



# Supporting nurse mentors to reduce the barriers to implementing alcohol Interventions and Brief Advice (IBA) in primary care

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## EXECUTIVE SUMMARY

This project aims to reduce barriers to the implementation of alcohol Identification and Brief Advice (IBA) in primary care by providing expert support to nurse mentors to:

- develop a leadership role in IBA including provision of ongoing training and support to staff members
- encourage ongoing evaluation of activity and outcomes in IBA

Alcohol, together with obesity and smoking are the three biggest lifestyle risk factors for disease and death in the UK.

There is a wealth of evidence that supports IBA in primary care as both effective and cost effective in reducing the risks associated with drinking alcohol. On average 1 in 8 higher or increasing risk drinkers receiving the intervention will reduce their alcohol consumption to lower risk levels, reducing the potential for alcohol-related harm.

Despite the strong evidence base for IBA there remain barriers to implementation of this relatively simple intervention in primary care including; professional feelings of lack of role adequacy and role legitimacy, lack of knowledge and skills, perceived lack of support by staff; patient/ client/ staff reluctance to engage and lack of monitoring.

Nurse mentors have an important role in primary care leadership to support multi-agency learning, education and innovation in practice. However, nurse mentors are not usually identified to be trained in the specifics of alcohol IBA. The findings of this project suggest that providing a relatively low level of support to nurse mentors based in primary care leads to a significant increase in the delivery of IBA:

- There was a marked increase in the percentage of patients screening positive at an initial screening test going on to receive IBA, from 30% at the beginning of the project to 48% at the project end.
- There was a modest increase in the percentage of patients who received an initial screen being assessed as requiring a brief intervention from 13% at the beginning of the project to 15% at the project end indicating that clinicians were identifying increasing or higher risk drinkers more effectively.

Following the implementation of the project staff at the surgery appear to be more effective at identifying alcohol-related harm and at providing brief interventions to this group.

An unexpected finding of this project was the nurse mentors' unique position to provide leadership not just in terms of knowledge, encouragement and monitoring, but also their ability to identify and make positive changes to operational aspects of delivery.

This project indicates that by supporting nurse mentors in leading on the implementation of IBA there is potential for reducing alcohol-related harm within the existing resources of the surgery. This could support primary care in the practical implementation of an evidence based cost effective intervention which has experienced patchy uptake.

## INTRODUCTION

It is estimated that nine million people in England regularly drink above the Government's previous sensible drinking guidelines<sup>1</sup>. This figure is likely to have increased since the guidelines changed in 2016 to 14 units per week for men and women. Drinkaware calculate that approximately 3.5 million middle-aged men are drinking more than 14 units per week (equivalent to six pints of 4% beer), with an average intake of 37 units per week (16 pints of 4% beer). Just over half (53%) of these drinkers don't believe their drinking could have an impact on their health<sup>2</sup>.

Alcohol, together with obesity and smoking are the three biggest lifestyle risk factors for disease and death in the UK<sup>3</sup>. It is estimated to cost society: £21 billion annually in terms of crime, social and health issues; the NHS cost is £3.5 billion per year with 25% of all acute male hospital beds occupied by someone with alcohol-related harm<sup>4</sup>; and 11-17 million working days lost each year due to alcohol-related sickness absence<sup>5</sup>.

There is a wealth of evidence that supports alcohol IBA in primary care as both effective and cost effective in reducing the risks associated with drinking alcohol and National Institute of Health and Care Excellence (NICE) guidance suggests that such prevention should be prioritised as 'invest to save' measures<sup>6</sup>. On average 1 in 8 higher or increasing risk drinkers receiving the intervention will reduce their alcohol consumption to lower risk levels, reducing the potential for alcohol-related harm.

Despite the strong evidence base for IBA there remain barriers to implementation of this relatively simple intervention in primary care including:

- Professional feelings of lack of role adequacy and role legitimacy, lack of knowledge and skills
- Perceived lack of support by staff
- Patient/ client/ staff reluctance to engage – in some circumstances because of concerns about confidentiality
- Lack of monitoring<sup>7</sup>.

### **The delivery of IBA in primary care**

The alcohol Direct Enhanced Service (DES) was introduced as part of the 2008/09 GMS contract changes and it continued until 1 April 2015 when it became a contractual requirement for all practices to identify newly registered patients aged 16 or over who are drinking alcohol at increased or higher risk levels. The aims of the DES were to encourage practices for case finding in newly registered patients aged 16 or over and to deliver simple brief advice to help reduce alcohol-related risk in adults drinking at increasing or higher risk levels and consideration of specialist referral for dependent drinkers. Brief advice, supported by written information to back it up, is as effective in

most situations than longer lifestyle counselling sessions of 20 minutes and more<sup>8 9</sup>.

The DES required that practices screen newly registered patients aged 16 or over, using one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaires: FAST or AUDIT-C. FAST has four questions and AUDIT-C has three questions, with each taking approximately one minute to complete. The DES stated that patients with a score of five or more with AUDIT-C should be given the full AUDIT and be offered brief advice for a score between 8 and 19, or be considered for referral to specialist services for a score of 20 or more.

However, payment was based upon calculation of the number of newly registered patients, aged 16 or over in the financial year, who have been screened using either the FAST or AUDIT-C tool without the requirement for brief interventions/ referral on to specialist services to be delivered, leading to questions about how effective the DES would be:

“One often raised issue is that the DES payment is collected when a patient completes FAST or AUDIT-C and it is recorded by the practice, regardless of the score or 'brief advice' being delivered. The original guidance only stated that practices 'should' subsequently complete a full AUDIT and offer brief advice to at-risk drinkers, or referral for those indicating dependency. Not surprising then that recording of 'brief advice' or 'referral' activity on the same systems usually appear significantly lower<sup>10</sup>.”

There have been other reported problems with the delivery of the alcohol DES. During 2009–2010, Haringey practices participating in the alcohol Direct Enhanced Service (DES) identified just 2% of new patients as AUDIT positive despite the fact that an estimated 26% of Haringey residents drink above recommended limits<sup>11</sup>. In addition, over half of the practices didn't identify any of their patients as AUDIT positive, whereas some practices identified all of their patients as AUDIT positive. A review found, to give just two examples, that 75% of practices were using incorrect screening questions, and that only 50% of practices were offering face-to-face brief advice. This suggests that the systems used within primary care can play an important part in implementation of IBA.

### **The nurse mentor role**

The Royal College of Nursing emphasises both the importance of the role of nurse mentors in the provision of high quality healthcare and the need to provide support and structure to the role of the nurse mentor to make it successful<sup>12</sup>. Nurse mentors have an important role in primary care leadership to support multi-agency learning, education and innovation in practice<sup>13</sup>.

Whilst registered nurses are in overall charge of the nursing care of a patient they cannot usually perform every task for every patient and therefore s/he will need to delegate aspects of that care to colleagues, usually health care assistants. This is certainly the case with regard to alcohol IBA in primary care. For example health care assistants (HCAs) often perform new patient assessments and reviews of care, both of which provide excellent opportunities for IBA. In order to provide support to HCA to carry out such tasks nurses are required to provide support and mentorship. Nurse mentors also play an important role in developing newly qualified staff across all areas of patient care; and practice placements are acknowledged as being one of the most important aspects of a trainee's educational experience in healthcare. However, nurse mentors are not usually identified to be trained in the specifics of alcohol IBA.

### **Project aims**

This project aims to reduce barriers to the implementation of IBA in primary care by providing expert support to nurse mentors to:

- develop a leadership role in IBA including provision of ongoing training and support to staff members
- encourage ongoing evaluation of activity and outcomes in IBA.

This project will support nurse mentors in a primary care practice to reduce barriers to implementation of IBA in primary care by providing:

- Support to nurse mentors to train practice members in IBA
- Support to nurse mentors to mentor staff regarding IBA to encourage role development across the practice
- Support evaluation of impact of nurse mentor leadership on IBA including activity and outcomes.

## METHODS

This project was conducted with a large city-based practice in Birmingham in an area of deprivation with a practice population of 9,500. There are a total of nine GPs, five nurses and four HCAs. The practice has a specialism in provision of drug and alcohol treatment.

### Project plan

The project was designed to take place over a six-month period with the key activities and timescales outlined in table 1.

**Table 1**

<b>Activity</b>	<b>Timeline</b>
Identification of nurse mentors	<b>Month 1</b>
'Train the trainers' support to nurse mentors to support training to staff at the primary care practice	<b>Month 2-3</b>
Support regarding ongoing mentoring of staff including identifying barriers to provision of IBA and how to support staff to overcome these	<b>Ongoing</b>
Support to conduct basic audits of activity and to measure patient outcomes	<b>Month 1-6</b>

## FINDINGS

### **Identification of nurse mentors and initial meeting**

In the first month it was identified that there were two nurse mentors at the practice who would both be involved in the delivery of the project. In an initial meeting with the nurse mentors (month 2) several strengths and barriers to the implementation of IBA at the practice were identified.

#### ***Strengths***

The nurse mentors felt that use of their role for the implementation of IBA was appropriate as they oversee the work of the HCAs whose roles are central to health promotion (for example conducting new patient and diabetes checks) and they are experienced in providing brief interventions. Nurse mentors also have a clear idea of the roles of both the GPs and other nursing staff in the practice and are in a strong position to provide both educational and operational leadership regarding health promotion and prevention.

There were discussions regarding the fact that there were several opportunities to deliver IBA throughout the practice other than initial patient checks including regular reviews of health conditions including diabetes, mental health, cardiovascular and chronic obstructive pulmonary disease (COPD). It was felt that while HCAs would play a crucial role in delivering IBA, all staff in the surgery play a role in the delivery of IBA as alcohol plays such a significant role in physical and mental health issues. For example GPs may conduct an AUDIT-C in routine consultations (e.g. consultations regarding depression) and practice nurses may conduct an AUDIT-C as part of a hypertension review. Therefore it was felt that all staff at the surgery should be involved in the upcoming training.

The fact that the surgery had a specialism in substance misuse was also seen as strength both from the point of view that the knowledge within the practice regarding alcohol was good, and that the nurses felt supported to implement IBA as GP partners were supportive of the initiative.

Support for running a baseline audit was offered to nurses. However, it became clear that there was an identified member of staff in the practice administration team who ran all audits in the surgery and had an expertise in audit which could be utilised. Supporting the nurse mentors to run audits would not be an efficient use of time and resources in the current practice setup.

## **Barriers**

The practice was already using AUDIT-C on some templates \* including the New Patient Health Check, diabetes and hypertension templates. However, the nurse mentors identified that there were a number of templates that did not have AUDIT- C as a prompt for health care professions and it was felt that inclusion of this may increase provision of brief interventions.

Whilst the AUDIT-C template was available on several templates nurse mentors identified some organisational issues that may be hindering the effective delivery of IBA. For example, when AUDIT-C had been completed and indicated the need for a full AUDIT, on some templates the practitioner could click a link that took them straight to a full AUDIT form. However, this was not the case for other templates and the full AUDIT did not flow easily from the AUDIT-C test. This required practitioners to search for access to the form and it was felt that this may act as a barrier to busy staff, resulting in the AUDIT-C being completed without moving on to the complete the full AUDIT even if the score showed that this was indicated. As a result, the researcher liaised with administrators at the practice to support changes to the templates to include AUDIT-C on additional templates, and to ensure that where AUDIT-C was on a template, a quick link would be provided to the full AUDIT.

Whilst staff felt that their knowledge regarding providing a brief intervention was good, there were no patient leaflets available for staff. It was felt that this may limit brief interventions that were currently being provided. As part of the project, the researcher provided support to nurse mentors by providing a patient leaflet with the aim of improving provision of IBA at the medical practice. A leaflet was designed comprising the basics of information from the SIPPs project and including the new government guidelines on sensible drinking. The ability to print the patient leaflet off while the full AUDIT was being conducted was also introduced. Nurse mentors said that all patients completing a full AUDIT and scoring below 20 would be provided with a brief intervention, even if they scored below 8, to re-enforce a positive message regarding current behaviour. A copy of the patient leaflet can be found in Appendix A\*.

It was also identified that there was some confusion regarding referral on for specialist services for those who scored above 20 on a full AUDIT, and that some information in the surgery was out-of-date and related to an old service provider who no longer existed. Nurse mentors felt that the referral pathways also needed to be revisited with all staff at the surgery.

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\* Templates are software applications which support health interventions by providing a series of prompts for healthcare professionals. They also facilitate audit of activity.

\* There has since been an updated leaflet on the SIPs site <https://www.sips.iop.kcl.ac.uk/>

It was acknowledged that whilst staff had the knowledge they may feel less confident about addressing alcohol use with staff than some other issues (for example smoking) as alcohol use is a much more socially acceptable activity. It was felt that increased training to HCAs together with emphasising the message of reducing risk rather telling people to stop may help in supporting staff to deliver IBA.

Finally, time to provide interventions within a busy work schedule was identified as a barrier to successful implementation, together with the fact that there are a number of competing health promotion messages (for example smoking cessation and obesity awareness) to cover in short appointment times which are usually focused on another health issue.

### **Action plan**

It was felt that the nurse mentor role could be influential in leading on IBA in the following ways:

- Training HCA and nursing staff in IBA and encouraging/ monitoring its use
- Raising awareness amongst GPs by going through training at doctors' meetings
- Providing leadership on alcohol IBA within the medical practice
- Identifying and where possible rectifying operational barriers to the implementation of IBA

### **Baseline audit**

At month 1 an initial baseline audit was conducted with the following findings:

- 1,298 AUDIT-Cs completed in a 1 year period in 2015/16
- 13% scored 5 or higher
- Of these, 30% went on to have a full AUDIT

Research from 2015/16 shows that 25% of men and 17% of women in Birmingham are drinking above safe limits. It is estimated that there 117,000 hazardous/increasing risk drinkers; 39,000 harmful / high risk drinkers and 22,000 dependent drinkers in Birmingham<sup>14</sup>. The percentage screened with an indication that they required a full AUDIT is lower than the percentage of increasing and higher risk drinkers, suggesting that there could be improvement in identifying people at risk of alcohol-related harm at the practice. It would also appear that 70% of those identified as requiring a full AUDIT did not go on to receive this screening at the practice.

### **Training session**

A training session was provided at month 2 to the two nurse mentors which outlined:

- The rationale for IBA including prevalence and types of problems resulting from alcohol-related harm
- The findings of the baseline audit
- How to use AUDIT-C and full AUDIT
- The new patient leaflet

The PowerPoint presentation used in the above training session was made available to the nurse mentors to provide training to the staff at the surgery.

There was discussion about the low conversion rate from AUDIT-C to full AUDIT in cases where people score over 5. It was felt that time pressure and the inability to access the full AUDIT on several of the templates were contributing to this. The low rate of those scoring above 5 or more (indicating increasing and higher risk drinking) compared to the Birmingham average was also discussed. It was felt that improvements could be made to identification of people at risk by increasing staff confidence in discussing alcohol with patients.

At month 3 one of the nurse mentors at the practice went on long term sickness absence which delayed the project for a period of several months as the remaining nurse mentor's workload was significantly impacted upon. However, after three months' delay the remaining nurse mentor continued with the project. The project plan had originally included the monitoring of a sample of individual patient outcomes. Due to the sickness absence at the surgery and the additional workload placed upon the remaining nurse mentor this element of the project was not able to be carried out. It was also pointed out that the ability of staff to monitor outcomes was limited in a primary care setting as they would often be seeing people as infrequently as once a year to review health conditions.

### **Training and awareness raising**

Training was provided to four HCAs and five nurses (one remained on sickness absence leave). The PowerPoint presentation had also been looked at and discussed at each of the two doctors' meetings held at the practice so all clinical staff at the medical practice had been updated and trained.

Ongoing support was provided to the nurse mentor available via phone/ email contact and a meeting at the end of the project was arranged to evaluate its impact. The email and phone contact with the nurse mentor was limited, as they felt confident to implement the project.

### **Evaluation**

An evaluation session was carried out with one nurse at the end of the project (the second nurse remained on sickness absence). The following were identified as positive impacts on the surgery:

Whilst it was felt by nurse mentors that the staff had good knowledge regarding alcohol it was felt that prior to the project staff had not been fully trained in the delivery of IBA and that this had increased confidence in discussing alcohol use with patients both in terms of knowledge and in confidence. Staff now felt that this was an effective intervention legitimate to their role. It was also felt that some simple changes to processes (an easier route to the full AUDIT and the provision of a patient leaflet) had made a significant difference to make delivery of IBA quick and easy. The nurse mentor felt that the project had also given her a better understanding of how HCAs work within the practice in general and reported that they provided more ongoing support to HCA as a result of the project.

As a result of confusion about how to refer people on to specialist services, identified by a nurse mentor during the project, a referral form has been created for onward referral which had increased confidence and it was felt also provided a better service for patients. The nurse mentors have decided that they would include an annual audit on IBA and an annual training update to all staff at the practice to deal with it as an ongoing issue within the medical practice. This was in recognition that with other competing initiatives awareness regarding IBA was likely to reduce over time.

### **End of project audit**

At the project end the audit was repeated with the following findings:

- 290 AUDIT-Cs were completed in a four month period during 2016/17
- 15% (44) had a score of 5 or more
- Of these 48% (21) went on to have full AUDIT.

This indicates that provision of brief interventions had increased by 18%. There had also been a modest increase in the numbers who were scoring 5 or more on the AUDIT C screen from 13% to 15%. However, the number of AUDIT-C screens being completed appeared to have reduced from 108 to 73 per month. This may reflect the fact that there had been long term staff absence leave, and also the fact that Christmas and New Year fell over the period of the second audit, with more public holidays and annual leave being taken.

Finally, the end of project audit was conducted over a four month period and the baseline audit measured activity over a year long period. The end of project audit may not be as reliable regarding activity at the surgery as the baseline audit due to its considerably shorter time span.

The substance misuse specialism may also explain why there was not an increase in the numbers of AUDIT-C screens delivered following the implementation of the project: the staff at the surgery already had a good awareness of the importance of treating alcohol and drug problems.

## IMPLICATIONS

The findings of this project suggest that providing a relatively low level of support to nurse mentors based in primary care leads to a significant increase in the delivery of IBA. There was a marked increase in the percentage of patients screening positive at an initial screening test going on to receive IBA, from 30% at the beginning of the project to 48% at the project end.

There was a modest increase in the percentage of patients who received an initial screen being assessed as requiring a brief intervention from 13% at the beginning of the project to 15% at the project end indicating that clinicians were identifying increasing or higher risk drinkers more effectively.

At a time when the workload of primary care is extremely pressured and where there are several competing health prevention issues the findings suggest that there is a need to make providing brief interventions as quick and straightforward as possible for the practitioner. An unexpected finding of this project was the nurse mentors' unique position to provide leadership not just in terms of knowledge, mentoring and monitoring, but also their ability to identify and make positive changes to operational aspects of delivery. For example, they immediately identified barriers in implementation of IBA regarding templates used at the surgery. One nurse mentor carried forward the initiative regarding a referral pathway for specialist services without any suggestions from the researcher. The nurse mentors have perhaps the most in-depth knowledge of how all staff at the surgery carry out their daily tasks and are therefore able to troubleshoot problems and make effective suggestions regarding solutions.

The practice where the project was delivered was highly experienced in substance misuse with strong support from the GP partners. The nurse mentors had excellent knowledge regarding alcohol misuse, as did the GPs and HCAs. This will not be the case in other primary care settings and additional support may be required were this project to be repeated.

Nurse mentors are ideally placed to provide support and training in the implementation of alcohol IBA across multi-professional roles in practice. Nurse mentors play an important role in developing newly qualified staff across all areas of patient care; and practice placements are acknowledged as being one of the most important aspects of a trainee's educational experience in healthcare. The project suggests that use of nurse mentors in leadership on IBA in primary care has the potential to embed the principles of IBA in primary care nurse practitioners.

## CONCLUSION

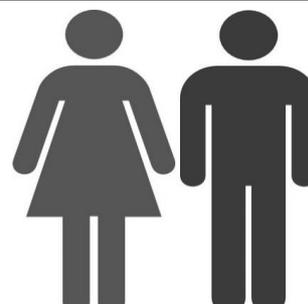
This project indicates that by supporting nurse mentors in leading on the implementation of IBA there is potential for reducing alcohol-related harm within the existing resources of the surgery. This could support primary care in the practical implementation of an evidence based cost effective intervention which has experienced patchy uptake.

## APPENDIX A

### New Government Alcohol Guidelines for Men & Women

You shouldn't regularly drink more than

**14 units a week**



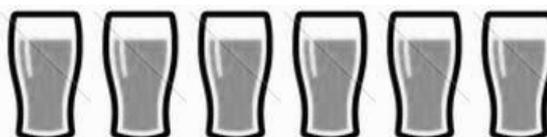
This means you should not drink more than this amount of wine...

1 small glass of wine 12% ABV=  
1.5 units  
93 Calories



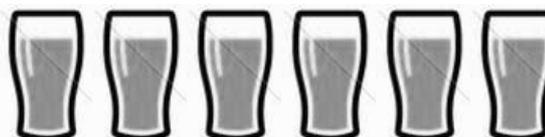
...OR this amount of lager or ale...

1 pint of beer: 3.5% ABV =  
2 units  
182 calories



...OR this amount of cider...

1 pint of cider: 4.5% ABV =  
2.6 units  
210 calories



...OR this amount of spirits...

1 single 25ml measure of spirits: 40% ABV  
=  
1 unit



### Cutting down

The key to successfully cutting down is to make small, but important, changes in your attitude towards drinking. Lots of little changes can add up to big change in your lifestyle. Here are some ideas:

Remember that home measures are often much bigger than you'd get when you're out. Buying small wine glasses or an alcohol measure are good ways of making sure you don't drink more than you intend to.

Try replacing the alcohol in your fridge with soft drinks. Luckily these days the soft option doesn't have to be dull, since the supermarket shelves are packed with upmarket cordials, smoothies and fizzy drinks.

**Opt out of rounds.** Drinking in rounds can make you drink a lot faster than you'd like or realise. Opt out or try buying drinks with a smaller group of friends instead.

**Watch out for cocktails.** They can contain more alcohol than you might think.

**Spread out your drinks throughout the night.** This will help your units go further.

**Try smaller measures.** Rather than sticking to pints, try sipping halves, go for a bottled beer or if you are drinking wine, opt for a small glass.

**Go diluted.** Try a more diluted alcoholic drink such as a spritzer or shandy.

**Space with soft drinks.** Have a soft drink or two with each alcoholic drink to help you stay hydrated.

### Five benefits to cutting back on alcohol

Keeping an eye on what you drink can have a positive effect on your overall health and well-being. It can help you:

**Watch your weight** Alcohol is heavy on calories. And with 682 calories in an average 13% bottle of wine, cutting down is a great way to stay in shape.

**Sleep soundly** Drinking less means that you get more high quality shuteye because alcohol interferes with the normal sleep process.

**Reduce stress:** Some people drink to relax, but in fact excess alcohol can actually make you feel more stressed because it's a depressant.

**Avoid hangovers** Keep to the government's low risk alcohol unit guidelines and you can kiss goodbye to a sore head, dry mouth and that dreaded "what on earth was I thinking last night?" hangover feeling.

**Stay healthy for longer** Cutting down can be great news for your long-term health. Drinking less alcohol reduces the risks of alcohol-related cancers, diabetes and heart disease. It puts less pressure on the liver too.

### Making your plan

Plan activities and tasks at those times you usually drink- when bored or stressed have a workout instead of drinking.

Explore other interests such as cinema, exercise, etc.

Have your first drink after starting to eat.

Quench your thirst with non-alcohol drinks before alcohol.

Avoid drinking in rounds or in large groups - avoid or limit the time spent with "heavy" drinking friends.

Switch to low alcohol beer/lager - take smaller sips.

## REFERENCES

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