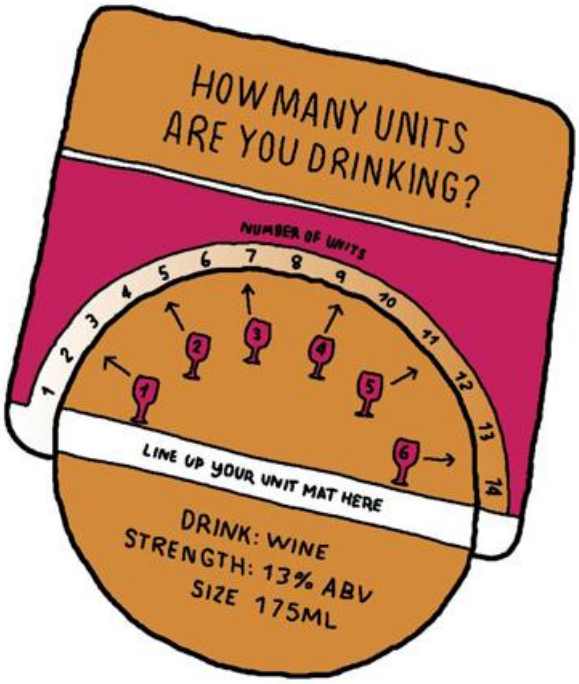
Implementation Report

Implementing ENACT: Evidence-Based Novel Alcohol Communication Materials



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1. Executive Summary

This implementation report was produced as part of a project titled 'Implementing ENACT: Evidence-Based Novel Alcohol Communication Materials', which was funded by an Economic and Social Research Council Impact Acceleration Account (ESRC IAA) impact project grant.

In this project, we co-produced educational alcohol health communication materials to help people understand their alcohol consumption, associated risks and provide tips on helping people reduce their alcohol consumption. The broader aim was to encourage individuals to drink in a more mindful way and reduce harmful levels of consumption. These 'ENACT materials' were designed for non-dependent drinkers who may be at heightened risk of alcohol-related harms. This includes individuals who drink above the UK Chief Medical Officers' (CMO) low risk drinking guidelines, but who fall outside of a clinical referral pathway. The aims of the materials were to improve drinkers' (1) understanding of their own alcohol intake, (2) perceived self-relevance of alcohol-related harms, and (3) self-efficacy to reduce their alcohol consumption.

In addition to developing the ENACT materials, we investigated possible routes for implementing them (the focus of this report). We interviewed ten key stakeholders working in public health to explore the suitability and requirements of different implementation routes and commissioning pathways. Twelve potential implementation routes (GP practices, NHS health checks, pharmacies, social prescribing, secondary care, community outreach clinics, pubs and bars, universities, emergency services, charities, dental practices, and other routes), and four possible commissioning pathways (integrated care board, devolved public health, charity, and alcohol industry funding), were considered.

In this report, we summarise the advantages and disadvantages of each implementation route and consider their potential feasibility and effectiveness. Some routes would require staff involvement (e.g., conversations with patients), whereas other routes would not (e.g., opportunistic collection of the ENACT materials in community settings). Overall, we concluded that GP practices, NHS health checks, and community outreach clinics (such as liver screenings) should be the primary implementation routes, and integrated care board funding and devolved public health funding are the most appropriate commissioning pathways. However, there is no one-size-fits-all approach, and different people will have different preferences on where and how they would like to receive information on alcohol use and health. An implementation model with multiple routes would be the gold standard, and likely to have the greatest population level effectiveness.

2. Background

Alcohol is consumed by the majority of UK adults (Anderson et al., 2013), and is associated with pleasure, recreation and celebration in UK culture (Madden, Morris, Atkin, Gough, & McCambridge, 2020). However, each year, alcohol use contributes to over 1 million hospital admissions and 24,000 deaths in England, placing a substantial economic burden (£3.5 billion) on the NHS (NHS, 2019a; UK Government, 2019). Families, local communities, and other public services are also negatively impacted by excessive alcohol use (Bristol City Council, 2020).

The UK Chief Medical Officers' (CMO) low risk drinking guidelines recommend that people drink no more than 14 units of alcohol per week (Department of Health and Social Care, 2016). This is based on evidence that drinkers who regularly exceed this amount have a 1% or higher lifetime risk of dying from an alcohol-related condition (Department of Health and Social Care, 2016) and are at an increased risk of various diseases, including cancer. Furthermore, this risk increases with the amount consumed (Bagnardi et al., 2015). In England, around 1 in 4 adults exceed these low risk drinking guidelines (NHS digital, 2018), and there is a common misperception that alcohol harms are restricted to heavy or dependent drinkers (Ling et al., 2012). At the population level, most alcohol-related harm is attributable to consumers who exceed the low risk drinking guidelines (but who are not alcohol dependent), rather than the smaller proportion of consumers who are alcohol dependent (Hall, Mooney, Sattar, & Ling, 2019).

Public knowledge of the CMO low risk drinking guidelines, alcohol units, personal level of consumption, and associated health risks is poor (Attwood, Blackwell, & Maynard, 2019; Kerr & Stockwell, 2012; Rosenberg et al., 2018). There are several potential reasons for this. First, there is considerable complexity in understanding the alcohol content of drinks, as alcohol unit content depends on drink type, size, and strength (alcohol by volume; ABV). Second, information is not readily available at the point of sale and consumption. The UK Government's Public Health Responsibility Deal with the alcohol industry aimed to improve public understanding of alcohol content and risk via alcohol product labelling (Blackwell, Drax, Attwood, Munafo, & Maynard, 2018), but this product labelling has been shown to be inadequate (Petticrew et al., 2016). Third, alcohol health campaigns that target specific groups (e.g., pregnant women, people who drink and drive, dependent drinkers) may have led to the erroneous perception that other drinker groups are not at risk. Moreover, our previous research suggests that there may be a disparity between knowledge of harm and perceived own risk; drinkers do not associate their own alcohol consumption to harm even if they acknowledge a *general* risk of alcohol on health (Attwood et al., 2019).

Consumers have a right to be better informed. To address this public knowledge gap and reduce the risk of alcohol-related harm, information-based, educational interventions are needed on alcohol content and alcohol harms, that are easy to understand, personally relevant, and available at the point of consumption. For alcohol health communication materials to be effective, integrated information on units and risks must be interpretable in the context of one's own level of consumption, to allow people to successfully regulate their drinking. As well as informing people of risk, it is important to support behaviour change. Belief in one's inability to change could lead to negative message reactance, whereby they are avoided or undermined, if harm is perceived but a solution does not seem feasible.

3. Aims and Methods

We interviewed ten key stakeholders to explore how the ENACT materials could be implemented (e.g., by whom, when, and where), the requirements for implementation (e.g., needs, priorities, and barriers), and the possible funding infrastructure. Interviewees included a junior doctor, a general practitioner (GP), a GP practice manager, a social prescriber, a social prescribing lead, a local authority senior public health specialist, a government office alcohol specialist, a government office NHS health checks specialist, and a liver outreach clinical nurse specialist. Some interviewees were identified via our own and our project partners' contacts, whereas others were identified by recommendations from other interviewees. We also spoke to a local authority health promotion manager before we designed the interview schedule. This informal meeting did not follow the procedure outlined below, but his insights have also been included in this report.

Interviews took place remotely via Zoom (Zoom Video Communications, 2022) and lasted approximately one hour. The interview questions are provided in the Appendix (Section 8). Interviews were semi-structured and informal; sometimes additional questions were asked, and other questions were removed based on the flow and direction of each individual interview, and knowledge of the interviewee. Interviews were audio recorded for internal purposes (to aid information recall). Audio recordings were summarised in written form, and comments were extracted to inform this report.

We also reviewed the academic literature for qualitative research on practitioner and patient views on giving and receiving alcohol-related health information, respectively. This evidence has been included to support interviewee comments, where applicable.

4. Results and Discussion

4.1. Potential implementation routes

The following potential implementation routes for the ENACT materials were considered:

- GP practices,
- NHS health checks,
- pharmacies,
- social prescribing,
- secondary care,
- community outreach clinics,
- pubs and bars,
- universities,
- emergency services,
- charities,
- dental practices,
- other.

Table 1 summarises the advantages and disadvantages of these potential implementation routes as identified by interviewees, which will also be discussed below.

Table 1. Suitability of potential implementation routes for the ENACT materials as identified by interviewees.

Implementation route	Suitability and advantages	Barriers and disadvantages
GP practices - Registrations - Consultations - Waiting rooms	• General practitioners (GPs) focus on illness prevention and have access to patient information. • An alcohol screen is required at GP practice registration. • Alcohol use is discussed if patients present with an associated complaint (e.g., vascular conditions, gastrointestinal conditions, mental health, diabetes). • GPs have an automated system called EMIS (EMIS Health, 2022) that alerts GPs when alcohol should be discussed (e.g., alcohol use has not been recorded in the last year, or brief advice has not been offered to a problem drinker). • GPs currently do not have anything tangible to offer at-risk drinkers who do not meet the criteria for a clinical referral pathway. • GPs have an established route for directing patients to online materials (Accurx, 2022). • Physical materials can be left in waiting rooms for patients to collect another time if they had a phone consultation. • Physical materials in waiting rooms can prompt patients to think about or discuss alcohol use with their GP even if attendance is related to a different complaint. • Physical materials in waiting rooms can be promoted by reception staff and could lead to a wider reach.	• There is no routine follow up when high alcohol use is reported by a patient at registration. The onus is on the patient to make an appointment. • Patients who make an appointment to discuss their alcohol use tend to be those who have reached problematic levels, so the target audience of non-dependent drinkers may be missed. • GPs have a high workload and limited time to discuss alcohol materials in a consultation if more urgent or serious complaints need to be prioritised. • Alcohol use is not routinely discussed by GPs if an associated complaint is not raised. Therefore, younger patients who are drinking at high-risk levels before the onset of an alcohol-related condition may be missed. • Discussing alcohol use out of context can disrupt the flow of the conversation. • Some GPs worry about being patronising or critical when discussing health behaviour change, and this may interfere with the doctor-patient bond. • Patients might feel overburdened with information. • More senior GPs who rely on their experience, knowledge, and judgment may be less inclined to use tools to deliver advice around alcohol. • Staff resources are needed to ensure that supplies of physical materials are maintained.

		• Storage space for physical materials is limited. • An increase in phone versus face-to-face consultations means it is more difficult to detect if a patient is being dishonest about their alcohol use, and there can be no direct handover of physical materials.
NHS health checks	• NHS health checks focus on illness prevention and staff have access to patient information. • Alcohol consumption should be discussed as standard, and the alcohol use disorders identification test for consumption (AUDIT-C) should be administered. • This is a time and a place where people are thinking about their overall health. • Adults aged 40 to 74 are targeted, which are an at-risk group for developing alcohol-related conditions. • Health checks are delivered by a nurse or healthcare assistant, freeing up GP time.	• Although alcohol health checks are expected, they are frequently not delivered in practice and/or alcohol data are not recorded. • The system of sending out invitations out is fragmented so not all patients are reached. • There is a low uptake; roughly 50% of people invited for a health check will attend an appointment. • There is limited time in the appointment (20 minutes) with many topics to cover, which leads to things being missed. • Health checks exclude younger people who might benefit from the materials. • Behaviour change can be more difficult with older adults when they have had the same patterns of drinking for years. An earlier age of intervention may increase effectiveness. • Some healthcare professionals feel uncomfortable discussing alcohol use, especially if they also drink over the recommended levels (feelings of hypocrisy). • The NHS are trialling a digital model so physical materials may not be appropriate.

Pharmacies - Over-the-counter conversations - Private consultation - Counter displays	• Pharmacies are easy to access, and most people use them (universal access). • Pharmacists have a precedent of training staff on how to talk to people about alcohol use (e.g., brief advice and AUDIT-C scratch cards) and other lifestyle topics (e.g., smoking and breastfeeding). • The use of pharmacies would reduce the pressure on GPs. • Certain purchases and medications could trigger conversations around alcohol use (e.g., rehydration sachets). • Consultation rooms that are used for health checks and COVID-19 vaccinations can provide privacy and an opportunity to discuss alcohol use. • Counter displays of the materials could be used to prompt people to think about their alcohol use if the materials do not take up too much room.	• Pharmacies tend to be more reactive rather than proactive (preventative medicine), so there might be lower uptake for issuing alcohol reduction advice. • Pharmacies would not be the first port of call for someone who was excessively drinking (i.e., there is no pill for excessive drinking). • There is a lack of privacy during over-the-counter conversations. • Some staff lack the confidence to challenge people about their drinking and worry about customers feeling judged. • Pharmacies are facing workplace and time pressures and they would need to consider how to integrate a new intervention into their existing workload. • There are COVID-19 related barriers such as social distancing and discouragement of lingering, although these barriers reduce as COVID-19 concerns and restrictions reduce. • Pharmacies are businesses so they would require renumeration and information on how much financial investment is needed (e.g., staff and other resources).
Social prescribing	• Social prescribers provide advice and signposting to services and support. • They would find it useful to have physical materials to help support those conversations. • Alcohol use is discussed sometimes. • Social prescribers remove some of the workload from GPs via referrals.	• Alcohol use is not routinely asked about as the focus is not on medical conditions. There is a wide referral remit that is patient and GP led. • Not everyone who drinks gets a referral to social prescribers. • Social prescribers do not have the capacity to talk to everyone about alcohol.

	• Social prescribers work with lots of venues in local communities improving access (e.g., churches, community groups).	• Some people do not want to talk about their alcohol or drug problems initially, and these concerns may only come out in later meetings after discussing related social or psychological problems. • Initial consultations ('guided conversations') are usually on the phone rather than in person, which limits the sharing of physical materials. • Services vary between local authorities and there is not always consistency.
Secondary care - Pre-operative assessments in hospitals - Accident and Emergency (A&E) attenders	• A&E departments have teams of alcohol support workers. They will probably concentrate on dependent drinkers, but they may also focus on those with alcohol-related conditions (such as a stomach ulcer or abdominal pain). • People who are going into surgery are asked how much they are drinking preoperatively. • It is a requirement of the NHS contract that any patient who stays for at least one night must have an alcohol screening if there are identifying risk factors. Alcohol liaison nurses make referrals if that is needed. • Physical materials that could be given out or assist conversations in these sessions could be helpful.	• Because hospitals are acute settings, staff might not have the resources for this sort of prevention work. • Patients who attend hospital for other complaints may not welcome discussions about their alcohol use. • People who attend A&E while intoxicated are not in an appropriate physical and psychological state to discuss their alcohol consumption.
Community outreach clinics - Alright My Liver	• The majority of people who attend 'Alright My Liver' events (University Hospitals Bristol and Weston NHS Foundation Trust, 2022) come because they are worried about their alcohol use. • During these events, everyone gets an alcohol screening questionnaire (AUDIT-C). People who score above a certain threshold on the AUDIT-C receive a liver scan (FibroScan), which indicates liver damage and risk of liver disease. Therefore, these screenings could be a teachable	• Clinicians would need carefully consider the eligibility criteria that people should pass to receive the materials (i.e., they would be less suitable for dependent drinkers). • Alright My Liver is a pilot, which currently has finite funding (until March 2023, with a possibility of a one-year extension). Therefore, alternative implementation routes would need to be sought if this scheme was discontinued.

	moment for people (i.e., they may be especially receptive to alcohol health communication materials), as alcohol is a risk factor for liver damage. • The clinicians talk to people about the risks of alcohol, and they encourage safer drinking and abstinence if that suits their case. Clinicians are keen to have our materials to hand out. Even though there are resources and referral routes for people who are dependent drinkers who need to achieve abstinence, there are fewer resources available for drinkers who drink over 14 units, but who do not see abstinence as a preferred or realistic goal. If risky drinkers are identified at screening, then there is a clear opportunity to hand out the materials. • Alright My Liver events are open to the public in various locations, including drop-in clinics in GP practices. There are no restrictions (e.g., based on age, like for the NHS Health Checks), making them more accessible.	
Pubs and bars	• Pubs and bars are a point of sale and consumption of alcohol so they may be ideal settings to offer an intervention. • There may be more funding available if going via the alcohol industry rather than the NHS or councils. • We could relate this work to No/Lo campaigns (connecting alcohol risks with No/Lo alternatives). Alcohol free and low alcohol drinks can cost just as much as alcohol for the consumer so pubs and bars would still make money.	• Working with the alcohol industry may lead to a conflict of interest and alienation of health colleagues (e.g., in the NHS, local authority groups, and public health). • To drink alcohol is one of the primary reasons that people go to bars/pubs so this may not be the time or place to try to dissuade people from drinking.
Universities - Student unions - Welcome fairs	• Targeting universities would be useful as students are less likely to be registered with GPs, less likely to need healthcare, and are therefore less exposed to health information around.	• Students may not be receptive to this information as their behaviour is seen as short term (as university is short term) and alcohol-related diseases may not be perceived as self-relevant.

	• University may be the first time that young people are drinking alcohol without parental supervision and protection. • Knowledge around alcohol units and harm tends to be poor in this population.	• Information will need to be adapted for this age group to improve self-relevance and therefore efficacy.
Emergency services - Police service - Ambulance service - Fire and rescue service	• Emergency services (typically the police and ambulance services) deal with people who are drinking too much alcohol. • It may be helpful for emergency services workers to have access to resources to share, especially online materials, as they sometimes follow people up. • Firefighters can fortuitously notice problematic alcohol use (via visual or verbal cues) when they do home fire safety checks. Therefore, firefighters may welcome having a resource at their disposal to share with people. They also complete a safeguarding report which is passed on to the most appropriate organisation depending on the nature of the concern. • People may be receptive to information from the fire and rescue service as they are well-liked and are there to help.	• Emergency services are stretched in terms of resources, funding, and time, and we do not want to add something that increases their workload. • Prevention work on alcohol may not be their top priority. • It is important to target drinkers before the point where emergency services are getting involved. • People are not responsive to prevention information at the time of crisis. • There is unlikely to be a need or space to carry around physical materials.
Charities	• Alcohol use and mental health are commonly comorbid; alcohol is used for self-medication of anxiety, depression, and other mental health conditions. Therefore, local organisations and charities specific to mental health and wellbeing may find resources on alcohol use helpful. • There is a precedent for local and national charities to produce alcohol health communication materials. For example, DHI's Project 28 (Bath) have produced flashcards for young people to communicate the possible negative consequences of drinking alcohol. Furthermore, Cancer Research UK (national) have produced online	• There are issues with dual diagnosis and a lack of joined up working. Many mental health services send people away if they are also experiencing an alcohol problem and ask them to deal with this first. • People who access mental health services may already be higher-risk drinkers (i.e., at the stage of treatment rather than prevention).

	infographics on the relationship between alcohol and cancer.	
Other	• The physical materials can also be left for opportunistic collection in a variety of settings that the public use, for example libraries and community centres. Alcohol awareness displays can link to books and other related resources in these settings. • The Making Every Contact Count (MECC) message is about making use of opportunistic meetings with the public, and potential chances to talk to someone about their alcohol use. Making discussions around alcohol use part of normal chats will help to reduce stigma, because alcohol harms can affect all drinkers, not just dependent drinkers.	• Resources left in community settings may not always be noticed by the public. • Appropriate signposting to support services would be needed.

4.1.1. GP practices

GP consultations provide a delivery avenue when patients are thinking about their health. Health professionals should be appropriately skilled to discuss alcohol risks and provide support to help patients reduce their alcohol consumption (SHAAP, 2022). The Drug and Alcohol Strategy for Bristol (2020) identified 'the design of information packs to support education in primary care settings on alcohol harms amongst regular drinkers who are not dependent' as a research priority. GPs are under growing pressure to initiate conversations with patients about their alcohol consumption. However, currently there is little tangible action for GPs who meet with patients who are drinking more than the recommended levels (and so are increasing their risks of ill health) (Lid & Malterud, 2012), but who do not meet the criteria for referral into a specialist clinical treatment service for alcohol problems.

Interventions currently exist for people who are considered to be drinking at extremely harmful levels. These include alcohol brief interventions (ABIs), which aim to increase awareness of the CMO low risk drinking guidelines and alcohol-related health risks (SHAAP, 2022). UK government guidance states that providers of NHS-funded services in England, including GPs, should routinely identify patients drinking above the CMO low risk levels and provide brief advice. Patients should be offered a referral for further assessment and specialist support if considered to be suffering from an alcohol use disorder (Public Health England, 2019). "Identification and Brief Advice" is one example of an ABI. It lasts 5-10 minutes and involves (1) a screening tool to identify risky drinking, and (2) the delivery of structured brief advice to encourage reduced alcohol consumption (Institute of Alcohol Studies, 2015). It aims to reduce alcohol consumption and harm in drinkers who exceed the low risk guidelines but are not actively seeking help for their drinking. It includes feedback on a person's alcohol use, information on alcohol harms and the benefits of cutting down, and alcohol reduction recommendations (Kaner et al., 2018). Physical or online alcohol health communication materials, such as our ENACT materials, may be a useful adjunct to these conversations.

GPs are a viable route of delivery as they are readily accessible to the general population. People typically discuss alcohol use and related complaints with their GP before accessing specialist alcohol services. GPs have role legitimacy in the delivery of advice concerning lifestyle issues, including alcohol consumption (Mules et al., 2012). Research shows that GPs can have a positive impact by helping to reduce alcohol use in their patients (Sturgiss et al., 2022). In addition, both GPs and patients find alcohol risk conversations acceptable in primary care settings when combined with other lifestyle consultations (such as a general health check) or when related to other presented health problems (Hutchings et al., 2006).

Our interviewees agreed that GPs could play a role in implementing the ENACT materials as there are several opportunities when alcohol use is discussed in GP practices. Patients are asked about their alcohol consumption when they register at a GP practice, when patients present with an associated complaint (e.g., vascular conditions, high blood pressure, gastrointestinal conditions, mental health conditions, and diabetes), and when GPs are alerted to missing alcohol data on their automated computer system (EMIS Health, 2022). However, there are some disadvantages to this implementation route. For example, if linking materials to GP registrations only, patients will only be offered materials when joining a new GP practice which happens infrequently, and anyone already registered with a GP would not be reached.

One interviewee identified that there is no routine follow up when high alcohol use is reported at GP registration. The onus is on the patient to make an appointment to discuss alcohol use (i.e., conversations are patient led rather than GP led). Furthermore, patients who make an appointment to discuss their alcohol use tend to be those who have reached problematic levels, so our target audience of at-risk drinkers may be missed, particularly if they don't recognise they are drinking at high levels or the risks of such drinking. Alcohol use is rarely discussed by GPs unless an associated complaint is raised. This is because GPs have a high

workload and limited time to discuss alcohol use in a consultation if more urgent or serious complaints need to be prioritised. Furthermore, there were concerns from some interviewees that discussing alcohol use out of context can disrupt the flow of the conversation. These responses highlight a need to discuss alcohol use more routinely, otherwise opportunities for prevention of alcohol-related harms for patients who are drinking at high-risk levels before the onset of an alcohol-related condition may be missed.

Other barriers for implementing the ENACT materials during GP consultations were identified. First, some GPs worry about appearing patronising or critical when discussing health behaviour change, as this may interfere with the doctor-patient bond. Second, GPs do not want patients to feel overburdened with information. And third, more senior GPs who rely on their experience, knowledge, and judgment may be less inclined to use tools to deliver advice on alcohol. However, despite some reservations, it was acknowledged by most interviewees that alcohol health communication materials could be used to help build rapport and support conversation with patients, without being patronising. For example, GPs can relay that most people find it difficult to calculate and keep track of alcohol units, therefore tools such as these can be beneficial.

Other studies have also reported clinician concerns about discussing alcohol use if it has not been raised by the patient or alcohol use is irrelevant to their presenting condition. Clinicians raise concerns about causing offence or provoking negative reactions in patients (Hutchings et al., 2006), including inducing feelings of shame in patients, and these concerns can be barriers to alcohol-related discussion (Sturgiss et al., 2022). These concerns appear somewhat justified as some patients thought that discussions around alcohol may evoke negative feelings and some reported having poor prior experiences in these consultations, such as feeling judged and shamed (Sturgiss et al., 2022). However, in the same study, patients who felt that they had a good rapport with their GP did not mind being asked or advised about alcohol issues if they felt the context was appropriate (Hutchings et al., 2006).

Other concerns reported by GPs in previous studies include patient dishonesty, presence of family members at consultations, patient denial (i.e., not accepting that their drinking was a health issue), the GP feeling that they lacked the knowledge and expertise to discuss alcohol concerns, and the GP feeling unable to define a safe level of alcohol consumption to the patient (Mules et al., 2012). The latter two points in particular centre around improving GPs' and patients' knowledge about alcohol harms and support the need for the development and implementation of the ENACT materials in GP settings.

Outside of consultations, physical materials could be left in waiting rooms (for patients to collect after a phone consultation or before visiting a GP in person). Physical materials in waiting rooms could prompt patients to think about or discuss alcohol use with their GP even if their original reason for attendance was related to a different complaint. One interviewee noted that there could be promotion weeks where physical materials are actively promoted by reception staff, and via posters and TV screens. Other studies have also identified waiting rooms as an opportunity to prompt patients to think about their alcohol consumption and to discuss it with their GP in their upcoming appointment (Sturgiss et al., 2022). However, this approach of leaving the ENACT materials for anyone to pick up is less targeted, and other people who may benefit from this intervention could be missed if this opportunistic method was the sole route of dissemination.

4.1.2. NHS health checks

Some interviewees suggested that NHS health checks could provide an implementation route as they focus on illness prevention and NHS staff have access to patient information. NHS health checks encourage people to consider their general health and lifestyle behaviours such as drinking, smoking, diet, and physical activity (NHS, 2019b). Therefore, patients are

prepared for questions about their alcohol intake and this expectation is likely to mitigate negative reactions, such as feeling patronised or shameful. The alcohol use disorders identification test for consumption (AUDIT-C) should be administered, and a discussion follows based on the patient's result (i.e., the healthcare professional should give advice on how to track and reduce alcohol consumption, and refer a patient to specialist alcohol services if their result indicates an alcohol use disorder) (NHS, 2020). Another advantage is that NHS health checks are delivered by a nurse or a healthcare assistant, freeing up GP time. Adults aged 40 to 74 are targeted, which are an at-risk group for developing alcohol-related conditions. But the disadvantage of solely implementing the ENACT materials during NHS health checks is that younger people who would benefit from these materials would not be reached.

One interviewee noted that the NHS health check system has some weaknesses that may limit its effectiveness as an implementation route. First, the alcohol section is frequently not delivered in practice and/or alcohol data are not recorded. Second, the system of sending out invitations is fragmented so not all target patients are reached. Third, there is a low uptake with our interview reporting that roughly 50% of people invited for a health check will attend an appointment. Fourth, there is limited time in the appointment (20 minutes) with many topics to cover, which leads to things being missed. Finally, the NHS are trialling a digital model so physical materials may not be an appropriate fit. Other barriers that interviewees identified were related to the healthcare professionals themselves. Some feel uncomfortable discussing alcohol use, especially if they also drink over the recommended levels (i.e., there are feelings of hypocrisy). Furthermore, some staff believe that behaviour change can be more difficult with older adults when they have had the same patterns of drinking for several years.

Research by Bareham and colleagues (2021) supports the use of NHS health checks as an implementation route. These meetings provide a clear opportunity to address alcohol use among older adults. Although they are still time limited, there is more capacity to discuss alcohol use compared to GP consultations where management of patient health conditions is prioritised. However, this study also raised a number of reservations among staff, including wariness of discussing alcohol use due the sensitive nature of the topic for older adults, worries about causing stigma by implying that someone's drinking is problematic, apprehensions about losing rapport with patients if staff caused offence, and concerns that older adults may be more resistant to making changes to their established drinking practices (Bareham et al., 2021).

4.1.3. Pharmacies

Interviewees noted that pharmacies are easy to access, most people use them, and they reduce the pressure on GPs. Community pharmacists have a precedent of training staff on how to talk to people about alcohol use (e.g., giving brief advice and AUDIT-C scratch cards) and other lifestyle topics (e.g., smoking and breastfeeding). These views are supported by McCaig and colleagues (2011) who suggest that community pharmacies are ideal places for offering alcohol interventions to a wide range of clients, especially those who have little or no engagement with other healthcare professionals, such as GPs. Certain purchases and medications could trigger conversations around alcohol use (e.g., rehydration sachets) if a targeted (versus general) approach to reaching our intended audience was preferred.

On the other hand, some interviewees expressed that pharmacies tend to be more reactive (i.e., providing medication to manage and treat conditions) rather than proactive (preventative medicine), so there might be lower uptake for issuing alcohol reduction advice in this setting. Furthermore, pharmacies might not be the first port of call for someone who was excessively drinking (e.g., there is no pill for excessive drinking). However, pharmacies may be an opportunistic route to implementation rather than a patient-driven (seeking out) route. In other words, people may enter a pharmacy for an unrelated reason, and the ENACT materials could

be available to read or pick up while they are waiting for their prescription, or an alcohol linked discussion could be pharmacist led.

Evidence suggests that customers are open to the idea of a medication and alcohol linked discussion with a pharmacist if this was routine, well-conducted and confidential (Madden et al., 2020). The importance of self-relevance was highlighted in this study. For example, some participants thought that medication and alcohol linked discussions would be less personally relevant to them as they had preconceived ideas about people with alcohol problems which dissociated them from the discussion. This reinforces the need for personally relevant alcohol health communication materials to help people to think about alcohol in terms of their own consumption and possible impacts on their health (i.e., perceived personalised risk).

One concern expressed by an interviewee was the lack of privacy during over-the-counter conversations. As echoed by other professionals, some pharmacy staff reportedly lack the confidence to challenge people about their drinking and worry about customers feeling judged. Furthermore, there were COVID-19 related barriers such as social distancing and discouragement of lingering, that had to be factored in, although these barriers reduce as COVID-19 concerns and restrictions reduce. Some of these barriers to implementation in pharmacies were identified in other studies. For example, public concerns about privacy and confidentiality, staff concerns and anxieties about lecturing and alienating customers (especially regulars) due to the sensitive nature of the topic, and lack of confidence and training among staff have all been reported (Hall et al., 2019). These barriers could be overcome with the use of private consulting rooms (i.e., as used for COVID-19 boosters and health checks) and staff training.

Another barrier is that pharmacists (like other healthcare staff) are facing workplace and time pressures and would need to consider how to integrate a new intervention into their existing workload. Pharmacies are businesses so they would require renumeration and to know how much financial investment is needed (e.g., staff and other resources). One interviewee suggested that there could be counter displays of the materials if they do not take up too much room, to prompt people to think about their alcohol use while they are waiting. There is evidence that this approach has worked in practice. For example, in a study by Hall and colleagues (2019), one pharmacist reported that they encouraged patients to complete an AUDIT-C scratch card and take a leaflet while patients were waiting for their prescription. And because patients could do this independently, it did not require additional staff resources. If the ENACT materials were too large, perhaps counter displays could instead include a sign-up sheet for people to order a free pack of ENACT materials to their homes, circumventing the spacing issue.

4.1.4. Social prescribing

In social prescribing, local agencies refer people to a link worker who provide holistic health and wellbeing advice and signposting to services for practical and emotional support (NHS England, 2022b). Local agencies can include GP practices, pharmacies, emergency services, hospital discharge teams, and non-profit organisations, and self-referral is also encouraged (NHS England, 2022b). The social prescriber and social prescribing lead that we interviewed reported that they would find it useful to have our physical ENACT materials to help support conversations around alcohol use. Some people do not want to talk about their alcohol or drug problems initially and these concerns may be revealed in later meetings after discussing a related social or psychological problem. Having materials to hand may help social prescribers to initiate these conversations earlier. Initial consultations known as ‘guided conversations’ are usually on the phone rather than in person, which limits sharing of physical materials. However, social prescribers work with lots of venues in local communities (e.g., churches, community groups) which improves access, and clients could visit one of several hubs to pick

up the pack of ENACT materials if conversations were initially remote (e.g., by phone). Social prescribers can remove some of the workload from GPs via these referrals.

One interviewee was worried about the appropriateness of social prescribing as an implementation route, but these concerns could be addressed. First, although alcohol use is discussed sometimes, it is not routinely asked about as the focus is not on medical conditions. There is a wide referral remit to social prescribing that is patient and GP led and staff do not have the capacity to talk to everyone about alcohol. However, conversations could be framed around improved wellbeing, and prevention of ill health generally. Second, not everyone who drinks gets a referral to social prescribers from GPs. However, this would not be problematic as we are not necessarily looking to reach people via that mechanism. Social prescribers could be alert to anyone who has heightened consumption or risk, regardless of the reason for the meeting.

4.1.5. Secondary care

Some interviewees suggested that hospitals are a possible implementation route as there are several opportunities to discuss alcohol consumption. For example, accident and emergency departments have teams of alcohol support workers and alcohol-specialist nurses. One interviewee suspected that support workers likely concentrate on dependent drinkers, but they may also focus on those with alcohol-related conditions (e.g., stomach ulcers or abdominal pain). In addition, it was noted that patients who are going into surgery are asked how much they are drinking preoperatively. Furthermore, the interviewee mentioned that it is a requirement of the NHS contract that any patient who stays for at least one night has an alcohol screening if there are identifying risk factors. This could therefore be a good route, unless it is likely to identify dependent drinkers, who are not the target audience here. Alcohol liaison nurses in hospitals may have more time to talk to patients compared to GPs, and they make referrals to other services and departments if that is required.

We also considered the potential utility of having the ENACT materials in secondary care cancer clinics. Individuals who have had been tested for suspected cancer may be more receptive to information about lifestyle behaviours that increase cancer risk (i.e., these could be a ‘teachable moment’). Physical materials to assist these conversations in secondary care settings could be helpful. There is evidence that patients who have been approached during hospitalisation to discuss their drinking reduce their alcohol consumption compared with controls (Kaner et al., 2007), thus demonstrating the potential utility of secondary care as an implementation route.

On the other hand, some interviewees thought that because hospitals are acute settings, staff might not have the resources for illness prevention work related to lifestyle behaviours. Some were worried that patients who attend hospital for other complaints may not welcome discussions about their alcohol use if this appeared to be irrelevant to their presenting conditions. In addition, a key challenge is that people who attend accident and emergency departments while intoxicated lack the receptivity to understand and retain this information, particularly if they are also injured and/or traumatised (Institute of Alcohol Studies, 2015). However, 25% of emergency department consultants’ time is spent on alcohol related incidents (Institute of Alcohol Studies, 2015), which highlights an opportunity and need for alcohol health education interventions.

Oxholm and colleagues (2020) explored health professionals’ and patients’ attitudes towards asking and being asked about alcohol, respectively, during a hospital stay. Barriers identified by health professionals included alcohol being a social taboo, embarrassing to talk about, and it being a private and personal issue. However, these barriers could be overcome if the ENACT materials could come with some staff-facing advice on how to approach these conversations. Staff were also concerned about this adding to their already high workload, poor training on

alcohol issues, fears of creating a conflict with patients, and their need to focus on medical issues (Oxholm et al., 2020). The last point is salient, given that alcohol problems are a medical issue affecting physical and mental health.

Other studies have suggested that nurses avoid bringing up the topic of alcohol use with patients in case they are wrong (i.e., they doubt their ability to detect the signs and symptoms of heavy alcohol use) (Hellum, Bjerregaard, & Nielsen, 2016). However, having our materials could attenuate this issue, as patients would have a tool to help to self-identify risk. In one study, it was suggested that routine questioning of all patients made it easier for staff to ask patients about alcohol because the targeting of patients was then not personal (e.g., based on the appearance of an alcohol problem) (Oxholm et al., 2020). However, more time and resources would be needed for this approach. This study and another also found that having solid clinical reasons to approach certain patients (e.g., alcohol habits related to the patient's condition) facilitates the health professionals asking patients about alcohol consumption as it makes them feel more confident and justified to do so (Oxholm et al., 2020; Tsai et al., 2010). This was supported by patient comments where they were positive about being asked about their alcohol consumption if it was relevant to their condition and if conversations were done in a non-judgemental and professional manner (Oxholm et al., 2020).

4.1.6. Community outreach clinics

Community outreach clinics which focus on organ damage that can be caused by alcohol use, are a very promising implementation route. For example, we spoke to a clinical nurse specialist working on the 'Alright My Liver' project (University Hospitals Bristol and Weston NHS Foundation Trust, 2022). Alright My Liver events offer free liver health checks in the Southwest with the aim to detect (and therefore treat) liver disease as early as possible.

These events are an ideal implementation route for several reasons. First, the majority of people who attend these events come because they are worried about their alcohol use, therefore people are likely more motivated to change their drinking behaviour. Furthermore, if a person learns that their liver is damaged after the scan, this could be a teachable moment for them (i.e., they may be especially receptive to alcohol health communication materials). Second, there is an opportunity for clinicians to talk about and distribute the ENACT materials. Everyone who attends gets an alcohol screening questionnaire (AUDIT-C), and people who score 5 or above receive a liver scan (FibroScan), which indicates liver damage and risk of liver disease. The clinicians then talk to people about the risks of alcohol and safer drinking and abstinence if that suits their case (i.e., if alcohol is the likely cause of that person's liver damage, instead of other causes such as viral hepatitis, obesity, high blood pressure, and diabetes). Third, the interviewee expressed a need for the ENACT materials because there is currently a gap in resources for certain drinkers. Even though there are resources and referral routes for people who are dependent drinkers who need to achieve abstinence, she expressed that there are less resources available for drinkers who drink over 14 units, but who do not see abstinence as a preferred/realistic goal. If risky drinkers are identified at screening, then there is a clear opportunity to hand out the materials. Finally, Alright My Liver events are open to the public in various locations, including drop-in clinics in GP practices. There are no restrictions (e.g., based on age, like for the NHS Health Checks), making them highly accessible.

However, there are some limitations. The interviewee suggested that we would need to carefully consider the eligibility criteria that people should pass to receive the materials, and they would not be suitable for dependent drinkers (who require specialist addiction support). Alright My Liver is also a pilot at this stage, which currently has finite funding (until March 2023, with a possibility of a one-year extension). Therefore, alternative implementation routes would need to be sought if this scheme was discontinued.

4.1.7. Pubs and bars

Currently, information about alcohol units, the low risk drinking guidelines, and alcohol health risks are not readily available at the point of sale and consumption. Therefore, pubs and bars could be an implementation route for the materials that addresses this. One interviewee suggested that there may be more funding available if the ENACT materials were implemented in bars and pubs (i.e., an opportunistic route). For example, if the alcohol industry commissioned this work rather than the NHS or local councils, there is potential to link the ENACT materials to advertising of alcohol free (≤ 0.05% ABV) and low alcohol (≤1.2% ABV) (NoLo) products. There may be a financial incentive for venues to support this, as NoLo drinks currently cost the same price as alcoholic drinks, so pubs and bars would still profit from these sales. Although from a public health perspective, arguably NoLo options should be priced lower than alcoholic drinks to encourage a switch. However, one interviewee thought that pubs and bars may not be a suitable implementation route, precisely because it is a place of sale and consumption of alcohol. People may have chosen to go to these venues to consume an alcoholic drink, therefore some may be less receptive to information that dissuades them to do so in this setting, compared to when they are in a healthcare setting for example.

4.1.8. Universities

One interviewee suggested that targeting universities would be useful as students are less likely to be registered with GPs, less likely to need healthcare, and are therefore less exposed to health information. University may also be the first time that young people are drinking alcohol without parental supervision and protection, and knowledge around alcohol units and harms tend to be poor in this population. However, students may not be receptive to this information as their behaviour is seen as short term (as university is short term) and alcohol-related diseases may not be perceived as self-relevant. If current behaviour is viewed as an anomaly for students (i.e., it wouldn't be carried forward in their later life), then the materials could instead focus on knowledge (not behaviour change), as that would be carried forward. If specifically targeting students, the information on the ENACT materials may need to be adapted to make it relatable to this audience and improve self-relevance. It is important to consider the target audience (and their demographic characteristics) who will be reached via the chosen implementation route to optimise the effectiveness of the intervention.

4.1.9. Emergency services

The emergency services respond to people who have been intoxicated or harmed by alcohol use. Alcohol use has a significant impact on the emergency services with 80% of weekend arrests, 35% of ambulance journeys, and 10-30% of fires being alcohol related (Institute of Alcohol Studies, 2015). Although alcohol use is clearly relevant in this setting, the emergency services are stretched in terms of staff resources, funding, and time, and it is important to avoid increasing staff workload. This implementation route would only work if there were already processes in place that the ENACT materials could support.

One interviewee suggested it may be helpful for emergency workers to have access to the ENACT materials to share, especially online materials, as they sometimes follow people up. He reported that the fire brigade often fortuitously identifies problematic alcohol use (via visual or verbal cues) when they do home fire safety checks, so they may welcome having a resource at their disposal to share with people. They also complete a safeguarding report which is passed on to the most appropriate organisation depending on the nature of the concern. There are local initiatives, for example in Wigan, where firefighters are trained to deliver alcohol IBA if they notice alcohol problems during home safety visits (Institute of Alcohol Studies, 2015). Although IBA is not part of standard training, nationally, it demonstrates that there is some precedent for alcohol interventions delivered by the emergency services. Furthermore, despite the target audience for the ENACT materials being at-risk social drinkers (versus dependent

drinkers), this targeted and opportunistic route could still probably be the right fit for the materials, particularly if they contain some information on clinical or support services.

The use of IBA by frontline police officers and paramedics is less common, due to several challenges such as the acute and fast paced workload (Institute of Alcohol Studies, 2015). One interviewee thought that alcohol interventions are unlikely to be a top priority for police officers and paramedics even if alcohol use contributes to criminal and health incidents, and there is unlikely to be space to carry around physical materials. The interviewee also suggested that people are unlikely to be responsive to prevention information immediately at a time of crisis, but they may be receptive following an incident, if alcohol was related. Therefore, if there were opportunities for emergency workers to follow people up, this could be a suitable route.

It is important to target drinkers before the point where emergency services are involved as well as afterwards. While prevention is ideal, people may be less receptive before an incident has occurred. If the emergency services are called, this could be a teachable moment for an individual. The reach may also be lower with this route, but the impact could possibly be greater for some individuals.

4.1.10. Charities

Charities could be a potential implementation route, whether they are focused on alcohol specifically or related problems (e.g., cancer and mental health). Interviewees suggested that local organisations and charities for mental health and wellbeing may find resources on alcohol use helpful, especially those which have some consultation aspect. As recognised by another interviewee, mental health has worsened, and alcohol use has increased for some people during the coronavirus (COVID-19) pandemic (Garnett et al., 2021; Mind, 2020), which highlights the need for further support and interventions. Alcohol use and mental health are commonly comorbid (Kushner, Abrams, & Borchardt, 2000). Alcohol is used for the self-medication of anxiety, depression, and other mental health conditions and conversely, heavy alcohol consumption can increase the risk of mental health conditions (Kushner et al., 2000).

Related to this are secondary care mental health services. However, one interviewee acknowledged that there is a problem of lack of joined up working for people with dual diagnoses; many mental health services send people away if they are also experiencing an alcohol problem and ask them to deal with this first (and vice versa). In addition, people who access mental health services may already be higher-risk drinkers (i.e., at the stage of treatment rather than prevention). Therefore, this population is currently outside of the scope of our materials anyway.

Some interviewees also mentioned local alcohol charities such as Bristol Drugs Project (BDP), a Bristol-based drug and alcohol services charity supporting people towards independence from drugs and alcohol (BDP, 2022), ROADs, and DHI (as previously described). One interviewee alerted us to Project 28 in Bath, DHI's young people's drug and alcohol service (DHI, 2018). They have designed and produced their own alcohol communication materials, with and for teenagers and young adults. These are pictorial flashcards which show the possible negative consequences of drinking alcohol (e.g., fights and aggression, hangovers, poisoning, accidents, unprotected sex, and other risks), and they are intended for one-to-one or group conversations to start conversations about alcohol use. DHI's adult drug and alcohol service (as well as ROADs and BDP), may therefore be interested in using the ENACT materials in their service consultations. Some interviewees recommended that we focus on local charities and organisations rather than nationwide ones as the former may be more receptive to the ENACT materials at this earlier stage, and these charities will be accessible to people in the local area.

In terms of national charities, Cancer Research UK (CRUK) have produced online infographics on the relationship between alcohol and cancer (Cancer Research UK, 2022), and they are focused on the ethos of prevention. Furthermore, one of our ENACT materials will use statistics cited by CRUK to communicate personalised cancer risks from alcohol use. Therefore, charities such as CRUK may be able to support the implementation of the ENACT materials.

4.1.11. Dental practices

An additional possibility, not identified by interviewees, but which we identified during our review of the academic literature is dental practices, given the link between alcohol use and oral cancer (Bagnardi, Blangiardo, La Vecchia, & Corrao, 2001; Bagnardi et al., 2015). One qualitative study with general dental practitioners found that knowledge of the CMO low risk guidelines was poor (Barber, 2010; Shepherd, Young, Clarkson, Bonetti, & Ogden, 2010). The dentists also universally agreed that alcohol consumption affects oral and general health, but this was not communicated to patients during dental consultations. The dentists reported that they had low confidence and experienced embarrassment when bringing up alcohol use, due to the perceived irrelevance to the clinical condition and potential disruption of the clinician-patient relationship. These barriers have also been expressed by other health professionals, highlighting a potential training need and use of the ENACT materials to facilitate these conversations. Like GP practices, the materials could be left in dental practice waiting rooms as an opportunistic method of delivery, especially if the materials emphasised the relationship between alcohol use and oral health.

4.1.12. Other

The physical materials could also be left for collection in a variety of settings that the public use, for example libraries and community centres, if implementation was designed to be opportunistic and discussion with a healthcare professional was not required. One interviewee had the idea of alcohol awareness displays that could link the ENACT materials to books and other related resources in libraries. Making Every Contact Count (MECC) is an approach to behaviour change that uses the day-to-day interactions that organisations have with the public to enable opportunistic delivery of healthy lifestyle information (Public Health England, 2016). Community settings may help to engage with traditionally hard to reach groups. On the other hand, resources left in community settings may not always be noticed by the public. In addition, as this would be an opportunistic route, appropriate signposting on the ENACT materials to support services would be needed.

4.2. Funding ENACT

4.2.1. Costs

The cost of implementing ENACT will depend on several factors, including but not limited to the type and number of implementation routes that will be used (e.g., targeting GP practices in Bristol versus across the Southwest), the type and number of patients/members of public we would like to provide the ENACT materials for (e.g., screening and providing the materials for people who meet certain inclusion criteria versus making the materials available for anyone who wants them), and the format of the materials (e.g., physical versus online or both). It will also be important to consider cost-effectiveness not simply absolute costs. For example, physical materials with a function may be more expensive to produce compared to paper-based or online materials, but if they are used more, and are more effective at driving behaviour change, then that could lead to cost savings in the future (i.e., an ‘invest to save’ measure). Furthermore, the more units of the ENACT materials that we produce, the cheaper the overall cost (economies of scale).

4.2.2. Potential commissioning pathways

We asked interviewees how the ENACT materials could fit in with pre-existing funding pathways and infrastructures. Four funding routes were identified: integrated care board (ICB) funding (formally clinical commissioning groups (CCGs)), devolved public health funding to local authorities, charity funding, and alcohol industry funding. The choice of funding routes may be dependent on the choice of implementation routes identified above.

4.2.2.1. Integrated care board funding

If the ENACT materials were implemented in GP practices (and other healthcare settings), they could be funded by one or more ICBs. All CCGs were statutorily abolished on 1st July 2022 and replaced with ICBs (NHS data dictionary, 2022). ICBs are 'statutory organisations bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS' (NHS Digital, 2022). Our local ICB is the NHS Bristol, North Somerset, and South Gloucestershire Integrated Care Board (BNSSG ICB), which is in the City of Bristol, District of North Somerset, and District of South Gloucestershire local government areas (NHS England, 2022a). Some of our interviews took place before July 1st, therefore, some interviewees referred to CCGs instead of ICBs. One interviewee suggested that the funding would come from the ICBs, but they did not know the process for how to apply for funding.

Remedy is an ICB-run 'GP Referral Support Tool, providing quick and easy access to clinical pathways and guidelines for GPs across BNSSG. It has been developed in collaboration with local clinicians and specialists, to support GPs with providing their patients with the care they need, in the right place with minimal delays' (NHS BNSSG ICB, 2022). Remedy is a repository for available resources (e.g., patient information leaflets, apps) and referral services, and details what the ICB will fund for patients. One interviewee suggested that although ICBs link clinicians with the appropriate services and resources, they may not fund the resources directly themselves. We would need to explore with our local ICB whether alcohol reduction interventions are an area that they are interested in funding, and if so, which patients they would consider offering this to.

ICBs are focused on public health and illness prevention, so the ENACT materials should fit within their remit. However, there may be differing practises between different ICBs. One interviewee identified that NHS strategic leaders are increasingly interested in alcohol use, which has been triggered by a 21% increase in alcoholic liver mortality during the COVID-19 pandemic (from 2019 to 2020) (Public Health England, 2021). Therefore, it may be possible to get funding from the NHS to implement the ENACT materials, whether these are physical or online (e.g., on the NHS website).

4.2.2.2. Devolved public health funding

Local authorities receive devolved public health funding from the Department of Health and Social Care in the form of the Public Health Grant. This grant currently funds NHS health checks for example. One interviewee stated that anyone in the Bristol City Council (BCC) public health team can build a case for funding, especially if it links to the Bristol One City Plan, the Drug and Alcohol Strategy, and the UK's national strategies. BCC receives the public health grant and supplementary funding for drug treatment services. When asking commissioners, it is the case of deciding where and what the priorities are. However, directors of public health have experienced budget cuts by about 25% since 2015/16 and further decreases in the public health budget are expected (BBC, 2022). It was reported that an announcement on the Public Health Grant for local authorities would be made soon (BBC, 2022).

One interviewee described how he had created alcohol health communication materials previously with Public Health Wales as part of their 'Have a word' campaign. He created plastic beakers which measured the amount of liquid that equalled a unit. People were given these and a scratch card with the AUDIT-C to help them to understand their consumption and they received alcohol brief advice. The UK government are currently funding local authorities to deliver both drug and alcohol treatment services, although this is typically for dependent drinkers which are not within the remit of this project. However, it was suggested by the interviewee that we could ask local authorities whether they would consider contributing a portion of this funding to such a project, because ultimately, we are deterring people from becoming dependent drinkers, which will save costs in the longer-term.

4.2.2.3. Charity funding

In addition to being an implementation route, charities could also provide a funding pathway for implementing the materials in other settings (e.g., GP practices). Interviewees working in GP practices suggested that funding can come from charities and other voluntary sector organisations (if not the NHS ICBs), as GPs themselves do not produce these kinds of materials. According to the interviewee, charities such as BDP and ROADs receive most of the BCC money for delivering alcohol support services and could be open to funding the ENACT materials. We could also explore potential funding opportunities from the Alcohol Health Alliance or cancer charities.

Other alcohol charities have produced materials and resources that GPs might use (e.g., Alcohol Concern and Drinkaware), and we could look to those as examples. Drinkaware, an independent charity which aims to reduce alcohol-related harm by helping people make better choices about their drinking (Drinkaware, 2022a), have a shop which provides evidence-based alcohol education resources (Drinkaware, 2022b). As well as physical materials, online resources could be funded and showcased on charity websites for practitioners to refer patients to.

As well as funding the ENACT materials, charities may also fund the staff resources needed to deliver these materials. Charity based healthcare is prevalent. For example, one interviewee described how their GP practice works with BDP. Staff from BDP are based in their practice a couple of days a week and do methadone reviews. Perhaps a similar partnership could be set up with this or another alcohol charity in GP settings, and charity staff could discuss alcohol use with patients using the ENACT materials as an aid.

4.2.2.4. Alcohol industry funding

It is possible that there may be more financial support available if we decide to seek funding via the alcohol industry rather than the other routes. The alcohol industry may consider commissioning the materials if for example we connect our materials to buying alcohol-free and low alcohol strength (NoLo) options. This type of partnership has worked previously, therefore there may be a case to bring in some external alcohol industry support. For example, BCC recently worked with the alcohol industry to conduct a field study. They found that increased availability or NoLo options in bars and pubs increased the chances of consumers buying these drinks. BCC has a pledge for healthy places in their Drug and Alcohol Strategy and they want to work with industry not against them. Helping to communicate health information about drinking less alcohol fits with the strategy about healthy places.

However, one barrier highlighted by an interviewee is the Bristol Ad Policy, which is restrictive on advertising anything that might be associated with drinking alcohol. Therefore, matching this project with NoLo products could be restricted. One interviewee also suggested that alcohol industry funding may lead to a conflict of interest and alienation of health colleagues (e.g., those working in the NHS, local authority groups, and public health), which is something

he has personally experienced. However, this may depend on the nature of the funding relationship. The alcohol industry paying for some evidence-based materials (that they have not been part of design of) may evoke a different response from health colleagues compared to a research collaboration for example.

4.2.3. Criteria for funding

We asked interviewees what they thought we would need to present to a prospective funder to encourage them to invest in the implementation of the ENACT materials. Broadly speaking, we would need to demonstrate that there is a significant need for the ENACT materials, and that the materials are effective (i.e., there is a solid evidence base). Preliminary evidence would support a case for funding, and effectiveness could be evaluated via an initial field study trialling the ENACT materials in people's homes. There are funding mechanisms, such as the ESRC IAA grant that funded this work, that could support this effectiveness testing research.

Interviewees had different opinions on the best criteria to define and assess effectiveness, and thus the outcomes of interest in a pilot evaluation study. Several interviewees said that they would be most interested in seeing behavioural change (i.e., reduced alcohol consumption and harm as measured by fewer units of alcohol per week). Some argued that this would also be strengthened by data on the impact of the ENACT materials on treatment referrals and other health outcomes in the longer term (e.g., lower blood pressure, reduced liver disease and diabetes incidence). Psychological health outcomes (e.g., improved wellbeing, and reduced anxiety) were also highlighted. One interviewee suggested that psychological outcomes would be easier to measure in a non-dependent population who are not yet experiencing comorbid physical health complications. They also suggested that NHS funders would be interested in health economic outcomes, such as quality adjusted life years, and provision of the materials would likely be based on need (i.e., screening/eligibility criteria to access them) rather than providing universal access for potential prevention, due to the costs involved.

One interviewee suggested that effectiveness could be indirectly measured by GP practice attendance rates (phone calls and visits to the practice). She said that reduced attendance among 'frequent attenders' could be attributed to patients not needing the service as often because their health is less negatively impacted when drinking less alcohol, or because they have been provided with more self-help information. However, it would be difficult to determine the cause of drops in attendance. Furthermore, there could be patients who drink excessively but who rarely visit their GP, so these people would not be captured by that measure.

Other interviewees acknowledged that it would be challenging and time consuming to observe behavioural change (i.e., reduced alcohol intake), since drinking alcohol is a behaviour that people enjoy, and therefore difficult to change. In addition, observing effects on other health conditions would require longitudinal studies over several years. Therefore, to reach these longer-term goals, there are initial steps in this direction of successful behaviour change that first need to be met. For example, one interviewee said it would be unrealistic to expect 25% of people who received a leaflet to reduce their alcohol consumption, but 25% could be expected to say that they learned something new, found it useful, or made them reflect on their own behaviour, which would be an initial success. The following stages of behaviour change could be followed, for example a person (1) reading and engaging with the ENACT materials (2) recognising that their consumption levels could be harmful to their health, (3) intending to change their drinking habits, (4) reducing their alcohol consumption in the short-term, and (5) maintaining this behaviour to change their health. Effectiveness clearly depends on the timescale, and it is important to be realistic about what might be feasible to change in the time available.

Other considerations mentioned by interviewees included clinician perceptions and use of the ENACT materials, in addition to those of the social drinkers. Although at-risk social drinkers are the primary target audience, the professionals who deliver the materials are the other beneficiaries and therefore the materials must be acceptable to them too. For example, if the materials are perceived to be adding to the professionals' workload, then this will cause tension. The materials must help to address the barriers of staff discussing alcohol use with the public and be a quick and easy adjunct to conversations that are already being had.

One interviewee suggested that the materials may be more readily accepted as an approved tool if they were embedded in GP training, so it may be important to approach primary care network training schools. He also explained that he holds a regular forum with commissioners and commissioners need some indication about how the outcomes of an external project would influence their own outcomes (e.g., about reducing numbers of dependent drinkers, getting people into treatment).

5. Conclusions

In this report, we explored the suitability of twelve possible implementation routes for the ENACT alcohol health communication materials (GP practices, NHS health checks, pharmacies, social prescribing, secondary care, community outreach clinics, pubs and bars, universities, emergency services, charities, dental practices, and other), four possible commissioning pathways (integrated care board, devolved public health, charity, and alcohol industry funding), and the potential criteria for funding.

Table 2 summarises our assessment of the potential effectiveness (degree to which the ENACT materials could improve drinkers' knowledge including acceptability and engagement) and feasibility (likelihood of implementing the ENACT materials effectively) of each implementation route. Our recommendations are that GP practices, NHS health checks, and community outreach clinics are the preferrable primary implementation routes. Integrated care board and devolved public health funding therefore appear to be the most fitting commissioning pathways. Pharmacies, social prescribing, secondary care, pubs/bars, charities, and dental practices could be secondary implementation routes, but they have more limitations. We considered universities and emergency services to be unsuitable.

Each route has advantages and disadvantages, and several barriers were identified. For example, in GP practices, there may be no follow up when high alcohol use is reported at registration, and alcohol use is not routinely discussed in consultations unless the GP considers alcohol use to be relevant to a patients' presenting condition. Similar comments related to the latter were echoed in secondary care and pharmacy settings. If the onus is on the patient to raise the issue of alcohol consumption, and patients are not aware that their current behaviour could lead to future harm, then opportunities may currently be missed. Furthermore, if GPs only raise the issue of alcohol consumption after patients have developed a condition that is caused or exacerbated by alcohol use, then there is a missed opportunity for alcohol harm prevention.

Unsurprisingly there were certain environmental barriers that were universal, such as staff shortages, lack of time and resources, and high workloads. Interestingly, social-psychological barriers faced by staff were consistently reported by interviewees and were corroborated by research evidence. Some staff appear to experience awkwardness, embarrassment, and a lack of confidence to discuss a patient's alcohol use due to a variety of fears around causing stigma and offence, damaging rapport, and feelings of hypocrisy. Better tools and training to help staff have these potentially difficult conversations is clearly needed and the ENACT materials could support these. Normalising conversations about alcohol consumption and harm would benefit both clinicians and the public and would help to reduce stigma, since alcohol harms can affect all, not just dependent drinkers. In addition, as the Making Every Contact Count approach to behaviour change has highlighted, there are also various opportunistic routes for implementation that would not require input from a professional (e.g., leaving the materials in waiting rooms and countertops). Therefore, any interactional barriers could be avoided entirely.

There is no one-size-fits-all approach, and there will be individual differences in route preferences. For example, some individuals may be more receptive to discussions around alcohol use when speaking to a clinician in a healthcare setting (e.g., GP consultation, NHS health check, community outreach liver screening, pharmacist visit, or in hospital), and the ENACT materials could be a helpful adjunct during consultations to support staff. However, other drinkers may not be engaged with any clinical contact. For some drinkers, engaging with the ENACT materials in a pub or bar may offer a teachable moment as people are thinking

about their drink consumption, whereas others may not be receptive to health information in these settings, or they may prefer to drink at home. An implementation model with multiple routes would be the gold standard, to have the greatest population level effectiveness.

Table 2. Potential effectiveness and feasibility of each implementation route.

Implementation route	Effectiveness	Feasibility	Reasons
GP practices	High	High	• Engaged and wide reach • Alcohol & health are discussed • Clinically trained staff • Conversation & opportunistic collection
NHS health checks	High	High	• Engaged and targeted reach • Alcohol & health are discussed • Clinically trained staff • Conversation & opportunistic collection
Pharmacies	Moderate	High	• Engaged and wide reach • Health is discussed • Clinically trained staff • Opportunistic collection only
Social prescribing	Moderate	High	• More limited reach • Alcohol & health sometimes discussed • Conversation only
Secondary care	Moderate	Moderate	• Alcohol use sometimes discussed • Clinically trained staff • Limited time & resources • System change needed to facilitate
Community outreach clinics	High	High	• Engaged and targeted reach • Alcohol & health are discussed • Clinically trained staff • Conversation & opportunistic collection
Pubs and bars	High	Moderate	• Wide reach • Place where alcohol is consumed • Venue acceptability barriers • Conflict of interest barriers
Universities	Low	High	• Not the target audience • Low engagement • Opportunistic collection only
Emergency services	Low	Low	• Low engagement • Limited time & resources • Alcohol use not often a priority
Charities	Moderate	High	• Wide reach • Feasibility and effectiveness depend on the charity
Dental practices	Moderate	High	• Alcohol & health sometimes discussed • Clinically trained staff • Conversation & opportunistic collection
Other (e.g., libraries)	Moderate	High	• Wide reach • Opportunistic collection only

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8. Appendix: Interview Questions

[Interview with _____ (name) on _____ (date).]

Part 1: GP Surgeries

1. **Do you think that GP surgeries are a viable setting for rolling out the alcohol health communication materials?**

- If yes/no, why/why not?

[If 'yes', continue to Question 2. If 'no', continue to 'Part 2: Other Settings'.]

2. **How do you think the materials should be delivered in GP settings? What do you think patients would think of them?**

Prompts:

- How is alcohol consumption normally discussed? (E.g., patient or GP led conversations?)
- Would they be delivered by GPs, nurses, or other professionals?
- Could alcohol use/the materials be discussed during particular consultations (e.g., general, testing, screening, NHS health checks)?
- How might this differ depending on the mode of the interaction (e.g., face-to-face, phone)?
- Could they be promoted or picked up in the waiting rooms?
- Do we need to consider possible individual differences among patients? (E.g., the likely personal profile of patients would use the materials).
- Can you think of any other barriers for professionals or patients?

3. **Do you have a working knowledge of GP surgery infrastructure or funding?**

[If 'yes', continue to Question 4. If 'no', continue to 'Question 6'.]

4. **How would we get the materials into GP surgeries?**

Prompts:

- Which organisation might commission them (i.e., fund the future production at scale, e.g., Clinical Commissioning Groups or other places)?
- What funding opportunities might be available to us (i.e., scheme/pathway and funds available)?
  - What can the funds be spent on (e.g., design, production, delivery, renumeration)?
  - Who can the funds be spent on (e.g., are there guidelines that would 'ration' interventions to certain patients or certain areas of the population?)
  - What is the maximum amount that can be spent on each patient?
  - Would GP surgeries require renumeration (e.g., a fee per patient)?
  - How and when can we apply?

- Do you foresee any barriers to implementing the materials in GP settings? How could they be overcome?
  - E.g., time/workload pressures, worries about passing judgement/losing rapport).

If any of this information is covered on an organisation's website, please direct us.

5. To get the materials into GP surgeries, what would the funders need from us? What would we need to demonstrate?

Prompts:
- What outcomes do these funders care about? What are their priorities and success criteria?
- Would these materials first need to be evaluated with a randomised controlled trial (or other experiment) showing effectiveness, before being rolled out?

6. What do you think 'effectiveness' of these materials would look like? *[Skip if did not answer Questions 4 and 5:]* **How would the previously mentioned funders define 'effectiveness'?**

Prompts:
- For example, a change in people's health, knowledge (e.g., about units/risk), individual-level behaviour (e.g., reporting more mindful drinking), or population-level behaviour (e.g., lower consumption)?
- What would we need to measure to demonstrate 'effectiveness' to the funders? What would they want/need to see change?

7. Are you aware of any similar alcohol health communication materials that are implemented in GP settings?

Prompts:
- If yes: what, when, who, where?

8. Is there anything else that we need to consider about GP settings?

Part 2: Other Settings

1. What other settings should we consider for implementing these materials?

Prompts:

- *[If they don't have suggestions, list ours.]* We have identified a list of possible alternatives. E.g., hospitals, pharmacies, charities, local authorities (e.g., housing), housing associations, health agencies, social prescribing, mental health services, police service, ambulance service, libraries, universities/student unions, community centres, social care services, bars/pubs, gyms/sports centres.
- What would your top three be?
- Do you think any of these settings/services might be a good (or bad) idea? Why/why not?

[If they have suggestions, continue to Question 2. If they don't, continue to 'Part 3'.]

2. How do you think the materials should be delivered in these settings? What do you think the public/service users would think of them?

Prompts:

- How is alcohol consumption normally discussed in these settings?
- Who would they be delivered by?
- Do we need to consider possible individual differences? (E.g., the likely personal profile of people would use the materials).
- Can you think of any other barriers for professionals or the public/service users?

3. Do you have a working knowledge of the infrastructure/funding in any of the previously mentioned settings?

[If 'yes', continue to Question 4. If 'no', continue to Question 6.]

4. How would we get the materials into these settings?

Prompts:

- Which organisation might commission them (i.e., fund the future production at scale)?
- What funding opportunities might be available to us (i.e., scheme/pathway and funds)?
  - What can the funds be spent on (e.g., design, production, delivery, renumeration)?
  - Who can the funds be spent on (e.g., are there guidelines that would 'ration' interventions to certain people or certain areas of the population?)
  - What is the maximum amount that can be spent on each person/service user?
  - Would the service require renumeration (e.g., a fee per person)?
  - How and when can we apply?
- Do you foresee any barriers to implementing the materials in these settings? How could they be overcome?
  - E.g., time/workload pressures, worries about passing judgement/losing rapport)

If any of this information is covered on an organisation's website, please direct us.

5. **To get the materials into these settings, what would the funders need from us? What would we need to demonstrate?**

Prompts:
- What outcomes do these funders care about? What are their priorities and success criteria?
- Would these materials first need to be evaluated showing effectiveness, before being rolled out?

6. *[Skip if answered in Part 1:]* **What do you think 'effectiveness' of these materials would look like?**
   [Skip if did not answer Questions 4 and 5:] **How would the previously mentioned funders define 'effectiveness'?**

Prompts:
- For example, a change in people's health, knowledge (e.g., about units/risk), individual-level behaviour (e.g., reporting more mindful drinking), or population-level behaviour (e.g., lower consumption)?
- What would we need to measure to demonstrate 'effectiveness' to the funders? What would they want/need to see change?

7. **Are you aware of any similar alcohol health communication materials that are implemented in other settings?**

Prompts:
- If yes: what, when, who, where?

8. **Is there anything else that we need to consider about these settings?**

Part 3: Further Resources and Contacts

1. **Are there other people we should speak to about this? Please could you provide their email address?**

2. **Do you have any resources that you could share with us, that might be helpful?**

3. **Do you have any further comments or questions?**

Thank you very much for your time. *[Stop recording – if applicable.]*

Address:

Tobacco and Alcohol Research Group, School of Psychological Science, University of Bristol, 12a Priory Road, Bristol, BS8 1TU

Website:

https://www.bristol.ac.uk/psychology/research/brain/targ/