirements.

Item 6: Developing and tailoring the Brief Alcohol Intervention package (low risk drinking guide) for use with older adults, constitutes the initial phase of the research study. The procedure has been designed in this way to allow the materials to be developed with input from the CPNs recruited to the study, to ensure the information is appropriate and relevant to the older adult clients and the services in which it is aimed. Following this initial stage of the research, a copy of the tailored materials will be made available to the committee.

Yours Sincerely

Rachel Bard

Trainee Clinical Psychologist

Enclosures: Brief Alcohol Intervention Booklet

REC Reference 12/EM/0101

Nottingham2 NRESCommittee.EastMidlands- (HEALTH RESEARCH AUTHORITY) [nrescommittee.eastmidlands-nottingham2@nhs.net]

Dear Rachel,

Thank you for submitting your revised Brief Alcohol Intervention package. This has been reviewed and approved by the Vice-Chair of the REC.

Kind regards
Tracy

Please note a hard copy of this document will not be sent out unless specifically requested.

Heather Harrison and Tracy Leesley

East Midlands - Nottingham 2 Coordinator and Assistant Coordinator

Health Research Authority

Research Ethics Committee (REC) Centre

Direct line 0115 8539428 | Fax 0115 8539294

The Old Chapel, Royal Standard Place, Nottingham, NG2 6PS

www.hra.nhs.uk www.nres.nhs.uk

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NHSmail is approved for exchanging patient data and other sensitive information with NHSmail and GPs' recipients

NHSmail provides an email address for your career in the NHS and can be accessed anywhere

.....

Appendix F: Demographic Information Sheet

For each of the following items, please select *one* response that best describes you or fill in the blank as appropriate

1. What is your gender: ☐ Male ☐ Female
2. What is your age: _____
3. Ethnicity: To which of these groups do you consider you belong?
 - White ☐ British
☐ Any other White background (please specify)
 - Mixed ☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other mixed background (please specify)
 - Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background (please specify)
 - Black or Black British
☐ Caribbean
☐ African
☐ Any other Black background
☐ Chinese
☐ Other
4. What is your present marital status?
 - ☐ Married
 - ☐ Co-habiting
 - ☐ Single
 - ☐ Widowed
 - ☐ Divorced
5. How would you describe your employment status?
 - ☐ Employed or self employed: *Please specify* _____
 - ☐ Retired: *Please specify previous occupation* _____
 - ☐ Voluntary work: *Please specify* _____
 - ☐ Not currently employed
 - ☐ Other

Thank you for completing these questions as part of this research

Appendix G: Alcohol Use Disorders Identification Test

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 6 Lower risk, 7 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence



Appendix H: Drinks per Drinking Day

Please tick to indicate:

- ☐ Completed at initial appointment
- ☐ Completed at review appointment

Question	Client Response
How many days a week do you drink?	
On those days, how much do you drink?	

Appendix I: Brief Intervention



How to help you change
your drinking

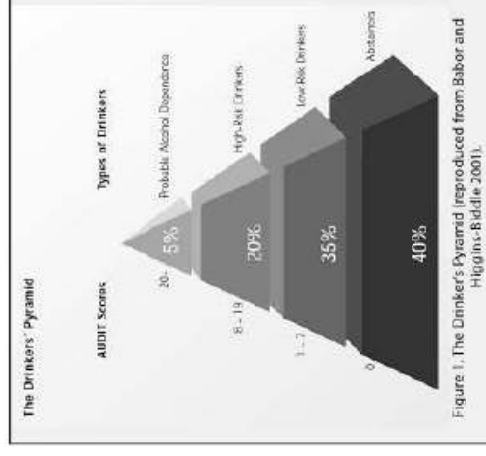


About this booklet

We hope that reading this booklet will help you to think about your drinking and will give you some ideas about how you can make changes to your current drinking pattern. We've included lots of information about alcohol and tools to help you along the way.

What's everyone else like?

The drinker's pyramid describes four types of drinkers and shows the percentage of the whole population that fall into each category.



What is low risk drinking?

Low risk drinking involves making sure you limit your alcohol intake to amounts that are unlikely to put you at risk or cause harm to yourself. Research and evidence suggests that regularly drinking more than the recommended daily amount has its risks.

The risks of drinking can be higher for older people, even when drinking is at a low level. It is important to think about whether the amount you drink might be harmful to your physical or mental health.

There may be times when you will be at risk even after one or two units, for example, if you are taking certain medications or have certain health conditions.

Risky drinking

Regularly drinking more than the recommended daily amount can lead to social, medical or financial difficulty. Below are some effects risky drinking can have:

- Memory loss
- Depression and anxiety
- Frequent colds, reduced resistance to infection
- Aggressive or irrational behaviour
- Liver damage
- Numb or tingling toes
- Painful nerves

There are some risks that are more likely to affect older people who drink, as we become more sensitive to the effects of alcohol with age.

2

As people get older, they:

- Have less body mass and have a higher concentration of alcohol in the blood stream when they drink
- Are more likely to be taking medications which should not be taken with alcohol
- Are more likely to have other health conditions
- Are more likely to experience sleep problems from alcohol use
- Can have an increased risk of injury from falls and accidents
- Have an increased risk of stroke if alcohol is overused.
- Have less efficient liver metabolism
- Are more likely to have increased impairments after drinking

Why do people drink alcohol at risky levels?

Many people enjoy having a drink with friends or with a meal and drinking alcohol can make us feel happy and relaxed. However, some people drink for other reasons and may drink alcohol to help them cope with things that are happening in their lives.

For some older people, this may be to cope with a loss of their health or independence, or the loss of someone close to them. Other people may drink to combat boredom or loneliness. For some, drinking alcohol may be a way to cope with physical health conditions and pain, or low mood, anxiety or depression. Alcohol can also help people to get rid of unwanted thoughts or memories.

Most of us drink because alcohol makes us feel good in the short term, but it's easy to forget the negative long term effects alcohol can have. Drinking at higher levels is likely to lead to further problems, rather than make you feel better.

3

Reasons for my drinking

People drink alcohol for many reasons (see page 3) and often have different patterns of drinking, each of which will have their own reasons. For example, having a drink in the afternoon may be to socialise; having a drink at night may be to help with sleep. You might find it helpful to think about the reasons you drink alcohol. You might want to write them down to remind you.

How alcohol and medication affect each other

Drinking alcohol whilst taking medications can change the effects of the alcohol, the medication or both. This is known as an interaction. Different medications have different interactions with alcohol.

[illegible]

What targets should you aim for?

Men	Women	Risk
No more than 3-4 units per day on a regular basis <i>e.g. 2 pints of beer</i>	No more than 2-3 units per day on a regular basis <i>e.g. 2 small glasses of wine</i>	Lower risk
More than 3-4 units per day on a regular basis	More than 2-3 units per day on a regular basis	Increasing risk
More than 8 units per day on a regular basis <i>e.g. 4 pints of beer</i>	More than 6 units per day on a regular basis <i>e.g. 2/3 bottle of wine</i>	Higher risk

It is recommended that you have at least 2 alcohol free days each week.

Tips to help you cut down

- Keep a record of your drinking – you can use the drinks diary at the back of this booklet
- Reduce the strength of what you drink (e.g. change from whiskey to beer)
- Set yourself drinking rules. i.e. always have 2 drink free days a week
- Have your first drink later in the day
- Take up new hobbies or interests you used to enjoy that don't involve alcohol
- You may want to pursue voluntary activities outside of your home

Tips to help you cut down at home

- Use smaller glasses
- Measure drinks and count what you consume
- Slow down the pace at which you drink. Make each drink last
- Add soft drinks – have less alcohol per drink and more mixer
- Keep less or no alcohol in the house
- Drink alcohol free drinks, i.e. alcohol free beer, juice
- Ask others not to bring so much alcohol to your house. If someone shops for you, ask them to bring you less or no alcohol.
- Keep occupied and plan things to do with your time – this will help you to drink less

Goal for changing my drinking

If you are now thinking of making positive changes using this booklet, that is great. You can discuss your goal for reducing your drinking, with your CPN and you may want to write it in the space below to remind yourself. Remember to look after yourself physically and mentally.

Drinks Diary

Day	Type of drink	Number of drinks	Units	Total units for day
Example	Pint of lower strength lager Single small vodka and coke	1 1	2 1	3
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				
1. Fill out the diary using the basic alcohol units information If you're not sure about the units in a drink, try and choose one that seems close to it rather than miss it out altogether 2. Add up the units for each day and write the total in the last column				TOTAL

Notes:

Some useful numbers:

If you have concerns about your alcohol use and don't feel able to talk about these worries in your appointment, a list of useful numbers to get more support are included below:

Drinkline

The National Alcohol Helpline

0800 917 8282

Drinkline offers free, confidential information and advice on alcohol

Alcohol Advice Centre

Drop in: Mon, Weds & Fri – 9.15am – 12.15pm

Further information about alcohol use can also be found at:

Drinkaware

www.drinkaware.co.uk

Alcohol Concern UK

www.alcoholconcern.org.uk

Alcohol Concern UK offers a range of factsheets on alcohol and mental health. These are available free of charge and can be downloaded from their website.

Appendix J: Interview Schedule

- 1) Experiences of the 8 week trial
 - a. Thank you for participating and trialling the alcohol screening and brief intervention, could you start by telling me how you have found it?
 - i. Can you tell me any obstacles / difficulties you came across?
 - ii. Have you found any positives / benefits?
- 2) Attitudes toward alcohol use in older adult clients
 - a. How did / do you feel asking your clients about their alcohol use?
 - b. How have your clients responded to being asked about their alcohol use?
 - c. What benefits do you see for your clients in discussing their alcohol use with them?
 - d. Do you feel it is important that you ask your clients about their drinking?
 - i. Why / why not?
 - e. In what ways do you feel alcohol use may impact on a client's mental health?
- 3) Brief intervention and further implementation / development
 - a. How did you find the training session?
 - b. How would you feel about using the information booklet with your clients?
 - c. How do you think your clients may respond to the information?
 - d. I'm wondering how clients may change their drinking behaviour, what do you think about this?
- 4) Implementation
 - a. If this was to become routine practice, what do you think would need to be in place?
 - b. What do you think your colleagues would think about doing this as part of your practice?
 - c. How would you feel about routinely screening for alcohol use?
 - d. How do you feel this would fit with the work you do?

Appendix K: Short Alcohol and Alcohol Problems Perception Questionnaire

The questions in this section are designed to explore the attitudes of staff working with people with alcohol use disorders. There are no right or wrong answers. Please indicate the extent to which you agree or disagree with the following statements:

- 1 = Strongly agree
- 2 = Quite strongly agree
- 3 = Agree
- 4 = Neither agree or disagree
- 5 = Disagree
- 6 = Quite strongly disagree
- 7 = Strongly disagree

		Strongly agree	Quite strongly agree	Agree	Neither agree or disagree	Disagree	Quite strongly disagree	Strongly disagree
		1	2	3	4	5	6	7
1	I feel I know enough about causes of drinking problems to carry out my role when working with drinkers							
2	I feel I can appropriately advise my patients about drinking and its effects							
3	I feel I do not have much to be proud of when working with drinkers							
4	All in all I am inclined to feel I am a failure with drinkers							
5	I want to work with drinkers							
6	Pessimism is the most realistic attitude to take towards drinkers							
7	I feel I have the right to ask patients questions about their drinking when necessary							
8	I feel that my patients believe I have the right to ask them questions about drinking when necessary							
9	In general, it is rewarding to work with drinkers							
10	In general I like drinkers							

Thank you for taking the time to complete this survey

Appendix L: Participant Information Sheet (CPNs)

Brief Alcohol Intervention in Mental Health Services: Feasibility for Older Adults

Researcher: Rachel Bard, Trainee Clinical Psychologist, University of Leicester

Contact: E. (XXXX) T. (XXXX)

We are inviting you to take part in a research study. Before you decide whether you would like to, it is important that you understand why the research is being done and what it will involve. Please take time to read through the following information and ask us if there is anything that is not clear, or if you would like more information. You may also wish to discuss it with your line manager, who is aware of the research and has agreed for you to take part within work time.

What is the purpose of the study?

We are looking at ways in which Mental Health Services for Older People can ask clients about their alcohol use and help people to become more informed about the amount they drink and the impact this can have on their health.

In this study, we will trial a way for staff to ask their clients about their alcohol use, as well as a way to give clients more information about the impact that drinking, even at low levels, can have on their physical and mental health. Clients will be asked to fill in a short questionnaire about their drinking and will be given some information related to the amount they drink. We will ask some clients to fill in a drink diary and come back for another appointment after four weeks.

We will then ask the opinions of the staff members about this experience of asking their clients about their drinking. We will interview the staff to find out what they thought of the information they gave to their clients, how they felt about using it and what difficulties they came across. This will help to tell us how Mental Health Services for Older People can continue to help their clients to know more about the risks of drinking alcohol in the future.

Why have I been chosen?

You have been chosen because you are a Community Psychiatric Nurse working within Mental Health Services for Older Adults. We are inviting all CPNs in your team to participate.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study in a team meeting and will go through this Information Sheet. If you agree to take part, we will then ask you to sign a Consent Form. You are free to withdraw at any time, without having to give a reason.

What will happen to me if I take part?

Your service has agreed for any willing staff to take part in this study during work hours.

If you agree to take part, you will be invited to join a short meeting, lasting only 15-30 minutes to give some feedback on a newly developed intervention package for older adults. If you cannot attend the meeting, you will be able to send your comments via email. You will then be

asked to attend a 40 – 45 minute training session, where you will be trained to obtain consent, given the brief intervention materials and a manual for implementing them.

We will ask you to trial using these materials with the clients on your caseload over an 8 week period. You will be asked to gain consent from your client and where they agree, complete the alcohol screening questionnaire with them and give them the feedback on their result. The questionnaire will only take 2-3 minutes to complete and can be scored very quickly and simply. If a client scores between 7 and 19 on the questionnaire, indicating ‘harmful’ or ‘hazardous’ drinking, you will be asked to go through the Brief Intervention materials with them, giving them information about the possible risks of their drinking. This will take no more than 10 minutes within an appointment. You will then be asked to give the client a Drink Diary to complete at home and arrange a review appointment to see them again in 4 weeks time. During this brief review, clients will be asked whether they have made any changes to their drinking. You will only be asked to trial using this Brief Intervention with a maximum of 5 clients.

You will then be asked to participate in an individual interview with the researcher, which will last no more than 45 minutes. Questions will be about your experiences of using the Brief Alcohol Intervention materials and what obstacles you came across in addressing alcohol use with older adult clients. You will be asked to complete a short questionnaire about working with people who drink alcohol during this interview.

Confidentiality

Questionnaires and interview transcripts will be labelled with a numeric code instead of your name and in doing so, all your responses will remain anonymous and confidential.

What are the possible disadvantages and risks of taking part?

No significant risks have been identified in this study.

What are the possible benefits of taking part?

This is an opportunity to potentially influence how alcohol problems are addressed in older adults with mental health problems. You may also benefit by taking part in the training and becoming more informed about alcohol use and how this can affect the health of your clients, as well as finding out more about screening tools and monitoring clients’ alcohol use for future work.

Will my taking part in this study remain confidential?

We will use an audio recorder to record the interviews, so that we can accurately represent what has been said and analyse them later. You will not be identified by name and the recordings will be transcribed and all the comments analysed together to give us a full picture of people’s experiences. A professional transcriber may assist in the transcription of interview data. This person will not be given your name or other information identifying you and they will be required to sign a confidentiality agreement. All information will be stored securely and treated in the strictest of confidence.

Nothing you say in the interviews will be reported back to anyone who was not present at the time, except anonymously in the form of a report of publication about the study. **We may use**

direct quotations of what you said in the interview, but this will always be anonymous and no one will be able to tell that it was you who said it.

How will the findings of the research study be used?

A summary report will be disseminated to the older adult mental health services and results may be presented at healthcare conferences. The study will be written up and submitted as a partial requirement for the Doctorate degree in Clinical Psychology and will be submitted for publication to selected journals in Autumn 2013. A copy of the final report will be available from the researcher in Autumn 2013 if you wish to request it.

Who is funding the research?

The research is being funded by the University of Leicester and is sponsored by XXXX NHS Trust.

Who has reviewed the study?

All research that involves NHS patients or staff or uses NHS premises or facilities must be approved by an NHS Research Ethics Committee before it can go ahead. Thus, this study has been reviewed by the East Midlands – Nottingham 2 Research Ethics Committee. When a research study gets approval, it means that the committee is satisfied that your rights will be respected, that any risks have been kept at a minimum and that you have been given enough information to make an informed decision about taking part.

Further information

If you require any more information about this study now or in the future you may contact the researcher, Rachel Bard, Trainee Clinical Psychologist, University of Leicester (T: XXXX E: XXXX)

Thank you for taking the time to read this and considering taking part in this study

You will be given a copy of this information sheet and a signed consent form to keep

Appendix M: Consent Form (CPNs)

Title of Project:

‘Brief Alcohol Intervention in Mental Health Services: Feasibility for Older Adults’

Name of Researcher: Rachel Bard, Clinical Psychologist Trainee, University of Leicester

Thank you for agreeing to take part in this research project. Please read this consent form, and ask any further questions you would like to about what will be involved.

Please initial box

- | | |
|---|--------------------------|
| 1. I confirm that I have read and understand the information sheet dated 13/2/12 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | ☐ |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. | ☐ |
| 3. I understand that I will be interviewed, and that the interview will be audio recorded, and then transcribed. | ☐ |
| 4. I understand that a professional transcriber may be used to transcribe my interview and that this person will be required to sign a confidentiality agreement. | ☐ |
| 5. I understand that my identity will remain anonymous throughout the study and that if quotations are used from my interview, that my identity and the identities of other people I may mention will also be anonymised. | ☐ |
| 6. I understand that data from the interview will be kept securely at the University of Leicester for a period of five years. | ☐ |
| 7. I understand that my interview will be included as part of a Doctoral thesis, and that results will be published in academic journals and fed back to Participants. | ☐ |

I agree to take part in this study.

Name of Participant

Date

Signature

Name of person taking consent

Date

Signature

Appendix N: Participant Information Sheet (Patients)

Brief Alcohol Intervention in Mental Health Services: Feasibility for Older Adults

Researcher: Rachel Bard, Trainee Clinical Psychologist, University of Leicester

Contact: E. ([XXXX](#)) T. (XXXX)

We are inviting you to take part in a research study being carried out by the University of Leicester and being supported by XXXX NHS Trust. Before you decide whether you would like to, it is important that you understand why the research is being done and what it will involve. Please take time to read through the following information and ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

We are looking at ways in which Mental Health Services for Older People can ask patients about their alcohol use and help people to become more informed about the amount they drink and the impact this can have on their health.

In this study, we will trial a way for staff to ask their patients about their alcohol use, as well as a way to give patients more information about the impact that drinking, even at low levels, can have on their physical and mental health. You will be asked to fill in a short questionnaire about your drinking and will be given some information related to the amount you drink. We will ask some patients to fill in a drink diary and come back for another appointment after four weeks. At most, only about 10 minutes over two appointments will be required.

We will then ask the opinions of the staff members on what they thought of the information they gave to their patients, how they felt about using it and what difficulties they came across. This will help to tell us how Mental Health Services for Older People can continue to help their patients know more about the risks of drinking alcohol in the future.

Why have I been chosen?

You have been chosen because you are a patient accessing the mental health services for older people. We are inviting all patients to participate in the research.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and will go through this Information Sheet with you. If you agree to take part, we will then ask you to sign a Consent Form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive in any way.

What will happen to me if I take part?

All patients who agree to participate will be asked to fill in a short questionnaire about alcohol. This will be given to you during your appointment with your Community Psychiatric Nurse. The questionnaire will only take a few minutes to complete and your CPN will score it

immediately and will talk to you about your score. Even if you do not drink, we are interested in your score.

Depending on your score, your CPN may give you some further information about how alcohol might affect your physical and mental health. Your CPN may also give you some information to take home with you and you may be asked to complete a quick diary each day you have an alcoholic drink. You will then be asked to come back and see the CPN again after 4 weeks and they will make an appointment with you to do this. You will be asked to bring your drink diary with you to this appointment.

Confidentiality

Questionnaires will be labelled with a number instead of your name, keeping all your responses anonymous and confidential.

What are the possible disadvantages and risks of taking part?

The only disadvantage of taking part in this study is that you may have to consider the amount of alcohol you drink and the impact on your health.

What are the possible benefits of taking part?

Taking part may help you to become more informed about alcohol use and how this can affect your health, or the health of others close to you.

What happens when the research study stops?

When the research stops, you will continue to receive your usual care from the mental health team.

What if something goes wrong?

If you have a concern about any aspect of this study, you should ask your CPN to speak to the researchers, who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this using the NHS Complaints Procedure.

If you wish to make a complaint about the study, you can contact the XXXX Patient Information and Liaison Service by writing to PALS, XXXX, or telephoning XXXX.

Will my taking part in this study remain confidential?

All information collected about you during the course of the research will be kept strictly confidential and any information about you which leaves the NHS site, will have your name and address removed so that you cannot be identified or recognised.

If at any time your CPN becomes concerned about your drinking or your mental health, they may inform other members of the mental health team caring for you. You will be told about this if it happens.

How will the findings of the research study be used?

A short report will be disseminated to the Older Adult Mental Health Services. The study will be submitted as a requirement for the Doctorate degree in Clinical Psychology and will be

submitted for publication to selected journals in Autumn 2013. A copy of the final report will be available from the researcher in Autumn 2013 if you wish to receive it.

Who is funding the research?

The research is being funded by the University of Leicester and is sponsored by XXXX NHS Trust.

Who has reviewed the study?

All research that involves NHS patients or staff or uses NHS premises or facilities must be approved by an NHS Research Ethics Committee before it can go ahead.

This study has been reviewed by the East Midlands – Nottingham 2 Research Ethics Committee. When a research study gets approval, it means that the committee is satisfied that your rights will be respected, that any risks have been kept at a minimum and that you have been given enough information to make an informed decision about taking part.

Further information

If you require any more information about this study now or in the future you may contact the researcher, Rachel Bard (T: XXXX E: XXXX).

Thank you for taking the time to read this and considering taking part in this study

You will be given a copy of this information sheet and a signed consent form to keep

Appendix O: Consent Form (Patients)

Title of Project:

‘Brief Alcohol Intervention in Mental Health Services: Feasibility for Older Adults’

Name of Researcher: Rachel Bard, Clinical Psychologist Trainee, University of Leicester

Thank you for agreeing to take part in this research project. Please read this consent form, and ask any further questions you would like to about what will be involved.

Please initial box

1. I confirm that I have read and understand the information sheet dated 13/2/12 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. I understand that this will not affect my medical care. ☐
3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
4. I understand that data collected during the research will be kept securely at the University of Leicester for a period of five years. ☐
5. I would like to receive a short summary of the study when the study is complete: ☐

If yes, I consent to my address being taken for this purpose.

I agree to take part in this study.

Name of Participant

Date

Signature

Name of person taking consent

Date

Signature

Appendix P: Confidentiality Statement for Transcribers

APPENDIX A



School of Psychology – Doctorate in Clinical Psychology

Confidentiality Statement for Transcribers

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.

As a transcriber you have access to material obtained from research participants. In concordance with the BPS ethical guidelines, the Doctorate in Clinical Psychology Research Committee requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

General

- I understand that the material I am transcribing is confidential
- The material transcribed will be discussed with no-one
- The identity of research participants will not be divulged

Transcription Procedure

- Transcription will be conducted in such a way that the confidentiality of the material is maintained
- I will ensure that audio-recordings cannot be overheard and that transcripts, or parts of transcripts, are not read by people without official right of access
- All materials relating to transcription will be returned to the researcher

Signed

Date 24/1/2018

Print Name

Researcher

RACHEL DODD

Project Title

BRIEF ALCOHOL INTERVENTION IN MENTAL HEALTH
SERVICES: FEASIBILITY FOR OLDER ADULTS

Appendix Q: Statement of Epistemological Position

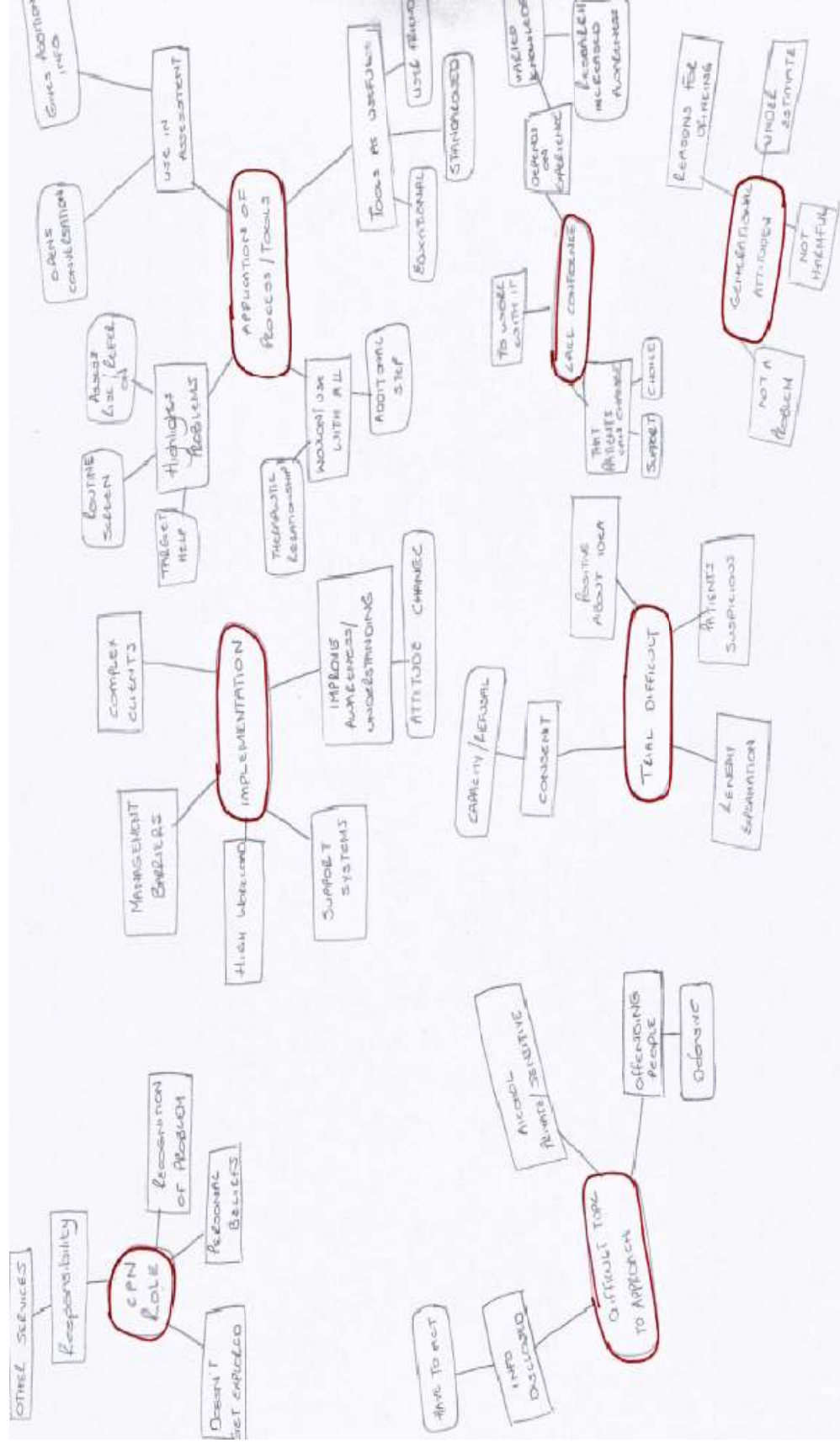
Braun & Clarke (2006) make clear the importance of stating the epistemological underpinnings of any thematic analysis research. Although thematic analysis is not bound to any pre-existing theoretical framework and provides theoretical flexibility, the researcher took an essentialist / realist approach, through which to report the experiences, meanings and reality of the participants. Language reflects meaning and experience and allows these to be articulated.

A semantic level approach was adopted, where themes are identified within the explicit and surface meanings of the data, before the analytic process progresses from a stage of description to one of interpretation. This progression allows the significance of identified patterns and their broader meanings and implications to be considered.

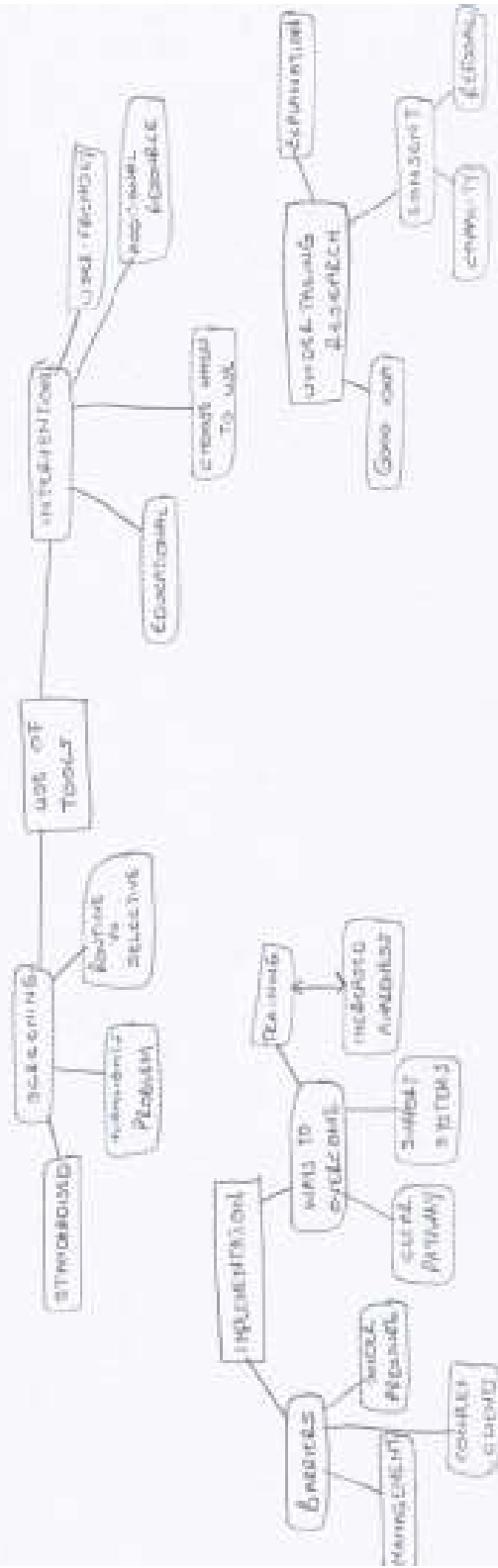
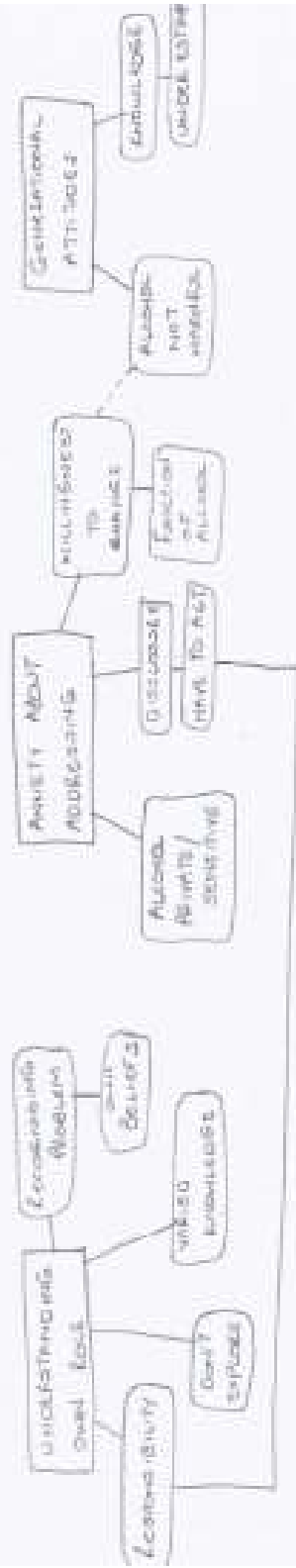
Appendix R: Chronology of Research Process

Summary of research activity	Dates
Research proposal development	March – June 2011
Submission of proposal to University peer review	June 2011
Submission to REC & discussion at REC committee	March 2012
Ethical approval and R&D approval granted (after amendments)	May 2012
Development of BI package	March –June 2012
Recruitment commenced & data collection	July 2012 – January 2013
Interviews with CPNs	November 2012 – January 2013
Transcription and thematic analysis	December 2012 – April 2013
Writing of thesis	November 2012 – April 2013
Submission of thesis	April 2013

Appendix S: Development of Thematic Map



THESE THINGS ARE



Appendix T: Final Thematic Map

