Counties Manukau Health Alcohol Harm Minimisation Programme

Evaluation Report 2020

Ko Awatea Research and Evaluation Office

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COUNTIES MANUKAU HEALTH

KO AWATEA

HEALTH SYSTEM INNOVATION AND IMPROVEMENT

Contents

List of abbreviations

ABC	Assessment, Brief Advice, and referral for Counselling
AHM	Alcohol Harm Minimisation
AOD	Alcohol and Other Drug (AOD) – usually in the context of AOD providers/services
AUDIT	Alcohol Use Disorders Identification Test – a ten question assessment tool
AUDIT-C	Alcohol Use Disorders Identification Test-Consumption - a three question tool
CADS	Community Alcohol and Drug Services (Auckland)
CAYAD	Community Action on Youth and Drugs
CM Health	Counties Manukau Health
CM	Counties Manukau
DHB	District Health Board
ED	Emergency Department
ELT	Executive Leadership Team
FASD	Fetal Alcohol Spectrum Disorder
FIT	Police Family Intervention Team
FSM	Family Success Matters (previously Family Start Manukau)
GP	General Practice
HPA	Te Hiringa Hauora/Health Promotion Agency
IT	Information Technology
LSFS	Living Smokefree Service
MADSF	Metro Auckland Data Sharing Framework
MCIS	Maternity Clinical Information System
MoH	Ministry of Health
NGO	Non-Government Organisation
NMNP	Non-Maaori, non-Pacific
NZDep	New Zealand Deprivation Index
PDSA	Plan-Do-Study-Act
PHO	Primary Health Organisation
PMS	Patient Management System
QI	Quality Improvement
REO	Research and Evaluation Office
SBIRT	Screening, Brief Intervention and Referral to Treatment
WHO	World Health Organisation

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Evaluators would like to extend their deep appreciation to all the evaluation participants who have so courageously shared their experiences of care with us. Inclusion of consumer voices in evaluation ensures that healthcare staff are able to listen and learn from community experiences, and is critical to ensure that services are designed to serve the rights, needs, and interests of the populations they serve. Therefore, including consumer voices is fundamental to Counties Manukau Health's vision to achieve health equity.

Evaluators would also like to acknowledge staff from the health and social sector who participated in this evaluation, for the time they took to contribute their perspectives and experiences, for their work on the Alcohol Harm Minimisation Programme, and their support and commitment to the improvement and transformation of the programme and their services.

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Finally, thank you to the Alcohol Harm Minimisation Team, who have worked tirelessly to make progress on drivers of alcohol-related harms in the Counties Manukau community. Alcohol harm is a complex problem requiring many changes and solutions. This mahi requires staff who are passionate, resilient, and visionary in their planning and commitment to change.

Executive summary

Hazardous alcohol use and alcohol-related harms contribute to physical and mental ill-health, social, and economic burdens in the Counties Manukau population and are key drivers of health and social inequities. In 2016, in response to community and clinician concerns about the large and inequitable health and social burdens experienced by individuals and whaanau due to alcohol, Counties Manukau Health (CM Health) developed a programme aimed at reducing hazardous alcohol use and alcohol-related harms. The programme focusses on alcohol as a key determinant of population health and wellbeing outcomes, and prioritises prevention and early intervention actions.

An Alcohol Action Plan was developed in 2016, to guide activities and projects within the programme. The goal, focus areas and objectives of the plan are as follows:

Goal

Together, the CM Health system will work to reduce hazardous alcohol use and minimise the harms from alcohol, and achieve equity in key alcohol indicators for Maaori, Pacific people, and communities with health disparities by 2020.

Focus areas

1. Pursuing equity in access to high quality and culturally appropriate healthcare services, particularly the Alcohol ABC Approach (i.e. Assessment, Brief Advice, and referral for Counselling or other specialist help when indicated).
2. Working with communities and intersectoral partners to influence the social determinants of hazardous drinking and alcohol-related harm.

Objectives

1. In three key health settings (general practices, Middlemore Hospital, community/locality):
    i. Implement or further develop a systematic, sustainable, and equitable Alcohol ABC Approach.
    ii. Build the capacity and capability of those working in these settings to be able to provide equitable access to a high quality and culturally appropriate Alcohol ABC Approach.
    iii. Develop a system for data collection, recording, and output of key indicators for monitoring and evaluation.
2. Strengthen integration between the Alcohol ABC Approach and mental health and addiction services, including Alcohol and Other Drug (AOD) providers.
3. Support and enable communities/groups to take action on alcohol harm reduction.
4. Support and enable inter- and intra-sectoral collaborative work aimed at alcohol harm minimisation.

An evaluation of CM Health's Alcohol Harm Minimisation Programme 2016-2020 was commissioned by the Alcohol Harm Minimisation Team. The evaluation aimed broadly to describe and understand success and quality aspects of the programme, to support future work. The objectives of the evaluation were to assess programme implementation processes and delivery to determine what worked well and what didn't work well. Further objectives were to assess how successfully the

programme activities achieved short term outputs and outcomes, and to identify key learning and improvement points that can inform future development of the programme.

The evaluation design is a non-experimental, mixed method, process and outcome evaluation that involves the use of semi-structured interviews, document review, and Alcohol ABC Approach monitoring/audit data to respond to key evaluation questions.

The process evaluation aimed to understand perceptions and experiences of the delivery of the Alcohol ABC Approach among patients and staff, staff experiences of programme implementation, key risks and issues that arose during the implementation and how these were resolved, and key implementation enablers and success factors. Semi-structured interviews were completed with six programme staff, six key stakeholders, eight patient participants, and 19 staff participants from key health settings (i.e. general practices, Middlemore Hospital Emergency Department, CM Health Maternity Service, CM Health Living Smokefree Service, and Hand Therapy Outpatient Clinic at Manukau Health Park). Programme and project risk registers, and key milestone and/or enablers registers were reviewed.

The outcome evaluation aimed to understand how successful the programme was in increasing equitable delivery of the Alcohol ABC Approach in the priority settings, and to determine how successful the programme activities were in increasing the three programme 'domains' of influence (i.e. leadership, advocacy and the development of data, intelligence and evidence-based advice) on the determinants of hazardous drinking and alcohol-related harms. These evaluation questions were answered through review of Alcohol ABC Approach monitoring data from five projects, i.e. collaborating general practices, Middlemore Hospital Emergency Department, CM Health Living Smokefree Service, CM Health Maternity Services and Hand Therapy Outpatient Services (Manukau Health Park). The latter evaluation question about domains of influence was explored through qualitative interviewing, as outlined in the above paragraph.

The evaluators acknowledge the inequities experienced across several groups within the Counties Manukau region pertaining to age, sex, religion, and ethnicity. However, as a Crown agency, a conscious decision has been made to prioritise Tiriti partnerships. This is from both a rights-based and needs-based position, drawing deliberate and responsive attention to implications of this work for Maaori.

Executive summary of process evaluation findings

Process evaluation findings explore four key themes pertaining to patient and staff participant experiences of having conversations about alcohol:

- Key theme one - "It's a normal thing": Social norms, change, and Alcohol ABC conversations.
- Key theme two - "It's not a subject any stranger asks": Whanaungatanga and manaakitanga facilitate mana-enhancing conversations.
- Key theme three - "It's not just youth that are binge drinking": Recognising implicit bias in Alcohol ABC conversations.
- Key theme four - "I need my health": Conversations about alcohol are valuable and important.

- Key theme five - “We’re learning it is okay to ask”: Staff confidence to approach conversations about alcohol.

Alcohol use is inherently social; norms, expectations, behaviours, and beliefs surrounding alcohol are informed by social environments (Herbert, 2017). Aotearoa has a pervasive culture of high-risk alcohol use (Law Commission, 2010). However, negative stereotypes surround alcohol use disorder or consumption behaviours that fall outside of perceived social norms. These create stigmatisation and barriers to conversations about alcohol use and interventions (British Columbia Centre on Substance Use [BCCSU], 2019). Perceptions held by patient participants regarding the acceptability of their alcohol use, readiness for change, and experiences of Alcohol ABC conversations, are complexly informed by these social norms and stigma. Participant insights highlight the importance of early interventions that support the de-normalisation of hazardous alcohol use, which is integral to Alcohol ABC assessment and brief interventions/counselling. Staff practices that demonstrate whanaungatanga and manaakitanga were described as potentially protective for participants and facilitated safer, non-judgemental conversations about their alcohol use. Such practices are a cultural imperative, and support services to address equity and Te Tiriti o Waitangi commitments as mandated in healthcare settings (Wilson, et al., 2021).

Process evaluation findings show that both staff and patient participants think the Alcohol ABC Approach is a valuable and important practice, though how staff are able to prioritise and operationalise the approach in their work differs across settings and in response to changing work dynamics on a daily basis (for example, leadership support, workload, staffing levels, and COVID-19 disruptions). While this evaluation has demonstrated significant improvement in staff skills to approach conversations about alcohol, implicit biases - particularly ethnic biases - continue to manifest in staff interactions with patients. Ethnic biases are a form of racism and determinant of health (Bloomfield, 2019). Addressing this racism is critical to ensuring future conversations about alcohol are equitable and culturally safe; this requires staff to thoroughly examine their own culture and better understand how this impacts on their interactions with others (Curtis et al., 2019). Addressing implicit bias of any form (i.e. related to ethnicity, age, sex, or something else) requires structured and ongoing intervention to identify and disrupt biased behaviours, as well as develop empathetic relationships and health improvement interventions.

Key enablers of programme implementation related to workforce (e.g. existing skills such as motivational interviewing, staff availability and prioritisation of the Alcohol ABC Approach, and community reach), organisation (e.g. information technology infrastructure, organisational culture, leadership and strategy, as well as processes and policies) or programme (e.g. resourcing, vision, communication and buy-in, relationships, and collaborative style). Staff participants highly commended the collaborative working style of the Alcohol Harm Minimisation Team members. Risks and issues of programme implementation related largely to staff capacity and procurement. Furthermore, the development of data infrastructure to support Alcohol ABC monitoring was challenging; requiring the team to tailor to unique information technology or other constraints across projects. COVID-19 was highly disruptive to implementation in some projects, causing workforce redeployment and re-prioritisation of pandemic responses.

Executive summary of outcome evaluation findings

The Alcohol ABC Approach is evidence based and best practice and should be continued, however, implementation outcomes have varied across projects. The Living Smokefree Service has successfully integrated the Alcohol ABC Approach into their core business, and indicates what is potentially possible with this work. This success has been enabled by a number of factors including pre-existing skill, experience, and confidence in motivational interviewing, familiarity with the 'ABC' approach which underpins both alcohol and smokefree programmes, strong leadership and a culture of innovation within the team, and the service focus on being client-focussed and holistic. No disparities of the Alcohol ABC Approach delivery across age, sex or ethnicity are apparent in Alcohol ABC monitoring for this service.

Increased uptake of the Alcohol ABC Approach over time is evident in the Hand Therapy Outpatient Service, despite set-backs to the project during COVID-19 lockdown periods. The Maternity Service and some general practices show relatively high and stable delivery of the Alcohol ABC Approach. However, many of the general practices collaborating in this project have relatively low coverage of Alcohol ABC, and in some cases, coverage is declining. It must be acknowledged that recent times have been very challenging for general practice, particularly due to the impact of COVID-19. Of the project settings described, Middlemore Emergency Department may be the most challenging setting for delivery of Alcohol ABC Approach. Low uptake of the Alcohol ABC Approach and the ethnic disparities evident in audit data in Middlemore Hospital Emergency Department suggest further consideration should be given to the feasibility of the current model of Alcohol ABC delivery in this setting. Furthermore, whether there are alternative options that may be more successful in enabling uptake of an equitable Alcohol ABC Approach should be considered. Disparities in Alcohol 'A' coverage by age group and ethnicity have occurred over several projects and service settings including general practice, Middlemore Emergency Department, Maternity Services, and Hand Therapy Outpatient Services.

Findings from qualitative interviews suggest that in many instances the Alcohol Harm Minimisation Team have exceeded expectations in their demonstrated leadership, advocacy, and data and evidenced based actions. While the goals and objectives of the programme were identified by some participants as "ambitious", they have simultaneously identified the work and related goals and actions as worthwhile, evidence based, and of value to key partners. Significant work still needs to be undertaken to support consistency and quality of Alcohol ABC monitoring across all settings.

Executive summary of conclusions

This evaluation report largely focuses on the implementation and outcomes of the Alcohol ABC Approach, and this focus is reflected in the evaluation recommendations for the programme. Long term monitoring of population level alcohol-related harm indicators is needed to support understanding of outcomes and impacts over time and should be a future focus of the programme. While the contribution of the programme to changes in such indicators may be considered, it will not be possible to attribute any change directly to programme activities due to the complex nature of causation of alcohol-related harms. However, strategic focus, resourcing, and activities aimed towards influencing the social determinants of hazardous alcohol use, is a critical focus of the

programme which should be retained. It is clear from existing evidence that the most rapid, effective, and cost-effective alcohol harm reduction comes from public health measures.

The Alcohol Harm Minimisation Programme commenced in 2016 and since then has achieved considerable progress towards the programme goals and objectives. Notably, staff who have completed Alcohol ABC Approach training demonstrate a self-reported improvement in knowledge, skills, and confidence to deliver Alcohol ABC, and enhanced perceptions of the value and importance of the Alcohol ABC Approach.

Presence of disparities in Alcohol ABC Approach monitoring data or audits, contextualised with qualitative insights from staff (e.g. implicit bias findings), demonstrate the current inequitable delivery of Alcohol ABC Approaches across CM communities. While this evaluation has highlighted the need to disrupt implicit biases held by staff, particular attention to eliminating racism is critical to creating services that meet the rights and needs of Maaori communities. Overall, several findings in this evaluation point to the need for decolonised[1] approaches to alcohol harm reduction. Decolonising health and care systems in Aotearoa are clearly aligned with health equity rights and aspirations of Maaori communities (Came et al., 2020), Te Tiriti responsiveness, and strategic priorities of CM Health.

The report concludes with 20 evaluation recommendations.

[1] "Decolonisation is both an individual and collective process of revealing and analysing the historic and contemporary impact of colonisation, and institutional racism, combined with political commitment to recognition of indigenous sovereignty" (Came, Warbrick, McCreanor, Baker, 2020, p.103).

Introduction

Hazardous alcohol use[2] and alcohol-related harms contribute to physical and mental ill-health, social, and economic burdens in the Counties Manukau (CM) population and are key drivers of health and social inequities. Alcohol is an addictive psychotropic drug, a carcinogen, and an intoxicant. It is a leading cause of violence and injury; a cause of many other conditions including alcohol dependence, liver cirrhosis, cancers, cardiovascular disease, and Fetal Alcohol Spectrum Disorder (FASD); and a contributing factor to many negative mental health outcomes including suicide. Alcohol-related harms extend beyond the individual with impacts experienced by children (including those exposed to alcohol in utero), whaanau, and communities. Alcohol-related harms experienced by CM residents are likely to be relatively high due to inequities in other areas of life (e.g. socio-economic disadvantage) contributing to a compounding effect of inequities in alcohol-related harm (Loring, 2014).

Widespread availability and easy access to cheap alcohol are important determinants of hazardous drinking and alcohol-related harms. For people living in the CM district there are, on average, five alcohol off-licence premises within a five-minute drive, and 30 off-licence premises within a 10-minute drive of where people live. One quarter of the schools and preschools are located within a five-minute walk of at least one off-licence premise, and over half are located within a 10-minute walk of at least one off-licence premise (Auckland Regional Public Health Service, 2016).

It is estimated that one in seven CM residents aged 15 years and over engage in hazardous drinking patterns (Ministry of Health (MoH), 2019). In adults who drink (i.e. excluding those who have not had any alcohol in the past year), approximately one in five adults in CM drink in a way that is considered hazardous or harmful to their health (Table 1). Among the CM Maaori community and Pacific populations, the percentages of people engaged in hazardous drinking and heavy episodic drinking[3] are much higher than other groups (Table 1). Although many Pacific people do not drink alcohol at all, those who do drink alcohol are more likely to have a hazardous drinking pattern than non-Pacific adults (MoH, 2016).

[2] Hazardous alcohol use is measured using the 10-question Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organization (Babor, et al., 2001). The AUDIT is a 10-item questionnaire that covers three aspects of alcohol use: alcohol consumption, dependence, and adverse consequences. An AUDIT score is the total of the scores obtained for each of the 10 items (scores can range from 0 to 40). Hazardous drinking is indicated by an AUDIT score of 8 or more, representing an established pattern of drinking that carries a high risk of future damage to physical or mental health.

[3] Heavy drinking is defined as consumption of six or more standard drinks on one occasion and is derived from Question 3 of the AUDIT.

Table 1: Alcohol use indicators for the CM Health population aged 15 years or more

Alcohol use indicators	Maaori	Pacific	Asian	European & Other ethnicity groups	Total
Percentage of people who drank alcohol (in past year)	80%	52%	52%	82%	67%
Hazardous alcohol use*	36%	35%	6%	20%	20%
Heavy drinking at least monthly*	29%	34%	11%	21%	21%
Heavy drinking at least weekly*	16%	20%	3%	13%	12%
***** *In people who drank alcohol in the past year.*					

Data source: NZ Health Survey for the population living in the Counties Manukau Health (CM Health) area, pooled crude data for 2017/2018 and 2018/2019, total response ethnicity.

A range of alcohol-related harm indicators, including alcohol-related mortality, hospitalisations, and Emergency Department (ED) presentations have been described in the 'CM Health Alcohol-Related Harm Profile' (2018), and overall this paints a picture of great concern in relation to inequities in alcohol-related harms (Wright, 2018). Data from Middlemore Hospital ED shows substantial numbers of alcohol-related presentations and significant inequities for Maaori people (Figure 1). Per quarter, by ethnicity groups, four to six percent of all ED presentations of Maaori people are directly related to alcohol, and approximately three percent of ED presentations are alcohol-related within Pacific and non-Maori non-Pacific (NMNP) groups. High numbers and percentages of alcohol-related presentations are also seen in males, people between the ages of 15 and 44 years, and people living in the most socioeconomically deprived areas (Sharpe, 2019b).

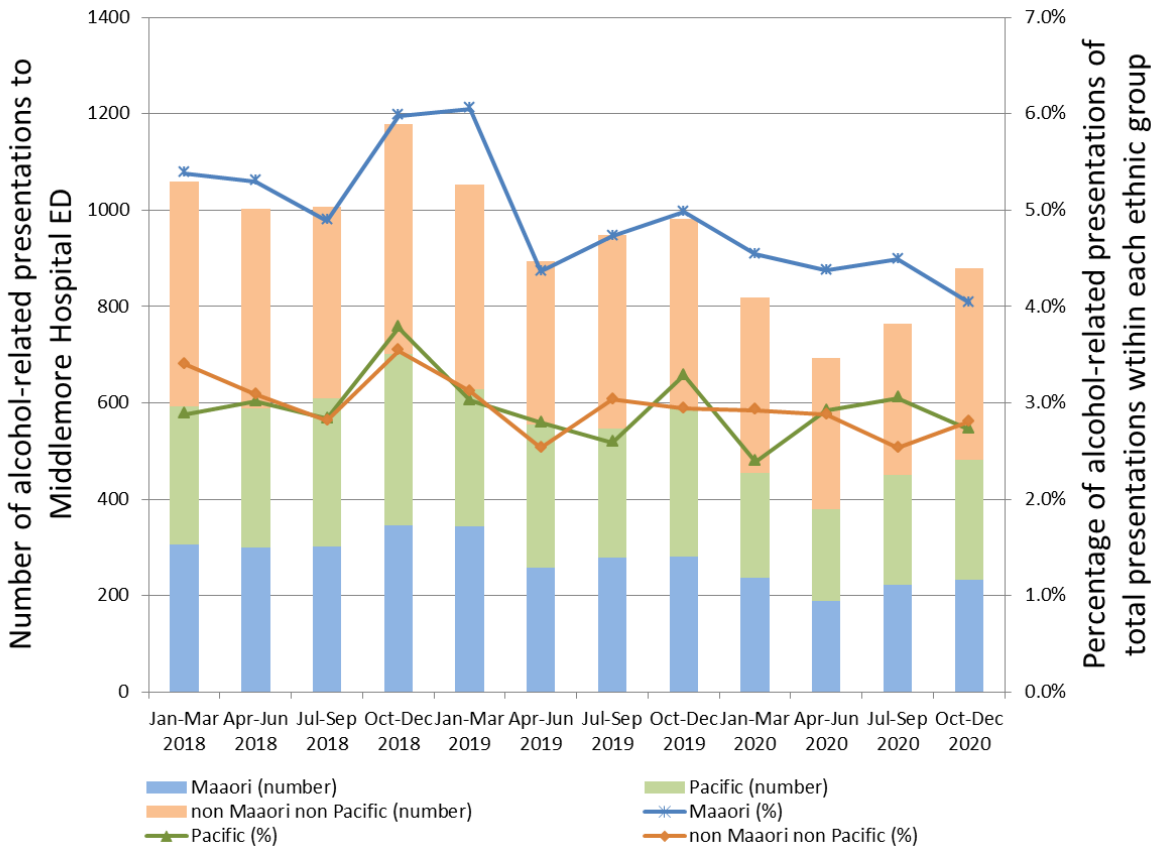


Figure 1. Alcohol-related presentations to Middlemore ED

Data source: National Non-Admitted Patients Collection, analysis by CM Health.

Analysis conducted at CM Health estimated there were approximately 2,900 alcohol-involved hospital admissions to Middlemore Hospital in 2018, accounting for three percent of all hospital admission events to Middlemore Hospital in 2018, and 4.3 percent of acute hospital admission events (Sharpe, 2019b). High proportions of alcohol-involved hospital admissions were seen in males, Maaori, Pacific peoples, NZ European/Other (i.e. NMNP/non-Asian) ethnic groups, people aged 15-24 years, and those living in the most socioeconomically deprived communities (Table 2). As well as causing an enormous impact on patients and their whaanau, alcohol use creates a significant health and financial burden for hospital services.

Table 2: Numbers and percentages of alcohol-involved hospital admissions at Middlemore Hospital, by demographic variables, 2018

Demographic variables	Number of alcohol-involved hospital admissions	Percentage of total alcohol-involved hospital admissions	Percentage of total hospital admissions in each subgroup
By sex			
Female	974	33.9%	1.8%
Male	1903	66.1%	4.5%
By ethnic group			
Maaori	802	27.9%	4.4%
Pacific Peoples	748	26.0%	2.6%
Asian	270	9.4%	1.8%
Other	1057	36.7%	3.0%
By age group			
0-14 years	49	1.7%	0.3%
15-24 years	724	25.2%	6.7%
25-34 years	573	19.9%	3.9%
35-44 years	431	15.0%	4.6%
45-54 years	411	14.3%	4.3%
55-64 years	361	12.5%	3.4%
65-74 years	214	7.4%	2.1%
75-84 years	95	3.3%	1.1%
85+ years	19	0.7%	0.4%
By NZDep2013 quintile			
1	261	9.1%	2.3%
2	317	11.0%	2.6%
3	333	11.6%	2.8%
4	485	16.9%	3.0%
5	1465	50.9%	3.3%
Missing data	16	0.6%	3.0%
Total	2877	100%	3.0%

CM Health Alcohol Harm Minimisation (AHM) Programme

In 2016, in response to community and clinician concerns about the large, inequitable health and social burdens experienced by individuals and whaanau due to alcohol, CM Health developed a programme aimed at reducing hazardous alcohol use and alcohol-related harms. The programme focusses on alcohol as a key determinant of population health and wellbeing outcomes and prioritises prevention and early intervention actions. This work has been prioritised by CM Health as part of the organisation's 'Healthy Together' strategic plan (CM Health, 2015). Reduction of hazardous alcohol use and alcohol-related harms will contribute to achieving the strategic goal of "working with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020" (CM Health, 2015, p.4).

The programme is underpinned by an equity approach which has two main focus areas: 1) pursuing equity in access to high quality and culturally safe alcohol Assessment, Brief advice, and referral for Counselling or other specialist help when indicated (ABC, i.e. the Alcohol ABC Approach, also known as Screening, Brief Intervention and Referral to Treatment (SBIRT)), which has been identified previously as a large service gap in CM Health; and 2) working with individuals, whaanau, communities, health agencies, and other stakeholders to influence the social and environmental determinants of hazardous alcohol use and alcohol-related harms.

These programmatic components draw on international evidence and World Health Organization (WHO) recommendations for alcohol harm minimisation. SBIRT is an evidence-based, cost-effective approach to identify, reduce, and prevent harmful drinking and alcohol-related harms (British Columbia Centre on Substance Use, 2019; Kaner et al., 2018; Love & Ehernbery, 2011; WHO, 2019). Implementation is recommended as best practice for individual-level interventions as part of a comprehensive strategy that also includes multiple public health measures (WHO, 2019). Accumulating evidence supports community organising and national legislation directed towards three particular measures: (i) raising the purchase price through mechanisms such as increasing taxes on alcohol and establishing minimum unit pricing, (ii) restricting availability and access to retailed alcohol (notably through reducing outlet density), and (iii) comprehensive bans on alcohol advertising across different mediums (Loring, 2014; Seigfried et al., 2019; WHO, 2018, 2019). The application of alcohol interventions, regulations, policies, and programmes within an equity framework is crucial (The Lancet Public Health, 2020; Loring, 2014; Roche et al., 2015; WHO, 2010). Not only does the absence of an equity lens risk failure to address disparities, it can also contribute to inadvertently deepening inequities (Loring, 2014; Roche et al., 2015).

Alcohol Action Plan

An Alcohol Action Plan was developed in 2016 to guide activities and projects within the programme. The goal, focus areas and objectives of the plan are as follows:

Goal

Together, the CM Health system will work to reduce hazardous alcohol use and minimise the harms from alcohol, and achieve equity in key alcohol indicators for Maaori, Pacific people, and communities with health disparities by 2020.

Focus areas

1. Pursuing equity in access to high quality and culturally appropriate healthcare services, particularly the Alcohol ABC Approach.
2. Working with communities and intersectoral partners to influence the social determinants of hazardous drinking and alcohol-related harms.

Objectives

1. In three key health settings (general practices (GPs), Middlemore Hospital, community/locality):

   i. Implement or further develop a systematic, sustainable, and equitable Alcohol ABC Approach.
   ii. Build the capacity and capability of those working in these settings to be able to provide equitable access to high quality and culturally appropriate Alcohol ABC Approach.
   iii. Develop a system for data collection, recording, and output of key indicators for monitoring and evaluation.
2. Strengthen integration between the Alcohol ABC Approach and mental health and addiction services, including Alcohol and Other Drug (AOD) providers.
3. Support and enable communities/groups to take action on alcohol harm reduction.
4. Support and enable inter- and intra-sectoral collaborative work aimed at alcohol harm minimisation.

Alcohol Action Plan activities

Work has been underway since 2016 to develop and implement a range of activities and projects related to the two 'focus areas' and four objectives. The logic model for the programme (Figure 2) depicts the main activities, intended outputs, and longer-term outcomes that are anticipated to be achieved with time (i.e. reduced inequity in access to the Alcohol ABC Approach and increased influence on the determinants of hazardous drinking and alcohol-related harms). The dotted line connecting 'outcomes' and 'impact' indicates that the CM Health programme is anticipated to contribute to population-level goals (i.e. reducing hazardous alcohol use, minimising the harms from alcohol, and achieving equity in key alcohol indicators for Maaori, Pacific people, and communities with health disparities), and indicates that progress requires contributions from a wide range of actors (including government and society) and implementation of a comprehensive range of alcohol harm minimisation strategies.

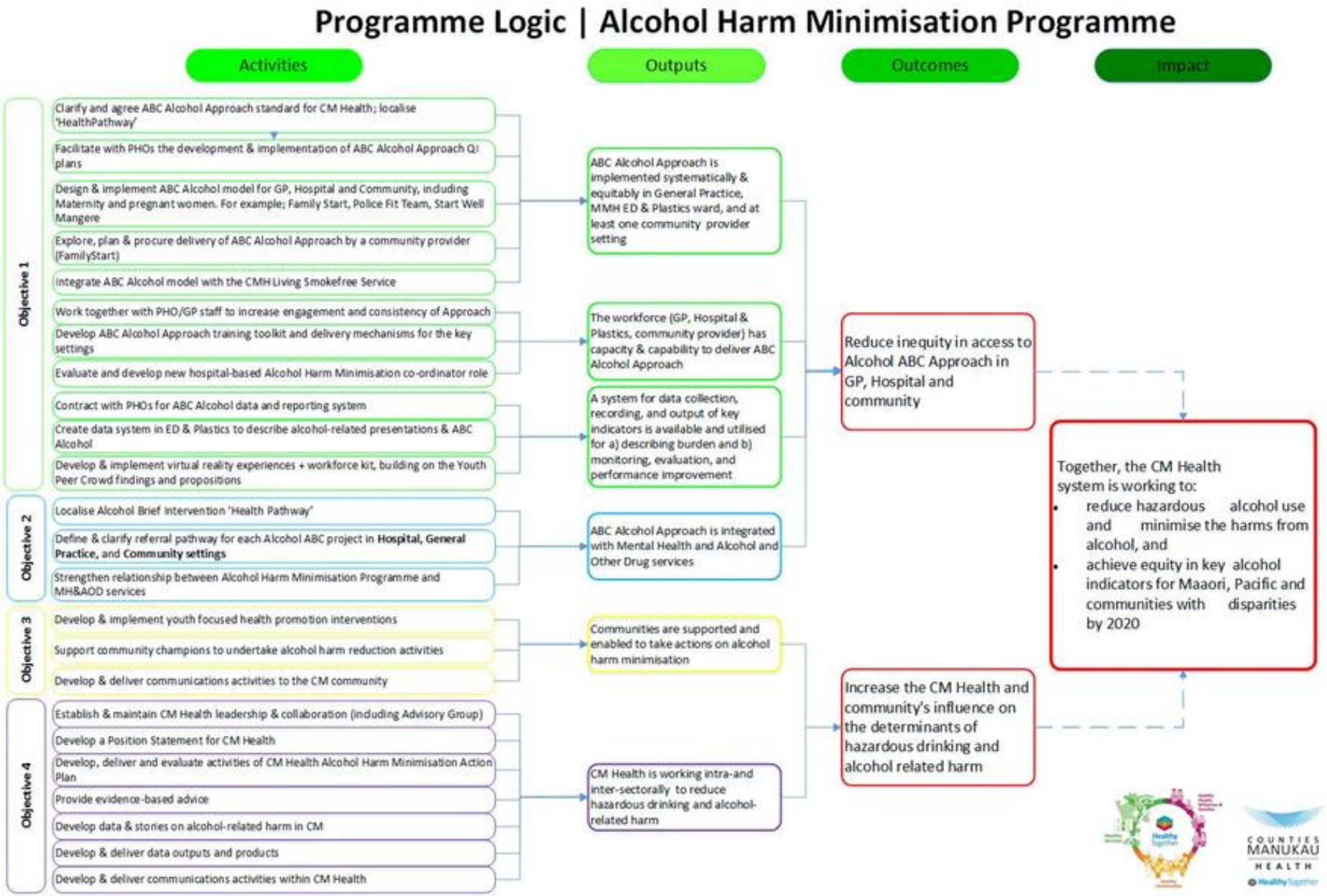


Figure 2: Programme Logic – Alcohol Harm Minimisation Programme.

Alcohol Action Plan activities – an overview of objectives one and two

Figure 3: Summary of the Alcohol ABC Approach

Related to objectives one and two, eight Alcohol ABC Approach projects were commenced across three broad settings: GP, Middlemore Hospital, and community-based settings. This work required adaptation of the Alcohol ABC Approach model to each project setting, development of supporting systems and processes, and customised training and sustained support for front-line staff to enable them to have skilled and empathetic conversations with individuals and whaanau about alcohol use. It was intended that projects would be developed and implemented in a collaborative and supportive way.

In CM Health, the Alcohol ABC Approach (Figure 3) is used for delivery of SBIRT, adapted from The Royal New Zealand College of General Practitioners "Implementing the ABC Alcohol Approach in Primary Care" guide (The Royal New Zealand College of General Practitioners, 2012). The ABC Approach was initially created to support smoking cessation in Aotearoa, New Zealand (henceforth Aotearoa). It has been adapted for alcohol, as a model for healthcare staff to understand the key steps in helping people recognise and change their drinking behaviours. The purpose of the Alcohol ABC Approach is to provide a systematic way of embedding alcohol assessment and advice into the health system and the everyday practice of all health professionals. For background information on the Alcohol ABC Approach, refer to Appendix A.

A brief description of the eight projects is provided below. The CM Health AHM Team worked collaboratively with staff in the settings to adapt and implement the Alcohol ABC Approach using project management and Quality Improvement (QI) methods. Although each project was different, there were common components, including:

- Project structures and processes such as regular meetings with project team members;
- Identifying key stakeholders and Alcohol Champions;
- Adapting existing processes and forms to include an alcohol assessment, i.e. the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) tool;
- Provision of resources (i.e. 1737 cards, Te Hiringa Hauora/Health Promotion Agency (HPA) pamphlets, CM AOD Service Map, Conversation Starter cards);
- Training for staff (on 'Having Conversations about Alcohol using the Alcohol ABC Approach');
- Encouraging staff to complete the HPA/Ministry of Health (MoH) Alcohol ABC eLearning module;
- Data collection, recording, and output of Alcohol ABC indicators;
- Monitoring and evaluation.

Project 1: General practice

Since 2017/2018, CM Health has contracted the five Primary Health Organisations (PHOs) in the CM Health region to deliver the Alcohol ABC Approach in GP. This work involves PHO and CM Health

staff working together to support 'collaborating practices' to implement QI Plans which focus on key areas: workforce training in the Alcohol ABC Approach; equitable access to Alcohol ABC for the enrolled population; development of data systems to support Alcohol ABC; and communication activities to support the work and raise awareness of the importance of alcohol assessments and management of problems. PHO alcohol champions support practices on a regular basis and learning is shared within and between practices and PHOs. Monthly meetings of PHO alcohol champions and CM Health staff are held to discuss progress, share enabling factors, brainstorm approaches to barriers and problems, and collaboratively adapt and support the Alcohol ABC Approach in GP. This work initially started with 11 collaborating practices, which are included in the scope of this evaluation. At the time of writing this report, there are now 22 collaborating practices taking part.

Project 2: Middlemore Hospital ED

This project started as part of the 2016-2018 Ko Awatea 'Mana Taurite/Equity in Health' Campaign and has continued since then with the support of an ED nurse who works as clinical lead for alcohol in ED 0.2 FTE (funded by AHM, Population Health Directorate). The AHM Team and ED staff are working together to implement the Alcohol ABC Approach in the ED, aligned with MoH requirements (from July 2017) for all EDs in Aotearoa to routinely collect data on alcohol-related presentations. A mandatory question was included in the CM Health Patient Management System from October 2017: 'Is alcohol associated with this presentation?'. Response field options include: 'Yes – alcohol is directly associated with presentation'; 'No – not directly associated'; 'Unknown – not known or could not be determined'; and 'Secondary – yes, from someone else's use of alcohol'.

Project activities have included: design of Alcohol ABC processes and documentation within the ED workflow, testing and further development of the model and tools (e.g. development of an 'Alcohol ABC sticker' that can be placed into the hard copy clinical notes), training and support of staff to be able to complete the mandatory question at triage, training and support of staff to be able to have conversations about alcohol during the assessment and stay in ED of patients with alcohol-related presentations, data collection and reporting activities, and a range of communications activities.

Project 3: Community-based social work provider in the Manurewa community

This project was funded by the HPA. The project is briefly described here as it was part of the CM Health alcohol work programme, however it is considered out of scope for this evaluation, as a stand-alone project evaluation has already been completed (Parwaiz et al., 2019). The project was a collaborative partnership, running from November 2017 to March 2019, between CM Health and Family Success Matters (FSM); a not-for-profit home-visiting social work provider located in Manukau. FSM delivers the Family Start programme, a child-centred, strengths-based approach which aims to improve early childhood and whaanau wellbeing outcomes.

The aim of the project was to adapt, implement, and refine the Alcohol ABC Approach with a social work team at FSM. Work occurred in four distinct phases, including: (i) engagement and planning, (ii) training, (iii) implementation, and (iv) completion. The work incorporated continuous QI methodology.

The evaluation demonstrated that the aims of the project were achieved and that staff and clients and their whaanau saw value and importance in having conversations about alcohol use and harms. Key recommendations highlighted:

1. The need to ensure appropriate project support, including the importance of buy-in and support from senior leadership and staff involved, as well as having adequate project level resource such as a project manager.
2. High quality training and supervision is vital for successful implementation;
3. The need for further development of resources/tools for delivery of Alcohol ABC Approaches and electronic systems for data capture and monitoring.

Project 4: CM Health Living Smokefree Service

Since November 2017, the AHM Team and Living Smokefree Service (LSFS) have worked together to integrate Alcohol ABC Approach into the LSFS model of care. There is synergism in combining these two components as they are both based on the 'ABC' approach and Smokefree practitioners are experienced in the motivational interviewing skills which underpin the approach. Addressing alcohol use in the context of stop smoking services makes sense as tobacco smoking and hazardous drinking tend to co-exist in individuals and whaanau. An integrated approach results in a more client-focussed, holistic service.

Project activities have included: adaptation of the Alcohol ABC model to fit with the LSFS workflow using iterative Plan-Do-Study-Act (PDSA) methods; 'Having Conversations about Alcohol' training of the LSFS Team; follow-up training and supervision sessions for further support and advice; and setting up data collection and reporting systems. Various process issues were encountered and resolved during the project. For example, Smokefree practitioners sometimes found they did not have adequate time to carry out Alcohol ABC, such as during 'walk-in' clinics. This was resolved by changing the process so that the alcohol assessment could be conducted at a subsequent appointment. The Alcohol ABC Approach is now considered 'business-as-usual' work for the LSFS staff.

Project 5: Whāngaia Ngā Pā Harakekeke (CM Police, in collaboration with CM Social Wellbeing Board)

In 2018, a collaborative project used QI methodology to implement and test the Alcohol ABC Approach with the Police Family Intervention Team (FIT) who follow-up with whaanau after a family harm callout. This project is considered out of scope for this evaluation as it was reviewed as part of the Social Wellbeing Board workplan. A brief description is provided here as this project included input and resource from the AHM Team.

The aim of the project was to design and test a model incorporating Alcohol ABC Approach into the FIT workflow. Work occurred in four phases: (i) planning (including interactive workshops to scope options and design the model), (ii) workforce training ('Having Brief Conversations about Alcohol') with a skilled facilitator, and (iii and iv) two iterative testing phases. Incorporating an adapted Alcohol ABC Approach was found to be appropriate, useful, and feasible. At the conclusion of the project, several key enablers of further progress were identified, including implementing a consistent and sustained training approach across the whole team and across all agencies involved in

family harm response and prevention, and developing Information Technology (IT) tools and systems for recording data and actions, and development of resources for front line staff (e.g. prompt cards) to facilitate use of the model in practice.

Project 6: CM Health Maternity Service

This project consisted of two main activities: (i) Alcohol ABC data systems development and (ii) Alcohol ABC Approach training for District Health Board (DHB) employed community midwives. In 2018 it was identified that CM Health was not able to access and report on patient alcohol assessment data entered in the Maternity Clinical Information System (MCIS). Improvements to the alcohol fields in MCIS were made, including incorporating Alcohol ABC fields adapted for the maternity setting, with the changes being released in June 2019. The AHM Team worked with the Health Intelligence and Informatics Team to develop reporting on Alcohol ABC indicators. In the second part of this project, the AHM Team worked with the Midwifery Manager to support DHB-employed community midwives to have conversations with their clients about alcohol use. The Team provided access to training opportunities with an external specialist alcohol trainer and advised on appropriate resources about stopping drinking alcohol during pregnancy.

In addition, the AHM Team worked with the Child, Youth, and Maternity Team to incorporate the AUDIT-C alcohol assessment into the Survive & Thrive tool for Sudden Unexpected Death in Infancy Prevention and the Early Pregnancy Assessment Tool in GPs.

Project 7: Middlemore Hospital Plastics Ward

From March 2019, the AHM Team worked with key staff on a project which aimed to adapt and implement the Alcohol ABC Approach in the Plastics ward. Two nurses attended 'Having Conversations about Alcohol' training and were identified as alcohol champions to advise and support other nurses on the ward when required. Brief training sessions on the Alcohol ABC Approach and its relevant processes on the ward were delivered during handovers to reach most staff. However, during this time the ward had begun transitioning from paper records to eVitals (an electronic system for capturing clinical details). The AUDIT-C assessment tool was not included in the eVitals system and this was found to be a critical barrier which prevented uptake of Alcohol ABC Approach on the ward. The decision was made to pause this project and wait until an eVitals AUDIT-C tool was available.

The key learning from this project was the importance of IT enablement to support staff to embed conversations about alcohol in their workflow, be able to document clinical details about alcohol systematically, and avoid duplication by being able to identify patients who have already completed an alcohol assessment in ED.

Project 8: Hand Therapy Outpatient Service at Manukau Health Park

In early 2019, having seen a communications piece by the AHM Team in the CM Health Daily Dose (now 'The Dose'), the section head physiotherapist in the Hand Therapy Outpatient Service approached the AHM Team for assistance in implementing Alcohol ABC Approach in the Hand Therapy Outpatient Service, which cares for many people who have alcohol-related hand injuries.

The implementation process involved engagement with staff to adapt the Alcohol ABC Approach and ensure it fitted into the workflow of the therapists, development of the alcohol data recording system as part of the clinical notes and reporting of Alcohol ABC indicators, and training of staff in having conversations about alcohol with patients. In 2020, alcohol assessments were paused for a time due to the impact of COVID-19 and the requirement for virtual consultations. Following this, a 'refresher' training session was organised for the team to build confidence and assist in restarting delivery of Alcohol ABC. One of the team is conducting a project on alcohol-related hand injuries and the whole team have been involved in a visual display within the department to raise awareness of the harms of alcohol.

Development of workforce training systems and resources

The AHM Programme supports CM Health staff and partners to access a range of training resources, with the aim of enabling staff to have the knowledge, confidence and skills to deliver the Alcohol ABC Approach in a culturally-appropriate and health-literate way. By September 1st 2020, in-person training with a specialist alcohol trainer from ABACUS Counselling Training and Supervision had been completed by 287 staff. Staff are assisted to access and link with existing resources and AOD services when required for their patients, e.g. alcohol resources from the HPA, 'Need to talk? 1737 – free call or text' service, and the Finding AOD Support brochure (http://www.aodcollaborative.org.nz/counties-manukau-service-map).

The AHM Team has also developed de novo, updated, or localised specific resources including:

- A booklet about the Alcohol ABC Approach outlining alcohol harm in CM, the evidence for Alcohol ABC Approach, and an overview of how to deliver the Alcohol ABC Approach, including the assessment tools recommended to be used at CM Health.
- 'Conversation Starter' cards using a structured approach called 'You, Them, Me' to support staff on how to deliver brief advice.
- Short videos demonstrating the 'You, Them, Me' approach, localised for CM Health.
- An e-Learning module tailored to CM.
- An FASD animation for pregnant women and their whaanau explaining why alcohol-free pregnancies are important.

In addition, CM Health has collaborated with the New Zealand Drug Foundation and members of the Youth Peer Crowd Advisory Group, in the development of a '360° Empathy Tool', an interactive workshop using virtual reality headsets designed for healthcare staff who are curious about the experiences and perspectives of young people. The aims of the tool are to help healthcare staff see life through the eyes of young people, effectively engage with young people, and tailor their interventions for young people. The tool was awarded Silver in the Public Good category at the Best Design awards, and has been presented at the Design for Social Innovation conference in Aotearoa and the Agents of Change Summit in San Diego. Currently, the training is being offered to health professionals in South Auckland, testing what is needed for a larger scale roll out.

Development of data systems for collecting, recording, and monitoring Alcohol ABC Approach projects

Indicators for the Alcohol ABC Approach have been developed and implemented in five projects (GP, ED, Hand Therapy Outpatient Service, LSFS, and the Maternity Service). Electronic and/or paper-based systems for collecting and recording data (including the AUDIT-C assessment tool) have been set up de novo, or adapted, in each project setting. Monitoring and feedback loops to the project settings are in development. In the GP setting, CM Health developed and provided an Excel spreadsheet template for PHOs to upload Alcohol ABC data over the period of 2017 – 2019. Informed by this work, in a subsequent step, an Alcohol ABC data standard was developed collaboratively with, and agreed by, the Metro Auckland Data Sharing Framework group and implemented regionally from June 2019 utilising the HealthSafe data sharing system.

Activities to strengthen integration with AOD services

Activities have focussed on increasing awareness in each project setting of 'C' services (e.g. Community Alcohol and Drug Service (CADS) and other community based AOD services) and how to refer patients/clients to them. Information about available AOD services is incorporated into staff teaching sessions and a range of resources have been developed (e.g. the CM Health Alcohol ABC Approach booklet) or are routinely shared and encouraged (e.g. the AOD Service Map/Finding AOD Support brochure , 1737 text or call Alcohol and Drug Helpline). In 2017, the 'Alcohol Brief Intervention' page of HealthPathways[4] was localised for the Auckland Region in collaboration with subject matter experts, including PHO mental health and AOD service co-ordinators.

From 2018 to 2019 a member of the AHM Team was involved in collaborative work with the South Auckland Social Wellbeing Board and groups representing mental health and AOD service providers and Non-Government Organisations (NGOs) in the CM region. The collaboration aimed to improve networking, communication, and relationship-building between health and social sector organisations. It resulted in several projects, including the provision of information about AOD services and streamlining of service referrals within the Manukau District Court system.

Alcohol Action Plan activities – an overview of objectives three and four

From the outset, the programme included a dual focus on health service development (i.e. Objectives 1 and 2) as well as incorporating a broad and comprehensive 'upstream' public health approach, with the intended outcome of influencing the social and environmental determinants of hazardous alcohol use and alcohol-related harms, through supporting and enabling communities to take actions on alcohol (Objective 3) and facilitating the DHB to work collaboratively across the health system and with other sectors/partners to reduce alcohol harms (Objective 4).

The AHM Team determined three domains of 'influencing' that would be the focus of activities for the period of the first Alcohol Action Plan: 1) increasing CM Health's **leadership** for action on alcohol; 2) **advocacy** to reduce hazardous drinking and alcohol harms, particularly in relation to the most cost-effective, pro-equity alcohol harm reduction strategies (also known as the 'three best buys'): strengthening restrictions on alcohol availability; restrictions on alcohol advertising,

[4] https://aucklandregion.communityhealthpathways.org/16539.htm

sponsorship and promotion; raising prices on alcohol through excise taxes and other pricing policies) and; 3) **developing and providing data, intelligence, and evidence-based advice** on alcohol.

Community-focussed activities (objective three)

Youth Peer Crowd work

Since 2016, building on the findings from New Zealand 'Youth Peer Crowd' research (Rescue – Behaviour Change Agency, 2016), CM Health has collaborated with Odyssey, the New Zealand Drug Foundation, Healthy Families South Auckland, Community Action on Youth and Drugs (CAYAD), SportNZ, Oranga Tamariki, HPA, and Curative creative agency to increase support for groups of young people (aged 13 – 25 years) who are burdened the most by alcohol-related harm in South Auckland.

In 2017, the group commissioned a piece of work to identify, test, and refine a range of tailored interventions for young people living in South Auckland. This work incorporated co-design and social innovation methods and resulted in the development of a challenge-based initiative called 'The Movement' offering healthy alternatives to drinking alcohol. In 2019, a proof of concept was implemented including branding and promotion of a single day 'pop-up' event in the Manukau town centre. Insights from this work have led to a broadening of the concept to encompass a more holistic approach to wellbeing and further development has been focussed on engagement with rangatahi to guide the kaupapa forward. The project is currently in its third co-design phase and is now led by one of the young people who attended the first activation. Independent evaluation of the Youth Peer Crowd work found that "The New Zealand Peer Crowd Projects are an excellent example of how multiple-partner, cross-sector projects can operate successfully, and is arguably an unusual case in the New Zealand public sector, given the large collection of government and community agencies working together in a unified way" (Dommet et al., 2020, p.23).

Supporting community champions

AHM Team members have supported a small number of community alcohol champions. David (Rāwiri) Ratū, a Maaori Warden and champion for reducing alcohol harm among Maaori, is the claimant for 'Wai 2624 – the Alcohol Claim', which is due to be addressed during the Waitangi Tribunal Health Services and Outcomes Inquiry. In collaboration with David, key influencing activities were undertaken, including supporting Maaori health leadership in feedback to the MoH on the WHO Global Alcohol Strategy, presenting on alcohol issues to Tumu Whakarae (National Maaori DHB General Managers group), engagement with Maaori Wardens in Ootara, chairing of a Maaori advisory roopuu over 2019-2020, supporting the coordination and hosting of the Waipiro Symposium (see below), and scoping of a research project in the CM area.

Two community groups have been supported by the AHM Team:

- In 2017, the team provided advice and support to the Maangere East Community Centre in planning a project and applying for and being granted a HPA community action grant, to explore ways to reduce social supply[5] to young people in Maangere East.

[5] "In New Zealand, adolescents under the minimum purchase age (18 years) are commonly supplied alcohol via social sources such as parents/guardians, friends and others (social supply)" (Huckle & Romeo, 2018, p.4).

- In 2019 and 2020, the AHM Programme Manager provided advice and support to Kuraconnect - Planet Youth Papakura, which is a community-driven initiative (based on an Icelandic model) aimed at preventing uptake of substance use by at-risk youth and whaanau in Papakura.

Kuraconnect aims to provide the Papakura community with whaanau wrap around community services, driven by the community focusing on known protective factors to prevent uptake of substance use, such as connection and active engagement in sport, recreation, and culture. The Icelandic model showed that participation in organised sport and prosocial activities, and strengthening the supportive roles of parents and schools will result in empowered young people making positive decisions (Sigfúsdóttir et al., 2009).

Community-based communication activities

The AHM Team collaborated with HPA and CAYAD to localise HPA's 'Pre-Testie Bestie' national campaign within the CM area. 'Pre-Testie Bestie' is the second phase of the 'Don't know? Don't drink' campaign. It is part of the Aotearoa government's efforts to address and prevent FASD and aims to reduce alcohol use during early pregnancy by encouraging women to stop drinking if there is any chance they could be pregnant. Localisation activities were informed by insights gathered from three focus groups with young women. Women wanted to know more about FASD and identified the need for a whaanau-based approach to reducing alcohol use. Local campaign activities included:

- Development and dissemination of an animation outlining what FASD is and how to prevent it;
- Pop-up stalls at Summer Jams and Waitangi Ki Manukau events to provide visibility and local engagement with the campaign messaging;
- Engagement of the CM community with Pre-Testie Bestie messaging through a social media influencer (Baby Mama's Club);
- Dissemination of Pre-Testie Bestie posters within the community, at key places including bus stops and malls (which would not have been covered by the national campaign);
- Development and implementation of a competition aimed at generating creative local community content on FASD led by CAYAD and Te Ara Rangatahi in Waiuku.

In terms of reach, the digital activities were a valuable part of the localisation. The Baby Mama's Club's South Auckland video was viewed over 46,000 times on Instagram with nearly 200 comments, and the FASD animation was viewed nearly 2,000 times via CM Health's Facebook page. Over 200 people engaged with physical stalls held in the community about supporting alcohol-free pregnancies. Separate to the Pre-Testie Bestie campaign activities, the AHM Team, in collaboration with the CM Health Communications Team, has coordinated a number of activities for FASD Awareness Day each year, including messaging through available communication channels such as The Dose, Paanui, Communitycations and Neighbourly, engaging staff through quizzes and surveys, and running a CM Health computer screensaver.

CM Health influencing work (objective four)

Leadership and collaboration

The AHM Team has led the development and delivery of the Alcohol Action Plan and has worked with Ko Awatea's Research and Evaluation Office (REO) to develop the logic model (Figure 2), and to plan and conduct an evaluation. The team convenes a two-monthly CM Health Alcohol Advisory Group meeting, for the purposes of providing leadership, guidance and support for the AHM Programme and improving alignment, collaboration, and co-ordination across the CM Health system regarding alcohol harm minimisation actions. In implementing activities of the Alcohol Action Plan, the AHM Team has endeavoured to work collaboratively with community and health/social sector partners. The team has worked and interacted with a wide range of groups, including Auckland Regional Public Health Service, HPA, Auckland Council and CAYAD, Alcohol Healthwatch, Maaori Wardens, Healthy Families, NZ Drug Foundation, Maangere East Community Centre, PHOs, FSM, Manukau Locality group, CM Social Wellbeing Board, and CM Police. In December 2019, CM Health and partners (HPA, Kookiri ki Taamakimakaurau, Haapai te Hauora, and National Hauora Coalition) coordinated and hosted the first Waipiro Symposium in Aotearoa, which brought together Maaori leaders in alcohol work.

Position statement

In 2017, CM Health developed and adopted a position statement on 'Reducing harms from alcohol in our communities', which provides an evidence-based foundation for alcohol harm minimisation work at CM Health.

Provision of data, intelligence, and evidence-based advice

The AHM Team has been working to improve data, information, and intelligence on hazardous alcohol use and alcohol-related harms in the CM population. Three reports have been published on the CM Health website:

- Counties Manukau Health Alcohol-Related Harm Profile (2018); a comprehensive profile which frames alcohol harm from a Te Tiriti o Waitangi perspective and describes indicators of alcohol-related harm. It demonstrates stark inequities in alcohol-related harms, particularly for Maaori people (Wright, 2018).
- Alcohol-Specific Hospital Admissions in Counties Manukau (2019); a supplementary report presenting information on alcohol-specific hospital admissions by geographic locality (Sharpe, 2019a).
- Alcohol-Involved Emergency Department Encounters and Hospital Admissions at Middlemore Hospital in 2018 (2019), which reports that alcohol use was associated in 2018 with substantial harms and inequities for people and that alcohol creates a significant burden and cost for hospital services (Sharpe, 2019b).

In addition, information and evidence-based advice on alcohol have been provided in other formats (e.g. papers/powerpoints to leadership groups, submissions, student research project) and as part of communications activities (e.g. infographic posters within the hospital). Team members have been involved with a number of evidence-based submissions to government consultations on alcohol-related policies, including FASD (2016), the Government Inquiry into Mental Health and Addiction (2018), Sale and Supply of Alcohol (Renewal of Licences) Amendment Bill (2018), Inquiry into Health Inequities for Maaori (2019), and pregnancy health warning labels on alcoholic beverages (2020).

Communication activities within CM Health

In 2018, CM Health's Communications and AHM Teams worked together to develop a communications strategy and plan for the AHM Programme, which prioritises three annual campaigns: (i) Dry July, (ii) FASD Awareness Day and (iii) the 'Alcohol Summer Campaign'. To date, activities have included:

- Hospital-based physical stalls with interactive and engaging activities for staff and visitors (resulting in interactions with more than 400 staff, patients, and whaanau members);
- Development of screensavers for all CM Health computers and laptops;
- Articles for The Dose, Paanui, and community newsletters;
- Three stories from staff participating in Dry July;
- One community story sharing their experience of FASD;
- Quizzes for CM staff and surveys with the community to raise awareness of alcohol harm (resulting in 707 responses from staff across three quizzes, and 620 responses from members of the community across two surveys).

In 2020, the Communications and AHM Teams worked together with staff in ED to contribute short videos of staff for 'Uncap our Potential' (https://www.uncapourpotential.org.nz/), a campaign delivered by Alcohol Healthwatch, which calls on New Zealanders to imagine Aotearoa with less alcohol harm and provides examples of ways people and communities can take action on alcohol. In the videos, staff and other community members talk about what it would mean to them if there was less alcohol harm.

CM Health contracted Curative creative agency to develop a communications framework for the programme, with the aim to create a recognisable and cohesive 'look and feel' across all communications activities and collateral in line with CM Health branding. This work included the development of a photo gallery of people and places in the CM community to be used to promote alcohol harm minimisation and prevention. In addition, Curative developed four 'personas' representing key groups in South Auckland for the AHM Team to use as a lens to inform workforce development and communications activities. For example, the development of CM Health's Alcohol ABC e-learning module follows the journeys of the four personas to identify their experiences of alcohol-related harm, and opportunities in the health sector for healthcare staff to have a conversation about alcohol and deliver an intervention.

Evaluation purpose

The purpose of this evaluation is to describe and understand success and quality aspects of the CM Health AHM Programme 2016-2020, to support future work. The programme sponsor, team, and stakeholders would like to learn about what has worked well and what has not worked well, with a view to improving, changing, and further developing the programme.

Methodology

This chapter outlines evaluation objectives, audience, evaluation team, participant summary, evaluation methods and questions, and ethics statement.

Evaluation objectives

The objectives of the evaluation were:

1. To assess programme implementation processes and delivery to determine what worked well and what didn't work well.
2. To assess how successfully the programme activities achieved short term outputs and outcomes.
3. To identify key learning and improvement points that can inform future development of the programme.

Audience

The audience for this evaluation is:

- CM Health AHM Programme sponsor/s
- CM Health Population Health Programmes Steering Group
- CM Health Executive Leadership Team
- CM Health AHM Team
- Staff involved with implementing projects and activities of the Alcohol Action Plan
- Other stakeholders (e.g. CM Health Alcohol Advisory Group)

Evaluation team

This evaluation was led by Ko Awatea's REO, in collaboration with the AHM Team (CM Health), Library and Knowledge Services (Ko Awatea), and Dr Sarah Herbert (University of Auckland) who provided expert guidance on the evaluation methodology, particularly pertaining to the recruitment, interviewing, and analysis of interview data from patient participants. External contractors supported the transcription of qualitative interviews.

Participant summary

This evaluation involved several participant groups including:

- AHM Programme staff at CM Health (identified as 'programme staff participants' throughout reporting),
- CM Health and PHO/GP staff involved with implementing alcohol projects ('staff participants'),
- CM Health and GP staff carrying out the Alcohol ABC Approach ('staff participants'),
- Other key stakeholders involved or supporting the AHM Programme (e.g. CM Health Alcohol Advisory Group members) ('key stakeholder'),
- Staff completing ABC Alcohol training ('training participants'), and
- Patients receiving the Alcohol ABC Approach in the key settings stipulated in the Alcohol Action Plan ('patient participants').

Semi-structured interviews with patient participants (N=8) were completed across several project settings including: GP (N=3), ED (N=2), LSFS (N=2) and Hand Therapy (N=1). Participant demographics are summarised in Table 3 below. Due to only one patient participant identifying with a Pacific ethnicity, to protect the participant's identity, this has been reported generically as 'Pacific' instead of the specific ethnicity.

Table 3: Participant demographics noted as number (N), followed by percentage (%) – patient participant group

Sex, N (%)		**Age, N (%)**		**Ethnicity, N (%)**	
Male	4 (50%)	20-39 years	3 (37.5%)	New Zealand European	3 (37.5%)
Female	4 (50%)	40-59 years	4 (50%)	Maaori	3 (37.5%)
		60+	1 (12.5%)	Pacific	1 (12.5%)
				Other	1 (12.5%)

Staff, programme staff, and key stakeholder demographics are combined in Table 4 to protect the identity of participants. In total 19 staff, six programme staff, and six key stakeholders were interviewed. Staff interviews (N=19) included staff from various project settings as follows: PHOs (N=5), GP (N=3), ED (N=4), Hand Therapy Outpatient Service and Plastics Ward (N=3), Maternity Services (N=2), and LSFS (N=2). Staff involved with the CM Police and FSM projects were not included as these projects are considered out of scope for this evaluation (this was further detailed in the Background). Key stakeholder interviews (N=6) included external AHM partners in key leadership and/or management positions from a range of organisations that can contribute to reducing hazardous alcohol use and related harms (this included members of the CM Health Alcohol Advisory Group). Programme staff (N=6) contributed through a focus group session. This included staff responsible for the conceptualisation, development, and delivery of the AHM Programme. Please note that for the demographic summary on Table 4, some participants identified with more than one ethnicity therefore the ethnicity total exceeds the total number of participants.

Table 4: Participant demographics– staff (N=19), key stakeholder (N=6) and programme staff (N=6)

Sex, N (%)		**Age, N (%)**		**Ethnicity, N (%)**	
Male	6 (19%)	20-39 years	16 (52%)	New Zealand European	18 (49%)
Female	25 (81%)	40-59 years	11 (35%)	Maaori	4 (11%)
		60+	4 (13%)	Pacific	4 (11%)
				Other	11 (30%)

In total, 287 staff received Alcohol ABC Approach training (as of September 1st, 2020) across 17 training sessions specifically designed to accommodate the needs and availability of different staff groups and respond to the unique setting in which they apply the Alcohol ABC Approach. Sessions were designed for social workers, ED staff, LSFS staff, Hand Therapy Outpatient Service staff, Police Family Intervention Team, GP staff, secondary care (e.g. Pukekohe Hospital), and Maternity Services

midwives. There were 273 survey respondents of 287 individuals trained, resulting in a 95 percent participation rate in the training survey. Key demographics of survey participants were not collected.

Evaluation methods and questions

This is a non-experimental, mixed method, process and outcome evaluation design that involves the use of semi-structured interviews, document review, and Alcohol ABC monitoring/audit data to respond to key evaluation questions, as outlined below.

Process evaluation questions and methods

Process evaluation questions and related measures are summarised on Table 5. A more detailed description of methods, including fidelity to the intended evaluation approach follows.

Table 5: Summary of evaluation methods for process evaluation questions

Process evaluation question	Indicators/Performance Measures	Data sources and methods
1. What were staff perceptions and experiences of the Alcohol ABC Approach implementation process?	Description of staff perceptions and experiences of implementation process, including what worked and what didn't, and what processes could be improved.	Qualitative data: thematic analysis of transcripts of staff interviews and/or focus groups.
1.1. What were staff perceptions about the value and importance of Alcohol ABC Approach?	Distribution of scores (on a 4-point scale), of staff attending training sessions, for the following statements: • My thoughts on the value of Alcohol ABC Approach: nil, low, good, or high value; • Likelihood that I will use the Alcohol ABC Approach in my day to day work: nil, low, high, definite; • The extent to which this session (i.e. Alcohol ABC) is relevant to your work: not at all relevant, of little relevance, relevant, or highly relevant. Description of staff perceptions about value and importance.	Quantitative data: analysis of staff evaluation survey questions completed after each Alcohol ABC Approach training session. Qualitative data: thematic analysis of transcripts of staff interviews and/or focus groups.
1.2. Was there an increase in knowledge, skills, and confidence of staff to deliver Alcohol ABC	Distribution of scores (on a 4-point scale – poor, okay, good, excellent), of staff attending training sessions, for the following statements: • My understanding of alcohol and alcohol-related harm for individuals and whaanau; • My confidence when talking about alcohol	Quantitative data: analysis of staff evaluation survey questions completed after each Alcohol ABC Approach training

Process evaluation question	Indicators/Performance Measures	Data sources and methods
Approach?	with individuals and whaanau; • My knowledge of how to assess for alcohol problems; • My confidence in doing alcohol assessments in my work; • My knowledge of how to provide brief advice about alcohol; • My confidence in providing brief advice about alcohol; • My knowledge of when to refer clients on to other services for help with alcohol; • My knowledge of how to refer clients on to other services for help with alcohol. Description of changes in staff knowledge, skills, and confidence, including what helped to support this, what didn't, and what could be improved.	session. Qualitative data: thematic analysis of transcripts of staff interviews and/or focus groups.
2. What were patient/whaanau perceptions and experiences of being asked about alcohol?	Description of patient and whaanau perceptions and experiences of Alcohol ABC conversations, including what worked and what didn't, and what could be improved.	Qualitative data: thematic analysis of transcripts of patient and whaanau interviews; accounts of patient stories if appropriate.
2.1. What were patient/whaanau perceptions about the value and importance of being asked about alcohol?	Description of patient, client, and/or whaanau perceptions about value and importance of being asked about alcohol, including whether they think this is an important activity for health services to undertake, and why or why not.	Qualitative data: thematic analysis of transcripts of patient and interviews; accounts of patient stories if appropriate.
2.2. What were patient/whaanau feelings and experiences of being asked about alcohol and receiving advice or help?	Description of patient and whaanau feelings and experiences of being asked about alcohol and receiving advice/help, including what worked and what didn't, whether they received the help they wanted/needed, and what could be improved.	Qualitative data: thematic analysis of transcripts of patient and whaanau interviews; accounts of patient stories if appropriate.
2.3. Was the support delivered	Description of patient and whaanau feelings and experiences of cultural safety of support	Qualitative data: thematic analysis of

Process evaluation question	Indicators/Performance Measures	Data sources and methods
appropriate for the cultures and beliefs of patients/ whaanau?	delivered, including what worked and what didn't, culturally safety of staff practice, and what could be improved.	transcripts of patient, client, and/or whaanau interviews; accounts of patient stories if appropriate.
3. What were the key risks and issues that arose during the implementation and how were they resolved?	Narrative summary and description of risks and issues, how they were resolved, what can be learned from these, and what can be improved to prevent issues arising.	Review of Programme and Project Risk Registers. Qualitative data: thematic analysis of transcripts of project staff interviews.
4. What were the key enablers and success factors that arose during the implementation?	Narrative summary and description of enablers and success factors, what can be learned from these factors, and what factors can be put in place or enhanced in order to improved implementation.	Review of Programme and Project Key Milestone and/or Enablers Registers. Qualitative data: thematic analysis of transcripts of programme staff interview/focus group.

Process evaluation question one

Face-to-face semi-structured interviews were undertaken from August to October 2020 with staff involved in the implementation or delivery of Alcohol ABC Approach. The interview guide (Appendix B) included questions regarding: (i) perceptions and experiences of implementing the Alcohol ABC Approach, what worked and what didn't, and what could be improved; (ii) perceptions and experiences of having conversations about alcohol with patients/clients (for staff with patient/client-facing roles) and what can be improved; (iii) risks and issues, (iv) enablers and success factors, and; (v) success of the programme in increasing leadership, advocacy, and provision of data and evidence-based advice on alcohol. The AHM Team participated in a focus group in August 2020.

All staff taking part in Alcohol ABC Approach training sessions were asked to complete an evaluation survey (Appendix C) at the end of the training session. The survey explored: (i) staff knowledge about alcohol-related harms, hazardous alcohol use, brief advice delivery, referral, and support services, (ii) staff confidence to approach conversations about alcohol, (iii) key learning and intention to apply this learning, (iv) training relevance for their work and perceptions of value and importance, and (v) training gaps and needed improvements. The survey consisted of a combination of closed and open response formats, including Likert scale statements on a table with several attitudinal and knowledge-based statements presented on a simultaneous pre and post table. These items were

represented as counts and proportions and were compared using McNemar Bowker's test which is the test for agreement. All p-values of less than five per cent were considered as statistically significant. The proportions were visually presented in terms of Chord Diagram using R program.

Process evaluation question two

Semi-structured interviews were undertaken with patients/clients[6] (henceforth 'patient participants') who had a conversation about alcohol with their care provider. The interview guide included open ended questions pertaining to: (i) perceptions and experiences of being asked about alcohol, (ii) perceptions about the value and importance of being asked about their alcohol use, (iii) whether they received the support/help they needed (where relevant) or experiences of changes to alcohol use or alcohol-related harm as a result of ABC conversations, (iv) observations of alcohol-related harm in their life or community, and (iv) what could be improved about ABC Alcohol delivery (Appendix D). Closed questions to collect participant demographics were also included.

Two AHM Team members were provided with qualitative interview training facilitated by REO evaluators and Dr Sarah Herbert. Participants who identified as Maaori were interviewed by a Maaori staff member who was able to facilitate koorero in te reo Maaori per the communication preferences of participants. Non-Maaori participants were interviewed by a Pacific member of staff who is a trained counsellor and has an understanding of the AHM work. Interviews were planned face-to-face in the homes of participants to ensure they could be whaanau inclusive, however, were limited to phone interviews due to COVID-19 restrictions. Resultantly, conversations became focused with the primary participants, and lack of visual aids around the presence and engagement of others inhibited whaanau inclusion.

The evaluation initially aimed to include 20 patient participants. The intended sample had to be adapted for two key reasons: (i) the financial and time costs associated with interviewing, transcribing and analysing this number of interviews; and, (ii) recruitment challenges in some settings. While the number of patients to be interviewed was reduced, key liaisons supporting the recruitment of patient participants experienced difficulty recruiting participants. This was due in large part to the increased focus in primary care on COVID-19, and resulting prioritisation of COVID-19 response preparation. Some services were closed all together during the Level 4 COVID-19 lockdown period, meaning that patient participants could not be recruited during this time period.

The evaluation also aimed to ensure that at least half of the participants were Maaori, and that the participants represented a broad range of AUDIT-C scores to ensure inclusion of a diverse range of participant experiences and perspectives. However, the small sample of potential participants resulted in lower-than-expected participation of Maaori (40% as outlined on the demographic summary), and an overrepresentation from participants on the high end of hazardous alcohol use assessment (AUDIT-C). This is further explored in evaluation strengths and limitations.

[6] 'Clients' is the preferred terminology used by Smokefree Services who support community members with their health and wellbeing, but not in response to acute health needs or ill health. The term 'patient' implies the language of medicine, and positions medical professionals as 'expert' in their relationships with people to whom they deliver care (Joseph, 2013).

Process evaluation question three

Programme and project risk registers and programme quarterly reports were summarised with respect to 1) risks and issues arising during the implementation period, 2) response to risks identified including whether and how they were resolved, 3) what can be learned from these, 4) what can be improved to prevent such risks and issues arising in the future. Qualitative data from interviews with patients, staff, key stakeholders, and programme staff participants also contributed to the identification of risks and issues and related learning and resolution strategies.

Process evaluation question four

Programme and project key milestone and/or enablers registers and programme quarterly reports were summarised with respect to 1) enablers and success factors during the implementation period, 2) what can be learned from these, and 3) what factors can be put in place or enhanced in order to improve implementation. Qualitative data from interviews with patients, staff, key stakeholders, and programme staff participants also contributed to the identification of risks and issues and related learning and resolution strategies.

Outcome evaluation questions and methods

Evaluation questions and measures related to short term outcomes of the AHM Programme are summarised on Table 6. A more detailed description of methods, including fidelity to the intended evaluation approach follows. The AHM Team acknowledge that a commitment to long term monitoring of population health outcomes related to alcohol use and alcohol-related harms is needed. However, this is not included in the scope of the current evaluation reporting.

Table 6: Summary of outcome evaluation questions and methods

Evaluation Questions	Indicators/Performance Measures	Data Source and Methods
1. How successful was the programme in increasing delivery of the Alcohol ABC Approach in the priority settings (GP, hospital, and community)?	Number and % of Alcohol A (ask/assessment), B (brief advice), and C (referral for counselling or other help) provided. • Reported quarterly, annually or other interval (depending on the project and availability of data) over the course of each project.	Quantitative data sourced from the following: ED audit of clinical notes; PHO data from HealthSafe; LSFS database; Hand Therapy Outpatient Service community forms online; MCIS.
1.1. How successful was the programme in increasing	Number and % of Alcohol A, B, and C by variables: • Ethnicity; • Age;	As for Q1 above

Evaluation Questions	Indicators/Performance Measures	Data Source and Methods
delivery equitably?	• Sex;	
2. How successful were the programme activities in increasing the three programme 'domains' of influence on the determinant of hazardous drinking and alcohol-related harm?:	See 2.1, 2.2, 2.3 below	See below.
2.1. How successful were the programme activities in increasing CM Health's **leadership** for action on alcohol in the DHB setting?	Feedback from respondents on the following success criteria: • Ensuring clarity of goal (the what and why), strategy (the way), and actions (the how to); • Delivering the AHM Programme and driving for results; • Working collaboratively & in partnership; • Supporting innovative approaches; • Creating change. Description of respondent's observations and experiences regarding CM Health's leadership for action on alcohol in the DHB setting.	Qualitative data: Interviews with key stakeholders. Document review (organisational documents, Executive Leadership Team (ELT) papers, programme documents).
2.2. How successful were the programme activities in increasing **advocacy** to reduce hazardous drinking and alcohol-related harm?	Feedback from respondents on the following success criteria: • Delivering clear and consistent evidence-based messages to staff and the CM Health community; • Providing evidence-based advice to support policy change; • Supporting and enabling Community Champions to take actions. Description of respondent's observations and experiences regarding effects of the programme activities on advocacy to reduce hazardous drinking and alcohol-related harms.	As above (see 2.1).
2.3. How successful were the	Feedback from respondents on the following criteria	As above (see 2.1).

Evaluation Questions	Indicators/Performance Measures	Data Source and Methods
programme activities in increasing the **development and provision of data**, **intelligence- and evidence-based advice** on alcohol?	• Providing a clear vision and plan for data development and provision activities; • Developing data to describe the problem, burden and cost to the health system; • Developing and providing data outputs/products; • Providing evidence-based advice to support policy change; • Providing evidence-based advice to support policy change; • Bringing an equity focus to data activities. Description of respondent's observations and experiences regarding how successful the programme activities were in developing and providing data and evidence-based advice about alcohol.	

Outcome evaluation question one

Outcome evaluation question one aimed to report on the number and percent of Alcohol A (ask/assessment), B (brief advice), and C (referral for counselling or other help) delivered in GP, Middlemore Hospital ED, the CM Health LSFS, CM Health Maternity Services, and Hand Therapy Outpatient Service. As noted in the Background, Alcohol ABC Approach projects with a community-based social work provider and the CM Police were considered out of scope for this evaluation. There were no Alcohol ABC data to report from the Middlemore Hospital Plastics ward as this project was paused while awaiting IT enablement of alcohol assessments.

An ongoing focus of the AHM Programme is support for the development of data capture systems. It is important to note that Alcohol ABC data systems are work in progress and require ongoing development and improvement. Some projects are more advanced than others and accordingly there is variation across projects in data availability, completeness, and reliability. Table 7 summarises, by project, the inclusion or exclusion of Alcohol ABC data used in the evaluation. As Alcohol ABC Approach indicators were adapted for each project setting, there are some differences between settings in the definitions of the indicators, which are outlined in Appendix E.

Descriptive statistics of number and proportion of Alcohol ABC Approach activities undertaken over time are presented in this report, including number and proportion under key demographics (age, sex and ethnicity where available as defined on Table 4) to better understand if Alcohol ABC coverage was equitable. Locality of residence and/or NZ deprivation score were intended to be reported but data were not available for any projects.

Table 7: Summary of ABC Alcohol data inclusion in evaluation reporting for settings and projects

Project	Data inclusion statement and rationale
General Practice	• Data are reported by quarter from June 2019, which is when Alcohol ABC data became available utilising the Metro Auckland Data Sharing Framework (MADSF) HealthSafe data sharing system, to December 2020. Prior to this, as described in the Background section of this report, Alcohol ABC indicators were developed and tested in a first phase which involved use of an Excel spreadsheet template for PHOs to upload data into. Informed by this, an Alcohol ABC data standard was developed collaboratively with, and agreed by, the Metro Auckland Data Custodian group. • Alcohol ABC data in HealthSafe are contributed to by 87 percent of practices in the CM Health area and cover 92 percent of the enrolled population aged ≥15 years. Data from some practices are missing as some Patient Management Systems (PMSs) require further development in order to extract data to Healthsafe. • Alcohol A and B indicators are included and reported, by PHO, for each practice collaborating in the project. Alcohol C indicator is excluded as data capture is poor. • Percentages of Alcohol A by ethnicity, sex, and age were estimated for each PHO using aggregated data from the collaborating practices.
Middlemore Hospital ED	• Data are reported by month from June 2019 to December 2020, based on manual audits of clinical records. • Each audit examined a non-random sample of records from one week of each month. • Audits included clinical records of patients seen in the ED with alcohol-related presentations and included only those hard copy clinical records that were available (i.e. that could be retrieved at the time). • Alcohol A, B, and C indicators are included. • Percentages of Alcohol A by ethnicity, sex, and age were estimated by analysing aggregated audit data for 2020, as the samples of each individual audit were too small for subgroup analysis.
CM Health LSFS	• Data are from the LSFS database and are reported by quarter January 2018 to December 2020. • Data are reported separately for LSFS clients who are pregnant and 'general' service clients (i.e. males and non-pregnant females). • Alcohol A, B, and C indicators are included.

CM Health Maternity Service	• Data are from the MCIS and are reported monthly from August 2019 to December 2020. • Data are reported for care provided by DHB-employed midwives and do not include care provided by independent community-based Lead Maternity Carers (as the project was with DHB-employed midwives). • Alcohol A, B, and C indicators are included. • Ethnicity and age variables are reported for Alcohol A indicator only.
Hand Therapy Outpatient Clinic	• Data are from Forms Online and reported monthly from January to December 2020. • Alcohol A, B, and C indicators are included.

Outcome evaluation question two

The success (or otherwise) of programme activities to increase CM Health's influence within the three domains of 1) **leadership** for action on alcohol, 2) **advocacy** to reduce hazardous drinking and alcohol-related harm, and 3) development and provision of **data and evidence-based advice** on alcohol was described in a narrative review. The AHM Team provided 'success criteria' for each domain (presented on Table 6) to support evaluative discussion around their influence in these domains. While evaluators attempted to provide information and reporting pertaining to these definitions, this was challenging due to the perceived overlap of domains as expressed by evaluation participants. For example, in qualitative responses, discussion around the development and provision of data and evidence-based advice frequently overlapped with this being important leadership (e.g. CM Health leading this data capture ahead of other DHBs) and advocacy (e.g. using the data to support decision making and advocacy) action.

The review drew on the following inputs:

- Project and programme documents providing information on the activities and what they involved;
- Organisation and programme documents demonstrating the influence of the programme;
- Qualitative data from key stakeholder interviews.

Semi-structured interviews with key stakeholders were guided by an interview guide (Appendix F) and aimed to gather information regarding: (i) perceptions about CM Health's leadership for action on alcohol; (ii) perceptions about CM Health's advocacy work to reduce hazardous alcohol use and related harm, and; (iii) their perceptions about CM Health development and provision of data and evidence-based advice on alcohol.

Key stakeholders were identified and prioritised for interviews by the AHM Team, based on their involvement in the AHM work. These participants included members of the CM Health Alcohol Advisory Group, programme/project sponsors and clinical leads, HPA representatives, and community-based organisation leaders whom the AHM Team has worked with. These individuals

were initially contacted by AHM Team members to inform them about the evaluation work, and later contacted by evaluators directly for the purposes of recruitment and informed consent.

Evaluators aimed to complete seven interviews before reassessing and recruiting for a second wave of interviews, with the intent to complete a total of 15 key stakeholder interviews. However, due to the impact of COVID-19 workforce disruption on data collection timelines, a second round of interviewing was never undertaken. Six of seven key stakeholders in the original group prioritised by the AHM Team agreed to participate in the evaluation and were interviewed.

Semi-structured interviews (N=6) were conducted by evaluators over phone (N=4) or face to face (N=2) in July or August 2020. All interviews were recorded and later transcribed by an external research assistant. Interviews were thematically analysed with the support of NVivo software.

Evaluation strengths and limitations

This evaluation included both staff and patient participants. The inclusion of patient participants is a key strength of this evaluation. Insights from patient experiences of being asked about their alcohol use by staff are critical to better understanding how services can be improved upon, and specifically how unconscious bias manifests in interactions with patients. These insights are fundamental to informing the evaluation recommendations and subsequent programmatic actions that should result from this evaluation.

There are three main limitations to this evaluation. Firstly, due to participant recruitment challenges outlined earlier, only eight of the intended 20 semi-structured interviews with patient participants were completed. Further, these interviews were facilitated over the phone due to the impacts of COVID-19, and therefore were not whaanau inclusive as intended. Subsequently, there is an underrepresentation of patient participants in this evaluation. This may have impacted on the diversity of views and experiences included. Future evaluation should ensure a focused recruitment of low-level alcohol users, as well as patients across all health settings or projects, and with sufficient representation by Maaori participants as the priority, as well as Pacific participants.

Secondly, systems for the capture of Alcohol ABC Approach data are still developing with the support of the AHM Team. Consequently, there is variation in the availability and reliability of monitoring data across project settings which has impacted on the inclusion or exclusion of these data in this evaluation report, as detailed on Table 7. In the GP setting specifically, further work is required to ensure that all PMSs used by PHOs can extract Alcohol ABC Approach data to Healthsafe and data are consistent with the Alcohol ABC data standard. With regard to reporting of the Alcohol ‘C’ indicator (i.e. referral for counselling or other help for alcohol), it is not possible to know if patients referred for further specialised counselling did access these services. Alcohol ABC data were analysed by ethnicity, sex, and age groups, but not by a variable to assess level of deprivation (e.g. NZ Dep).

Thirdly, this evaluation has been led by Ko Awatea’s REO to ensure an independent and critical evaluation of AHM Programme activities and achievements. While this was important to the AHM Team and sponsors, members of the REO hold less programmatic knowledge than the AHM Team members and therefore examples and evaluation content draw on what has been well documented

and will not be exhaustive. For example, the document review undertaken was based primarily on a high-level summary of risks and issues from across all care settings in the programme. The data used included a brief description of each risk or issue. However, the severity of issues and severity and probability of risks were not included in this high-level summary. Due to the retrospective nature of this report, evaluators are not able to determine the actual influence of the identified risks or enablers on the outcomes of the programme. Similarly, the lists of activities and achievements include only those that have been reported or documented by the team. Many of the more nuanced and subtle activities involved in delivering this complex programme were not included in this review; lists of enablers, activities and achievements provided for review are not exhaustive.

Long term monitoring of population level alcohol-related harm indicators is needed to support understanding of outcomes and impacts over time and should be a focus of the AHM Programme in the future. While the contribution of the AHM Programme to changes in such indicators may be considered, it will not be possible to attribute any change directly to AHM Programme activities due to the complex nature of causation of alcohol-related harms.

Ethics statement

This evaluation adhered to the ethical guidelines of the New Zealand National Ethics Advisory Committee and the privacy and confidentiality rules laid out in the Health Information Privacy Code. Evaluators made every attempt to ensure that the communication with staff and patients/clients/whaanau was respectful and culturally safe. This evaluation was out of scope for review by the Health and Disability Ethics Committee for Aotearoa. However, patient, staff and key stakeholder participants all provided their written informed consent to participate in this evaluation.

Findings and discussion

Evaluation findings are explored in two sections which include: (1) Process evaluation findings, and (2) Outcome evaluation findings. The findings and discussion have been merged to make it easier for readers to understand the implication of findings as they are presented. The inequities experienced across several groups within the CM region pertaining to age, sex, religion and ethnicity are acknowledged. However, as a Crown agency, there has been a conscious decision to prioritise Tiriti partnerships. This is from both a rights-based and needs-based position, drawing deliberate and responsive attention to implications of this work for Maaori.

Note that existing literature on perceptions and experiences of the Alcohol ABC Approach are overrepresented with staff views, with limited inclusion of patient participant perspectives. Further, many conclusions on patient receptivity are based on reports of staff interpretations. This is a significant gap in evidence and resultantly, patient experiences and perspectives have been prioritised in this chapter.

(1) Process evaluation findings

The process component of this evaluation aimed to understand:

1. What were staff perceptions and experiences of Alcohol ABC Approach implementation processes and delivery?
    1.1. What were staff perceptions about the value and importance of Alcohol ABC Approach?
    1.2. Was there an increase in knowledge, skills, and confidence of staff to deliver Alcohol ABC Approach?
2. What were patient and whaanau perceptions and experiences of being asked about alcohol?
    2.1. What were patient/whaanau perceptions about the value and importance of being asked about alcohol?
    2.2. What were patient/whaanau feelings and experiences of being asked about alcohol and receiving advice or help?
    2.3. Was the conversation with the health/other professional about alcohol appropriate for the cultures and beliefs of patients/whaanau?
3. What were the key risks and issues that arose during the implementation and how were they resolved?
4. What were the key enablers and success factors that arose during the implementation?

Process evaluation findings are presented in the following sections: (i) Perceptions and experiences of Alcohol ABC delivery among patients and staff; (ii) Enablers and success factors that arose during implementation; (iii) Risks and issues that arose during the implementation and how these were resolved, and; (iv) Summary of key learning points and considerations.

(i) Perceptions and experiences of Alcohol ABC delivery among patients and staff

This section explores five key themes pertaining to patient and staff participant experiences of being asked about their alcohol use by healthcare staff, or delivering Alcohol ABC Approach conversations. The data that was contributed by patient and staff participant groups were analysed separately. However, during initial review by the REO, it was apparent that presenting this content together would allow for significant reduction in repetition across themes, improved valuing of patient participant perspectives, and coherency of patient and staff participant perspectives. Subsequently, patient and staff perspectives are presented together. Attention will still be drawn to important nuances between the experiences and perspectives of these participant groups.

Key theme one - "It's a normal thing": social norms, change and Alcohol ABC conversations

Alcohol use is inherently social; norms, expectations, behaviours, and beliefs surrounding alcohol are informed by social environments (Herbert, 2017). Aotearoa has a pervasive culture of high-risk alcohol use (Law Commission, 2010); a social environment which can be compounded by human tendency to overestimate alcohol-related social norms (Dempsey et al., 2018). Overestimation can occur both in the perceived approval of certain behaviours by others, and perceptions of how others engage in these behaviours; these "misperceptions" can drive high risk alcohol use because people understand it to be acceptable (Dempsey et al., 2018). In parallel, negative stereotypes surround alcohol use disorder or consumption behaviours that fall outside of perceived social norms, creating stigmatisation and barriers to conversations about alcohol use and interventions (BCCSU, 2019).

Perceptions held by patient participants regarding the acceptability of their alcohol use, readiness for change, and experiences of Alcohol ABC conversations, are complexly informed by these social norms and stigma. During their interviews, participants shared perspectives that highlight the normalisation of alcohol use, including heavy or regular alcohol use, and their awareness of this normalisation as a culture of drinking in Aotearoa communities:

> *"I think **it is pretty normal for lots of people to get really [drunk].** I just drink to get wasted. I think **that's a big culture** in Auckland, maybe in New Zealand"* (PP05).

> *"I have been around drinking all my life. . . I'd say it probably has been just a normal [part of my life]. It's just not a big thing in my life, **it's a normal thing**. It's just part of my life, you know, to drink"* (PP04).

While participants described their own alcohol use, and the alcohol use of others in their whaanau or wider community, as normal, they also described an awareness of, and anxiety towards alcohol use that they felt might be perceived by others as unacceptable. *"It doesn't worry me, **because I don't drink all the time**"* (PP07). Participants also sought to distance themselves from those individuals they perceived as deviating from normal or socially acceptable consumption behaviours. For example, in the below quote, the participant first recognises some deviation from socially acceptable alcohol use (*"I know that I probably drink more than the average person"*), seeks to normalise their alcohol use *("there's a lot of people out there*.."), and then distances themselves from consumption behaviours considered not to be acceptable. The participant also links problem

alcohol use to a person's functionality. Ability to meet commitments to everyday activities then becomes an indicator of what is regarded as socially acceptable or not.

> *"I know that I probably drink more than the average person, I know that for sure. But then again, you can kind of mix with the same kind of people, you know. I think there's a lot of people out there functioning alcoholics. . . I think people think I'm an alcoholic, I think of [alcoholics as] some damn, inept bloody, you know, person that's just derelict, you know, wakes up in the morning and drinks"* (PP04).

The normalisation of harmful alcohol use can impact on participants' feelings of personal 'readiness' to change, and 'readiness' for treatment of alcohol addiction (where applicable). "Readiness typically indicates a willingness or openness to engage in a particular process or to adopt a particular behaviour and represents a more pragmatic and focused view of motivation as preparedness. Research has evaluated two distinct but related aspects of readiness: readiness to change and readiness for treatment" (DiClemente, Schlundt, Gemmell, 2004, p.104). Existing evidence suggests that personal readiness to change can be improved among patients with unhealthy alcohol use (Bertholet et al., 2009b). However, such research fails to distinguish across severity of unhealthy alcohol use to understand nuances related to the experiences and outcomes for alcohol users who perceive their alcohol use as socially acceptable, versus users who perceive their alcohol use as socially unacceptable.

It is crucial to acknowledge that 'readiness' as a personal or individual concept and psychological resource is dominated by Eurocentric interpretations that emphasise personal responsibility, motivation, and accountability for action and change (Ker, 2019). Such definitions in the context of this evaluation limit attention to the impact of broader social structures (e.g. policy, law, social norms) which reinforce cycles of self-blame and undermine participants' ability to (i) identify their drinking as hazardous and (ii) engage in sustained behavioural change. Further, this conceptualisation of 'readiness' is unlikely to resonate with Maaori people or Pacific people who may be more likely to consider readiness within a collectivistic context and/or in relation to their whaanau sense of readiness.

For those participants at the lower end of the AUDIT-C scale, the societal positioning of some alcohol use (e.g. heavy and/or binge drinking) as 'normal' undermines the development of a clear rationale and need for change at the individual level. AUDIT-C scores and subsequent labelling of hazardous drinking do not necessarily align with, or reflect, participants' perspectives of hazardous alcohol use as dictated by alcohol-related social norms in Aotearoa:

> *"I've been told before, probably that um I, well I probably do overindulge, then again, it could be worse. I mean, I do like to have a glass of wine or a couple of beers or whatever. . . I could think of a few things that I think about our National relationship with alcohol and so forth . . . The hospitality industry begins it all, sort of going out, oh yeah, come out, have meals, drink lots of wine of whatever. . . But I do think having alcohol is sort of like, you've got to have alcohol, you've got to have it there"* (PP01).

"I personally haven't really been harmed by anyone who is [drinking]. . . I don't feel like I'm in danger, or a lot of danger from people who are drinking a lot, but I do kind of think that's it's a big binge drinking culture" (PP05).

In the above quotes, participants minimise potential harm from their personal alcohol use and need for change by emphasising *"it could be worse"* and again express perceptions of their alcohol use as an acceptable and integral cultural artefact (*"you've got to have it there"* and *"it's a big binge drinking culture"*). These perceptions of alcohol normalisation are also reflected in staff narratives:

"Somebody who is sort of within the guidelines talking to them oh, you know, 'you're within the guidelines' and 'this is what is sort of healthy' just you know, because I know even when I've done that, the audit, a few questions with people at work, people have been shocked that they've been above the guidelines. They have realised that, you know, [it is] quite a low level [of alcohol consumption] before you get above the guidelines. . . My colleague at work, he was quite surprised that he was above the guidelines and that sort of thinking. But I don't think they have worrying drinking, but it's just so you're aware" (S11).

Similarly to patient participants, healthcare staff also sought to position their own drinking as normal and minimised a rationale for change (*"I don't think [staff] have worrying drinking"*). This trend has also been reported in the literature where social and cultural attitudes towards alcohol impacts implementation of SBIRT, for example, staff articulating feelings of hypocrisy based on personal or commonly accepted drinking behaviours (Derges et al., 2017). AUDIT-C scoring, which prioritises a clinical and physiological assessment of drinking behaviours to support early identification of hazardous drinking that could result in harm, therefore challenges societal framing of 'hazardous' drinking. Participants' experiences show there are differences between technical definitions of 'hazardous' alcohol use, and lay perspectives of 'hazardous' alcohol use. The importance of this is that participants may not perceive their alcohol use as hazardous. This may inform how healthcare staff approach Alcohol ABC conversations:

"When we started the conversation with alcohol harm, we got this phenomenon pretty much where people who identify as alcohol causing harm see those messages and agree with them, [but] people who don't agree with alcohol causing harm or don't think that they themselves have issues may see that information, but may not engage with it because they see that it's somebody else. So I think there's a little bit more thing for quite a bit more thinking to do about what that means for the foundations of this programme, which has been about using that approach of alcohol causes harm and we need people to understand that alcohol causes harm and engage with that to be able to do the actions that follow from that, which has been the premise for substance harm reduction for decades. ***But I think we've got that new information now to suggest maybe exploring different ways that start a conversation about wellbeing, start the conversation with how alcohol influences and shapes things, that acknowledges kind of where people are currently sitting with their own personal views to alcohol and doesn't require them to say alcohol was a harmful substance or alcohol is a drug, or to agree with those messages before they engage with the content of our programme****"* (KS03).

The aforementioned quotes demonstrate how readiness for change is linked to societal norms around alcohol use, and demand a more holistic interpretation of readiness which accounts for broader contexts in which whaanau live, work and socialise. This also points to the immense potential of Alcohol ABC Approach conversations to support de-normalisation of hazardous alcohol use where such narratives are not readily available in the community.

High motivation to change[7] was expressed by those participants who partake in riskier alcohol use (i.e. higher end of the AUDIT-C scale). These participants readily identified harm and disruption to their life or lives of their whaanau as a result of their alcohol use, and were frequently proactive in inviting discussion about their alcohol use by offering information to healthcare staff, directing conversation to this subject, or independently seeking support services: *"It was me I steered it all, I just had enough. I'd had enough [of drinking]" (PP02).*

> Participant: *". . . I found something on my part and **I wanted to give up actually**, alcohol yeah [it was] just annoying me, when I become frustrated about it but I can't, **like I can handle [making a change],** especially now I'm getting older a little bit.*
>
> Interviewer: *When the GP talked to you about it, were there things that you thought, oh, that's a really cool way of asking or where there things that you thought, oh, he didn't really talk about that in a really good way, or was it was it, um, nothing really that you wanted to have a chat about in terms of that?*
>
> Participant: *No, I want to, cause **I asked for it** actually"* (PP06).

Previous research, together with pre training insights from staff who participated in this evaluation, highlight that broaching conversations about alcohol use can feel unconformable or awkward; expectations of this type of experience can create an implementation barrier for staff (Gargaritano et al., 2020; Moriarty et al., 2012). However, disconnect between staff expectations and patient receptivity can exist (Matua Raki, 2012; Mitchell et al., 2017; Patston et al., 2017). Similarly, these examples highlight that conversations can be initiated and welcomed by patients who may identify as 'ready' for such discussions. The above excerpts demonstrate a readiness for conversations and a commitment to change and treatment in contexts where hazardous alcohol use has resulted in harm (e.g. financial, relational, or health and wellbeing) to participants. In these contexts, participants describe observing or seeing impacts on their whaanau, receiving feedback or concerns from whaanau, or noticing financial or relational disruptions in their home or working life.

Participant experiences of AOD services also demonstrate a tension between *personal* and *community* readiness for treatment and sustained behavioural change. In their stories, participants who have previous experiences of AOD support services frequently position their failure to sustain reduced alcohol use as a result of lacking personal readiness, while simultaneously identifying a range of broader social and environmental causes and constraints on this behaviour:

[7] This was expressed narratively by participants. Participants' motivation to change was not measured as part of this evaluation.

> *"I'd been to [my doctor] before and told her that I had a bit of a problem with the drinking and she sent me off to CADS so I went there and I did programme there. And then in all honesty,* ***I wasn't really ready to probably give it up"*** (PP02).

The above participant goes on to describe their alcohol use in the context of significant financial and personal stress at home, work pressure and stress, COVID-19 disruption, shame, loneliness, parental guilt, ease of access to alcohol in their local community, participation in social events where alcohol is central to celebrating, and used as a primary coping mechanism:

> *"So I went [to CADS] and just thought 'oh it should be all right, I'll be able to do it for myself'. And so I left it last year and then this year [my alcohol use] just all started back up again. I don't know whether it's because of the stress of COVID-19 and then the financial and personal stuff going on. I just found the alcohol to be my friend. It's the only thing that seemed to calm me down, not that I'm a violent person, it was just my friend. And you know, you've worked hard, had a stressful day at work. You come home to your friend. . . The alcohol becomes your best friend because you're lonely. It just soothes you, so it was really the only thing I really looked forward to was coming home after a hard day's work and just to get my box of beer and sit it in front of me. . . It was my way of dealing with the stress that I was having at work, so, 'oh well if you're not listening, then I'm going to go to my friend and he'll listen'. Mr Heineken and Mr. Woody would listen"* (PP02).

While recognising broader influences on their alcohol use, this participant internalises Eurocentric constructs of readiness through self-pressure that they will *"be able to do it for myself*", and finally self-blame for failing to succeed: *"I just need to try a bit harder"* (PP02). This self-blame and emphasis on personal readiness is frequently reinforced by staff:

> *"I think some people just aren't going to be receptive to it. It's always that thing, they may come in 4, 5, 6 times with an alcohol presentation, who are reluctant to answer your questions, and on the 7th time they decide they want help and listen to you and now answer the questions and take a bit of brief advice. It takes people wanting to do it as well which plays into it"* (S16).

> *"I think most of the staff are providing brief advice and offering the card and offering the drink check pamphlet as a way of saying, if you would like more support with these issues or issues of around alcohol, this is how you can access services. But it's, were basically then saying we're now handing this over to you rather than we are now going to organise this for you, which I think probably works well for most patients because, you know, it is up to them to seek further support and to drive the process further rather than us spoon feeding it to them"* (S07).

There is mixed evidence around whether readiness to change actually impacts on sustained reduction in alcohol use, which questions the clinical utility of readiness as underpinning stage-of-change behavioural interventions (Williams et al., 2007). Other factors have been considered perhaps more predictive of changes to alcohol use, including eagerness to "take action" (Bertholet, et al., 2009a) and confidence to change (Williams et al., 2007). Notably, all of these aspects emphasise individualistic concepts that may not fit comfortably with Indigenous or other

conceptualisations of readiness. Nor do they explore the impact of readiness on self-blame of people who access services. Consequently, staff and services need to be cognisant of the complexity of environments in which alcohol use is enacted, reinforced, and sustained and how their responses to conversations and actions around alcohol use may serve cycles of self-blame or absolve systemic responsibility for change. As described by one participant:

> *"It's just been nice talking to someone about it and I've got no, you know, like I said at this stage in my life I've got no qualms about, you know, and when that [staff member] rings me back, when I get back to him after COVID-19 I'm gonna see him and I don't think it's something,* ***I don't think you can just decide 'I want to give up drinking', I don't think, I don't think it's that simple. Well, I know it's not or else I would have quit****, you know, and so would every other man that's been out there saying they want to give up drinking, but I will go see that [healthcare staff]"* (PP04).

Participant experiences around positioning their alcohol use as normal or non-hazardous (low scoring AUDIT-C participants), or failing to sustain reduced alcohol use (high scoring AUDIT-C participants) demand a broader conceptualisation of readiness, which incorporates the capacity of whaanau and community to deliver needed environmental conditions, opportunities and supports for smooth restorative or recovery pathways. Community readiness models "take into account the broader realities that can make readiness challenging such as colonisation, intergenerational trauma, family violence, racism, coping mechanisms (i.e. Substance abuse, silence) and shame" (The Canadian Aboriginal AIDS Network, 2012., p.4). In the context of alcohol harm prevention, environmental conditions might include consideration to, for example, ability for communities to decrease ease of access to alcohol (i.e. density of alcohol outlets). The 2012 Alcohol Law Reform aimed to facilitate opportunities for community participation in local liquor licensing, however, meaningful participation has not been achieved (Macleenan, et al., 2019). Greater community control over the presence of alcohol in their communities remains an important component for self-determination.

While participants' experiences highlight the value in conversing around alcohol use as a primer to support readiness for future conversations (Bertholet et al., 2009b), it is important to acknowledge that achieving sustained change in alcohol use is a complex journey that is influenced by a range of social determinants and wider public health interventions.

Key theme two - "It's not a subject any stranger asks": Whanaungatanga and manaakitanga facilitate mana-enhancing conversations

Patient participants highlighted the risk of feeling judged or persecuted by healthcare staff, and/or society more broadly, about their alcohol use:

> *"It feels funny. I don't know, it's sort of like those kind of questions can be offending, I suppose, because they can work for you, but I think they can work against you. . . I sort of felt edgy answering [the Alcohol ABC questions], but I answered just cause they needed someone to do it I suppose. . . You start to get to think like people might be judging you because of your answer"* (PP03).

This quote highlights feelings of discomfort (feeling 'funny' and 'edgy') when responses may *"work against you"* or entail risk of being judged by others for their alcohol use. Engaging in the tikanga of whanaungatanga and manaakitanga were described as potentially protective for participants and facilitated safe, non-judgemental conversations around their alcohol use. This theme explores the tikanga or practice of whanaungatanga and manaakitanga by healthcare staff delivering Alcohol ABC Approach conversations. Existing evidence highlights this tikanga as integral to models of health that are responsive to Maaori (Graham & Masters-Awatere, 2020; Wilson, et al., 2021).

Manaakitanga (hospitality) is part of tikanga Maaori (Maaori custom) that centres on acts of sharing and caring (Mead, 2016). Whaanau experiences of health and care services frequently cite a lack of manaakitanga in staff actions (Stevenson et al., 2020). In healthcare contexts, practicing manaakitanga "will ensure environments where cultural practices and values are respected to have a contributory role in the health and wellbeing of whaanau" (Stevenson et al., 2020, p.68).

Whanaungatanga is an intrinsic value of Maaori culture, core to the effective delivery of Te Tiriti o Waitangi commitments (Berghan et al., 2017), and is fundamentally about relationships and connections, and working together to support each other across generations (Pere & Nicholson, 1991). In healthcare settings, whanaungatanga has many applications relevant to the professional practice of healthcare staff. This includes but is not limited to, the need for staff to connect with whaanau relationally (for example, through introductions, establishing needs) before embarking on a clinical discussion, and ensuring the inclusion of whaanau in shared decision making around care (Lacey et al., 2011). While most healthcare staff engage and interact with patients with positive intent, evidence demonstrates that misperceptions (i.e. judgement) and lack of connection between healthcare staff and patients from minoritised ethnic groups is common (Cooper et al., 2003; Cram et al., 2003), and contributes to negative outcomes for patients and staff (Lacey et al., 2011). Previous research has identified whanaungatanga as critical to culturally safe experiences of care that facilitate ongoing engagement of health and care services by Maaori (eg. Levack et al., 2016).

Whakawhanaungatanga has been described as the "making of culturally meaningful connections with others" (Levack, et al., 2016, p.489). While whakawhanaungatanga and whanaungatanga are Maaori terms used often in mainstream vernacular, it is important to note they are related but are not interchangeable. The 'whaka' incites the action to create or build; 'whanaunga' is the relation or connection and 'tanga' refers to the process of (Bishop, 1996). Whanaungatanga is a result of whakawhanaungatanga, the concept of connection and refers to the ongoing relationship (Mead, 2016).

Table 7 summarises different ways staff reported practicing whakawhanaungatanga with patients prior to approaching conversations about alcohol and include: maintaining a conversational approach, connecting through shared experiences, using humour to put them at ease, valuing whaanau voice and inclusion, and prioritising face-to-face conversations. These examples show a commitment from staff to connect and prioritise whakawhanaungatanga, before embarking on a clinical assessment of alcohol use.

Table 7: Summary of way staff reported engaging in whakawhanaungatanga with patients and whaanau

Practice points	Practice description	Examples from staff interviews
Maintaining a conversational approach	Staff attempted to normalise discussions about alcohol and make patients feel comfortable by maintaining a conversational approach. They described their efforts to ensure conversations don't feel scripted and ensure ease of flow on the topic of alcohol use around other clinical discussions.	*"Because a lot of our screening equipment, or tools that we use with the programme that we use, there's a lot of tick boxes, and for me, I try and just bring it into the conversation so that the women feel we're not just ticking the boxes, so just talking to them"* (S04). *"So initially you'll go in talk to the patient, take your vital signs and then you ask the conversation normally around the terms of so what bought you in today, you get a bit of a history of what's brought them in, you ask about the past medical history and you do like an examination if you need to of like listen to your lungs, listen to their heart, abdo's [abdominal examination], and something like that, takes some blood or the phlebotomist comes in and does some bloods, so, after you've done your physical assessment, or while you're doing your past medical history, then you can ask that question then normally, or so do you smoke, NO, do you drink alcohol, I do, how much do you normally drink, all that kind of stuff"* (S09). *"I don't read it like a script because I think if you read it like a script, it sounds very mechanical"* (S07).
Connecting through shared experiences	Staff described their efforts to empathise and connect to patients through shared experiences by describing stories about alcohol use of their own or a friend or family, or their experience or observation of harms.	*"I intimate that, 'hey, I've been there, done that, far be it for me to judge what you're doing', you know, and yeah, so but I would do that"* (S03). *"It is helpful for me to be able to share my experiences and share what I went through as a child and the effects it had on me. I can say I do know people who have passed away from drinking alcohol or as a result of drinking alcohol, so it does happen, it's not just us trying to drill more health things into them. That is helpful for me"* (S14). *"Some people in the team use their personal experiences around alcohol to put patients at ease and to kind of be able to relate to patients in a better way"* (S07).

Humour	Staff described using humour to connect with patients and put them at ease when approaching conversations about alcohol.	*"Sometimes the use of humour, a little bit, but without minimising the importance of what we're talking about, but just occasionally, I might have identified with a hangover or whatever it's at, and I would say, don't ask me how I know and they crack up"* (S03).
Value the whaanau voice and participation	Including whaanau or others present was an important aspect of whakawhanaungatanga with patients. In these quotes, the inclusion of support people or others present occurs in many contexts, from the presence of friends in emergency settings, to whaanau in GP settings who are also an enrolled population. Staff report acknowledging the significant others and including them in conversations whether physically present or absent. Inclusion of whaanau or support people was also very challenging in some Alcohol ABC settings due to environmental or systemic constraints. This is further explored following this table.	*"I guess I just acknowledge the family and the significant others, and bearing in mind that mostly sort of within our practice, the whole family tends to be our patients too, so there is that sort of familiarity with them and, not that we necessary talk about others, particularly. We tend, we don't we don't bring up other individuals, if they do well, then it's fine, but I guess it's just that sort of knowing that we are a family oriented practice and sometimes a family member will be actually sitting there with them, it's not uncommon to have, you know, a number of people in the room and sometimes it's the husband well, more like, more often than not, the wife who's dobbing and the husband and there sitting there together and the husband, he agrees and, yeah"* (S03). *"Like, with the younger generation – the teenagers – about their drinking, there was a bunch of girls that had come in that had been drinking, and they were in our adult waiting room, and one of the friends had fallen over and hurt her arm. At that time I used that tone to be able to gather them around – I go, 'I see that you've come in because you've been drinking. Do you know how much is in what you drink?', and these girls were drinking Cody's at 7 percent, something like that. I went, 'do you know how many standard drinks are in that drink?', and they said, 'yeah, one', I was like, 'oh really. Do you want to know a bit about how much standard drinks are in their drink?', I think there was two in that drink. It got them interested to find out because obviously we think that one standard drink is just a drink, so they were quite interested, I got the book and I showed them the standard drinks for each drink, they were quite intrigued"* (S15). *"I think, especially with Maaori families, it's good to talk about their children and grandchildren and being around, I talk a lot about whaanau, them being around for them - doing what you can to stay around as long as you can"* (S14).

Kanohi ki te kanohi	Staff ensured that conversations could be delivered face-to-face with patients, which was challenging with the disruption of practice caused by the COVID-19 pandemic.	*"So after the lockdown, we resumed asking patients again [face-to-face] and we could see on the data that our rates of asking was going up beautifully again. And then when we went back into lockdown again, this most recent time, we had to strip things right back again"* (S07).

While the practices described in Table 8 are meaningful to many Maaori and other patients, at times, whakawhanaungatanga is erroneously translated to mean 'rapport' or 'rapport building'. As Lacey and colleagues (2011) state "building rapport is important and is a usual step with all patients, however, engagement with Maaori patients and whaanau requires a further step. Whakawhanaungatanga requires clinicians to draw on their understanding of Te Ao Maaori and relevant patient and whaanau Maaori beliefs, values, and experiences. This may be in terms of the patient's whenua (land) connections, whaanau involvements, or use of te reo (Maaori language). This should not only include identification of these aspects of the Maaori patient, but critically should include some self-disclosure of the student / doctor about their own experience of these aspects" (Lacey, et. al. 2011, p.74). This aspect of whakawhanaungatanga was not described by staff participants, nor reflected in the examples provided in the table above, as central to their practice in establishing meaningful connections with their patients. As such, these findings highlight an area where cultural safety training of staff who deliver Alcohol ABC Approach could be strengthened to support improved engagement with whakawhanaungatanga with patients and their whaanau, that extends beyond mere rapport building.

Whanaungatanga in health and care settings should model responsibility, transparency and accountability (National Action Group, 1998), in a relational commitment that is ongoing in longevity (Hoskins et al., 2011). Approaching conversations about alcohol were mana-enhancing experiences for patients when this occurred in the context of a relationship. As articulated by a patient participant, *"**It's not a subject that any stranger asks you** though, you know but I don't mind, I don't mind answering questions"* (PP03). The emphasis on whanaungatanga as a foundation for mana-enhancing conversations around alcohol is further explored in the following participant quote:

> *"I have a really good relationship with my doctor. I have been with her for years, say 20 years I think I've been with the same doctor. So I felt a bit embarrassed telling her, but she was so understanding and so gentle and not judging me. You didn't feel judged. And that was the main thing is that she said 'I know you're determined to stop it' . . . I said look I had another, I had one bottle and other and I said 'I'm not going to sit here and lie to you' . . . She was really understanding"* (PP02).

In the excerpt below, a staff member shares their perspective around how whanaungatanga supported more open discussion about alcohol use during pregnancy. Resultantly, healthcare staff were able to provide support to the patient to discontinue further drinking during pregnancy. This example exemplifies how whanaungatanga is fundamental to effective and safe clinical care:

> *"I remember when I was a new grad out here, I hadn't done the education day, but had my colleagues to talk with, that had done the programme, and they had given me information to share with the women. I had a young mother that I was looking after, and she had disclosed to me, not the first time that I had met her, but when I developed a relationship with her, she disclosed that she was drinking in her pregnancy and was finding it hard to cut down on her drinking. That's when I got my colleagues involved, and they had just said to figure out how much she's drinking, what she's drinking, and to see what support she has had in the past and how long she's been a drinker for. I was able to support her in that pathway and*

reducing her amount of alcohol from the beginning of the pregnancy to before she was term, she was no longer drinking" (S04).

Staff approaches to both whakawhanaungatanga and whanaungatanga with patients to support positive and non-judgemental conversations about alcohol use differ across clinical settings. Some settings enable a commitment to whanaungatanga over time due to patients having a longer stay or repeated visits (e.g. GP, LFSF, Maternity Service or inpatient wards where patients are expected to be admitted for one or more nights):

"With our clients, generally we are seeing them for a couple of weeks at a time, depending on the client and where they're at with their [healthcare journey]. . . There have been occasional ones who have said 'yes I drink' and we say, 'can I ask you these questions?' for them to respond no. They shut down the conversation before we can even get to them. But again, that's respecting where they're at and what is comfortable for them . . . So we do park it for a future conversation" (S17).

"I think it's just kind of building that rapport before you actually ask that question, so it may even be not on the initial assessment, asking that question straight away, it may be the next time you come in for pain relief or something then having that conversation once they kind of know you a little bit more" (S09).

As the above quotes highlight, some settings present opportunities for staff to engage in whanaungatanga over time in order to re-approach or return to conversations about alcohol at a later date. Conversely, seeing patients again, building relationships over time and being able to return to conversations about alcohol was limited in other settings (e.g. ED or short stay inpatient wards), which meant staff had to adopt strategies to engage in whakawhanaungatanga and whanaungatanga during the initial assessment/presentation of an individual:

"I roll it out in my first appointment with a patient just because a lot of our patients actually don't come back to us for follow up. And I think in order to be able to have that conversation, it's important that we do it at the first session. So I usually make it part of my information gathering portion of the assessment. So I spend a bit of time at the beginning of my first time meeting a patient, building rapport, getting to know them a little bit, understanding why they're here, what their main issues are. And then I usually say to them, look, I need to do a little bit more information gathering so that I can provide you with best treatment today. And then I talk to them about their medical history. I talk to them about their allergies, talk to them about smoking, and then I talk to them about alcohol. And I usually put it into context of the reason why I'm asking these questions is that because we know that smoking and also alcohol can have a really big impact on your healing and we want to make sure we optimise the healing for you. So I think it really helps to put it into context for a patient, because if you go into the questioning cold without any warning, some people can be quite taken aback by that line of questioning" (S07).

This quote is a good reminder that while the ability to engage in whakawhanaungatanga and whanaungatanga with patients across repeated visits or a longer stay may be constrained in some

settings, others methods of engaging in the whanaungatanga process to put patients at ease should and are used by staff. In the above quotes, the staff member describes dedicating time to *"meeting a patient"*, *"getting to know them a little bit"*, and clarifying their needs or concerns, and returning to approach a conversation about alcohol at a different point in time during a short and single admission. Time-constrained and dynamic settings like ED are recognised as particularly challenging within the literature (Maynard & Paton, 2012). Vipond and Mennenga (2019) similarly suggest consideration of the 'right' time for SBIRT within an ED presentation, noting that the end rather than the beginning of the consultation may be more effective because of the opportunity to better connect with the patient.

Consistent with staff participants, patients emphasised the importance of staff practices to support the delivery of conversations about alcohol use in non-judgemental ways. Examples from participants' experiences where staff behaviours effectively demonstrated manaakitanga and committed to whanaungatanga include: staff being warm and friendly in the conversation, ensuring privacy and confidentiality of conversations, taking a casual approach without 'forcing' the conversation, acknowledging that the conversation can be awkward, understanding and acknowledging participants' health priorities, seeking to understand the underlying causes of alcohol use (where applicable), following up, and providing appropriate supports and solutions. A common thread across these insights is that practising manaakitanga and whanaungatanga facilitate compassionate and judgement free conversations:

> *"Yeah, I didn't mind her asking me that. It was just like I'm talking to you now, that's just how it was. I mean, I didn't take offense. . .She was really helpful and she was positive and it made, if I may say, it made going to a clinic or the Superclinic or whatever, it actually made going there, instead of being an unsettling [experience], it made me feel quite positive about it"* (PP01).

> *"The lady when she was asking the questions, she acknowledged that it could be a sensitive topic or something, so I thought that was really nice. Good. Yeah, I think my ladies' manner was really good so, it was, the whole conversation I felt pretty comfortable"* (PP05).

Patient participants emphasise the importance of *how* they are asked about their alcohol use, the context of being asked, and responses to being asked:

> *"I don't think there was anything wrong [with the conversation]. . . I know that this isn't going to be spread out among the community and I know I'm not going to be ostracised or whatever.* ***It's just the way you say it. So that's my way of looking at it"*** (PP01).

Some of the examples in this section highlight the inclusion of whaanau in conversations about alcohol from staff narratives. However, there are limited examples of whaanau being included in conversations or support pathway steps in the narratives of patient participants. While compliance with the Privacy Code may be cited as a constraint on whaanau inclusion, evaluators note that facilitating the inclusion of whaanau is prioritised based on the needs and rights of patients undertaking alcohol screening. That is, if patients support the inclusion of their whaanau, this practice can be supported whilst maintaining compliance with the Privacy Code.

Evaluation findings summarised in this theme align greatly with the assertion by Graham and Masters-Awatare (2020) that "greater efforts need to be taken to ensure that tikanga Maaori practices are supported within mainstream healthcare systems." Evidence demonstrates that effective practice of whanaungatanga and manaakitanga by healthcare staff directly impacts on access, experiences and outcomes of health and care services for Maaori (Lacey et al., 2011). Improving the cultural safety of care through engagement of tikanga, in the context of this evaluation, provides a positive and more supportive environment for patient participants to share openly about their alcohol use without fear of judgement. Therefore, the skills of healthcare staff directly impact services ability to progress toward CM Health's vision of achieving health equity.

Key theme three - "It's not just youth that are binge drinking": recognising implicit bias in Alcohol ABC conversations

Implicit bias refers to the "attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner" (The Joint Commission, 2016, para. 4). It is important to understand that all people hold implicit biases, and the development of implicit biases is a largely unconscious process of lifetime learning (commencing from birth) through exposure to experiences and messages that are both direct (i.e. your own) or indirect (shared by others) (Staats, Capatosto, Wright, & Contractor, 2015). Media and news programmes are commonly cited as contributing to the early development of implicit biases (Staats, Capatosto, Wright, & Contractor, 2015).

During interviews, staff relayed examples of biases related to particular individuals or groups, and the impact these biases have on how they interact with and respond to patients who access their services. These biases relate to age, sex, and ethnicity. A large body of existing evidence demonstrates that implicit biases impact healthcare staff, resulting in lower quality of care for patients due to their age, sex, ethnicity, or other non-modifiable characteristic that should not (but does) influence experiences of healthcare and health outcomes (Fitzgerald & Hurst, 2017). The impact of implicit bias has also been reported within SBIRT programmes with males, those who are unemployed, and certain ethnic groups more likely to be asked about their alcohol use (Johnson et al., 2013; Gifford et al., 2012). Table 9 presents quotes which illustrate persistent beliefs about groups of people that may be held by staff.

Table 9: Examining implicit biases of healthcare staff related to age, sex and ethnicity

Interpretation and implications	Staff reflections	Evidence
Younger people as a group have been identified as having hazardous behaviours around frequency of drinking. Such beliefs can result in the perpetuation of negative stereotypes about youth that can cause youth to feel judged or misunderstood when this is felt. Beliefs about age and associations with alcohol may also cause staff to feel unsure or less confident about approaching conversations about alcohol with patients of a particular age group. In the example presented, a staff member discusses the discomfort of younger nurses approaching "middle aged men" about their alcohol use. There is a risk that the discomfort of staff may lead to the withholding of care to which patients are entitled.	*"When you're younger you drink often and you don't really think about it, it's not until you get older – and I guess working in [health] – you see how harmful alcohol can be, not only for your patients but also other people around you"* (S16). *"It's a bit more difficult for the younger nurses, and having that conversation with middle aged men, trying to tell them that they are drinking more than they should be throughout the week and things like that – it can be a little bit intimidating for them"* (S14).	Beliefs about binge drinking and alcohol use being particularly associated with youth are commonly held in society. However, the rate of alcohol-specific hospital admissions in CM Health is comparable for those ages 45-64 years (Wright, 2018). Rates for both the 45-64 year age group and 15-24 years of age have gradually declined over a period of 6 years, while increasing for those ages 64 and over (Wright, 2018).

Staff may feel that particular populations groups as a whole aren't open or willing to discuss alcohol use. Exploration around where this belief or feeling comes from is important to understand how implicit biases may be affecting how staff interact with people from these population groups. These quotes also highlight a belief that drinking is part of the inherent nature of some groups *("it is in their system"*), and how challenging it can be to not think like this. Such views are victim blaming and can cause people to feel judged and misunderstood about their alcohol use. Staff also centralise themselves in their cognitive thought and care.	*"For example in the population near the Maangere Bridge area, they are a high priority population we have, there are heaps of projects there like CV and smoking behaviours and they were also – there are heaps of things. So one patient in coming for some complaints to the clinic and there is a big list for opportunistic finding of screening for alcohol, but the population there, they are not too open to discuss about their behaviour"* (S13). *"It's really hard at first, you always think, 'they will just drink again because it is in their system', but in my mindset, as long as I give the support that even if they drink, just give this number a call . . ."* (S19).	Alcohol use is a social activity in almost all societies (Cagney & Cossar, 2006). Values, attitudes and other norms impact drinking and drinking behaviours, rather than any biochemical or physiological factors that characterise populations or groups (Cagney & Cossar, 2006). There is no genetic predisposition to alcohol use (i.e. not 'in their system'), rather, differences in the norms and social acceptability of alcohol use in societies. The majority of New Zealanders drink alcohol (MoH, 2015). However, people living in areas of high deprivation were 0.7 times less likely to consume alcohol at a high frequency (3+ times per week) than people who live in the least deprived areas (adjusted for ethnic, age, and sex differences) (MoH , 2015). Illustrating that high levels of drinking occur across all levels of deprivation. However, adults living in the most deprived areas were 1.5 times more likely to drink alcohol hazardously than those living in the least deprived areas (MoH, 2015).

This example highlights a bias related to sex and ethnicity around alcohol use. When staff encounter patients who contradict or do not align with implicit biases, this may result in them feeling shocked, surprised, or interested by patients who they encounter with hazardous alcohol use. Feeling shocked, surprised or interested are common emotional responses when implicit biases are challenged or contradicted and therefore present an opportunity for staff to recognise implicit biases they hold so these can be addressed.	*"We've got quite high Asian population, so we quite often have an interpreter to speak Mandarin and the Chinese unexpectedly, quite a few of them are quite big drinkers especially the women interestingly enough, so we use an interpreter. . . It's surprising, yeah it is surprising the people that you least expect to drink a fair bit"* (S08).	Both men and women drink alcohol regularly, with men being only 1.1 times more likely to have drunk alcohol in the past year when compared to women. In CM Health, the prevalence of hazardous alcohol use for males (14%) is twice that of females (7%), illustrating that there is a disparity in hazardous drinking by sex (Wright, 2018). However, there are still high levels of hazardous alcohol use among women, particularly when stratified by ethnicity. Between 2011-2014, Maaori women had higher levels of hazardous alcohol use than non-Maaori men, and were nearly four times as likely to have hazardous alcohol use compared to non-Maaori women (Wright, 2018).

As described in the following participant quote, identifying assumptions or stereotypes that staff hold is integral to understanding why Alcohol ABC should be prioritised universally with all patients:

> "Participant: . . . *I probably wasn't aware how much people actually drink, like you can obviously go off yourself in your age group when you're like thinking about it, but you don't realise that it's not just youth that are binge drinking. It's everyone, especially in New Zealand. So I think that, that's kind of been the knowledge gap that's being filled, just understanding that you can't be super selective because it could be the old lady who's come in that's actually drinking half a bottle of gin every night kind of thing.*
>
> Interviewer: *So you have had to be careful not to make presumptions about who is drinking and how much.*
>
> Participant: *Yeah, yeah, not assuming, I guess, that people are or aren't drinking based on who they are and their age group and demographic kind of thing"* (S09).
>
> *"I'm sure [staff] clearly understand clinically the impact of alcohol in a pregnancy, but the priority of discussing it with all women rather than stereotyping or guessing who they should discuss it with and therefore, de prioritising it, if you looked at somebody and probably thought they didn't, they might not drink. And I think that happens with lots of things, so I think that is one of the main gaps was that, was filled with the training that we identified, was that this needs to be asked of everyone because it's everyone's problem potentially"* (S06).

The following quote provides an example of how implicit biases influence decisions that staff make in their work on a daily basis:

> *"We started getting some data around how many patients we were asking the AUDIT-C questions, we had a look at our the ethnicity breakdown and we were wanting to find out whether staff we're asking each ethnicity equally or whether they were asking some cultures or ethnicities more often than others. So we looked at it quite closely because we're trying to find out whether staff were feeling uncomfortable about asking certain cultures, whether they were targeting certain cultures. So, what they told us initially is that we were asking our Maaori and our Pacific patients less often than we were asking our New Zealand Europeans, our Asian patients, and also our Indian patients. We did a bit of brainstorming around why that might be and whether it was because we were feeling self-conscious about asking or concerned that we that the patient would think that we were profiling them or that we were asking them something that we wouldn't ask anyone else. So we did a bit of exploring around that"* (S07).

The above quote demonstrates how staff may make a decision to not ask patients about their alcohol use in response to implicit biases they hold; effectively excluding patients from care to which they are entitled. From staff narratives, another example included staff not asking patients from some ethnic groups about their alcohol use because they perceived that these groups would have hazardous alcohol use requiring brief intervention. Staff reported they would not do a screening on

the basis of being concerned they wouldn't have time in their consult to offer brief advice. Critically, it is imperative to acknowledge and act on how such biases contribute to health inequities. The quotes are also a powerful example of how implicit biases result in staff inadvertently prioritising their own insecurities (*"feeling self-conscious about asking"*) above patient needs and rights. Research identifies such discomfort as white fragility and recognises how white fragility maintains racial inequity (DiAngelo, 2018).

Ethnic bias (such as described in the above quote) is a particular type of implicit bias and form of racism which "refers to generally negative attitudes, feelings and beliefs about an individual because of the ethnic group they belong to and can influence behaviour, leading to discrimination" (Harris et al., 2006, p.367). There are examples of both over and under-representation of ethnic groups within alcohol screening programmes indicating the potential for ethnic bias to influence contrasting, though equally concerning mechanisms of inequitable care (Gifford et al., 2012; Johnson et al., 2013). Mukamal et al. (2007) found that people who were black and Hispanic were more likely to be asked about alcohol use and suggest that ethnicity was used a proxy for high- risk drinking in a US study. This type of targeted intervention can perpetuate systems of bias and racism, and may inadvertently contribute to disproportionate levels of alcohol-related harm, as well as poor socio-economic and other outcomes (Maynard et al., 2013; Mukamal et al., 2007). Conversely, fears of "stigmatising" or "victimising" people were perceived to inhibit universal application of screening and may contribute to the withholding of care (Derges et al., 2017). In Aotearoa, Maaori are ten times more likely to experience racism and discrimination in three or more settings than European ethnic groups (Harris et al., 2006).

Exploring the cultural safety of staff practice of Alcohol ABC conversations was a key focus of this evaluation. One way in which this was explored was by asking staff "how do you take into considerations someone's culture when asking them about alcohol use?". Overall, many staff found it challenging to articulate how they did this as part of their Alcohol ABC practice. Some staff perceived that attending to culture was natural and struggled to explicitly articulate how they do this, some needed time to think and reflect on their practice, while others weren't sure if they had answered the question correctly.

> *"Um, well, I, I'm, I'm, I'm not sure, um, I guess, having grown up in New Zealand and I know the ways, I know about lifestyles. . . I hope I don't sound as if I'm bragging or anything, but it feels as if it sort of comes somewhat naturally now"* (S03).

> *"I guess in a way, I don't know how I apply or think about people's cultural needs. It's knowing your audience"* (S16).

Healthcare staff have a clinical obligation to ensure the care they deliver is culturally safe; the inability to describe how this is operationalised in their daily work highlights a risk of operating from a dominant (Eurocentric or Paakehaa) cultural lens. Perceiving and behaving through a dominant cultural lens is a subconscious practice throughout day-to-day lifestyles that is frequently taken for granted, and rarely explicitly attended to. Increased explicit attention to how to address and respond to culture around alcohol is needed to ensure that staff do not interact with patients only through a dominant and normalised cultural worldview. This could effectively de-normalise and

ostracise Maaori and other ethnic groups' cultural beliefs, values, and shared behaviours and is a space in which racism is maintained and unchallenged.

While staff provided lots of examples of how their practice changes in response to patient reactions and environments in which alcohol conversations are approached (see previous theme), tailoring approaches based on cultural or ethnic identity was not something all staff were confident with or considered a priority:

> *"Generally I treat everyone the same, or slightly adjust it depending on the rapport I've got with the patients" (S14).*

> *"[Responding to] equity should be right across all, not just particular singled out groups. That's my personal opinion, because [I] see the person as a whole person and not their race or sex or whatever they may be and not specialise in other areas because they're actually causing discrimination amongst other groups. [The Alcohol Harm Minimisation Programme] singles out particular cultural groups, but what I'm saying is missing out on the others who have just as much need and issues they are confronted with right across the only, I'd like to see it blended right across all cultures, not between one or two singled out to be equitable"* (S02).

The conflation and interchangeable use of culture and ethnicity in staff narratives signals poor understanding of these concepts and implications for practice. While staff refer to 'cultural groups' in their discussion of their practice behaviours in the above quote, cultural and ethnic identity and biases are distinct. "Cultural identities include a broad set of identity constructs related to demographic subgroups such as ethnicity, sex, race, sexual orientation, and socioeconomic status, to name a few" (Worrell, 2019, p.1). While staff may have some awareness of a patient's ethnic identity from existing health information, unless they have engaged effectively in whanaungatanga, they are not likely to gain sufficient awareness of a patient's cultural identity.

Treating everyone the same (equality) on the basis of ethnic, cultural of other identities is dangerous practice which fails to recognise and respond to inequity in access, experience, and outcomes of healthcare services; ultimately compromising quality of care. Exploring commonly held assumptions and beliefs is an important step in supporting staff to examine implicit biases around alcohol use. Alcohol ABC training presented an opportunity for staff to identify misinformed beliefs or assumptions that they may unconsciously hold about people who use alcohol through the exploration of common assumptions around *who* drinks and *why*. However, implicit biases are learned over long periods, pervasive and persistent to change (Blair, Steiner & Havranek, 2011). Dismantling systems that reinforce implicit biases is a complex but mandatory journey requiring leadership from collaborating practices, within the AHM Team, and also organisational leadership beyond the scope of the AHM Programme.

Key theme four - "I need my health": Conversations about alcohol are valuable and important

Regardless of whether participants took action on their alcohol use following conversations, all patient participants perceived having conversations about alcohol use as an important and valuable practice that should be continued. They particularly recognised value in these conversations because of how their alcohol use impacts on other behaviours (e.g. smoking) and impacts on their health and wellbeing:

> *"[I want this] especially for health. It's not about money. It's not about everything, I just want help, I need my health. I want to go back like before"* (PP04).

> *"I think it's important if you're like wanting to quit smoking, because I know smoking and drinking often go hand in hand, so I get the importance of that"* (*PP05).*

> *"Yes I do [think it's important]. . . If we can't all talk about things like this, what are we going to do? Are we going to shut them up behind the too hard basket? And if we can't be adult enough to actually talk about things, then argh, it's going to let the whole cycle of things go on" (PP01).*

> *"I do think the more information we have about all these sorts of things, the more we can actually make intelligent decisions about things. . . That's got to be a good thing"* (PP01).

All patient participants identified harms from alcohol use personally or in their community and expressed concern about this. Recognising these harms informed their perceptions of the need to continue talking about alcohol. Examples raised included, drinking and driving, exacerbation of relationship stress, financial stress, family harm (including physical violence), intergenerational harm, and other substance abuse.

Participant actions and outcomes resulting from conversations around their alcohol use with healthcare staff were varied. Participants at the lower end of the AUDIT-C scale did not report changes to their alcohol use resulting from these discussions. Participants who identified as having hazardous alcohol use did report that conversations with healthcare staff were a catalyst to making changes to their alcohol use. This observation is supported by evidence that suggests people who are more alcohol dependant might benefit more from screening and brief intervention; higher personal 'readiness' to change and potential existing engagement in change behaviours may mean an SBIRT interaction acts as a supportive prompt within an ongoing journey (Drummond et al., 2014).

Changes included: reduced frequency of alcohol use (e.g. taking a night off from drinking); reduced volume of alcohol use (e.g. having only two beers at night instead of an entire box of beers); and changing the type of alcoholic beverage consumed (e.g. drinking wine and beer instead of spirits). Participants who reported these changes also reported a reduction in alcohol-related harm including reduced relationship stress within their whaanau, or reduced financial stress. In the scope of the evaluation, it was not possible to understand how long these behaviours and associated outcomes

were sustained. Nor is it possible to quantify the programmatic impact on the wider community from the qualitative insights.

Similarly, staff participants also consider the Alcohol ABC Approach, and public health action on alcohol-related harms, to be important. Staff shared the perspectives of patient participants when they identified alcohol-related harms and health impacts as a clear rationale for the importance of the Alcohol ABC Approach. However, staff also had some unique perspectives including: potential for Alcohol ABC Approach to support a more holistic health assessment that addresses the issue, and deliver follow up support (where needed):

> *"It's just integral. You're changing one health behaviour, somebody can change health behaviour, we may as well hit all health behaviours as we're at it. . . Alcohol has such devastating effects and is often underrating and we've got this big opportunity to go in"* (S10).

> *"We get significant numbers of patients who have trauma directly related to alcohol abuse and often these patients come back to us numerous times with alcohol-related injuries over a period of year. And so it was very clear to me that we weren't actually ever addressing the underlying issue. We were good at patching patients up again and sending them back out the door and get them moving and functional again. But then the same problems would happen again, and they'd come through the door with new injuries. So when staff went through the training, it really it was like a light bulb moment. Staff really felt like actually this is really important and we need to address this, we can't keep on sweeping this under the carpet"* (S07).

The ability of staff to reach or approach a wide range of community members for intervention through their services also made staff feel the approach was important: *"When I first started working, I probably was in the mindset of I know they are drinking, that's not an us thing, that's, the ward will ask them - something like that. . . Then thinking about it, people that come to the front door, about 80 percent of them only ever get to the emergency department. So I probably realise that we probably do have more of a vital role"* (S09). Largely, staff participants report that their perceptions around the importance of the Alcohol ABC Approach have increased as a result of involvement in the Alcohol ABC Approach implementation or training.

Staff who completed Alcohol ABC Approach training self-reported a significant improvement in their perceptions of the value and importance of the Alcohol ABC Approach in their work, and likelihood that they would use the approach (Table 9).

> *"I think for me, it's always seemed like a really important thing to do. In my team members though, I've seen a change in their thoughts around it from initially feeling a little bit reluctant around, gosh this is more demand on our time, to actually, yes, we need to be doing this. So I have seen a change in the team over time around how much they value it"* (S07).

Table 9: Proportion of 'good value' and 'high value' (or equivalent) Likert scale responses and p-values for scale items around value and application of the Alcohol ABC Approach.

Statement	Proportion of 'good value' and 'high value' (or equivalent scale item) scores, N (%)		
	Before	After	P-value
My thoughts on the value of the Alcohol ABC Approach	161 (58.9%)	262 (95.9%)	<0.0001
Likelihood that I will use the Alcohol ABC Approach in my day-to-day work	100 (36.6%)	253 (92.7%)	<0.0001

The migration graph (Figure 4), presented on the following page, depicts migration of responses from a simultaneous pre and post Alcohol ABC Approach training survey. Reading the graph from the left hemisphere (this represents responses "before") to the right hemisphere (this represents responses "after"), the coloured ribbons illustrate movement or travel of staff responses from before and after training.

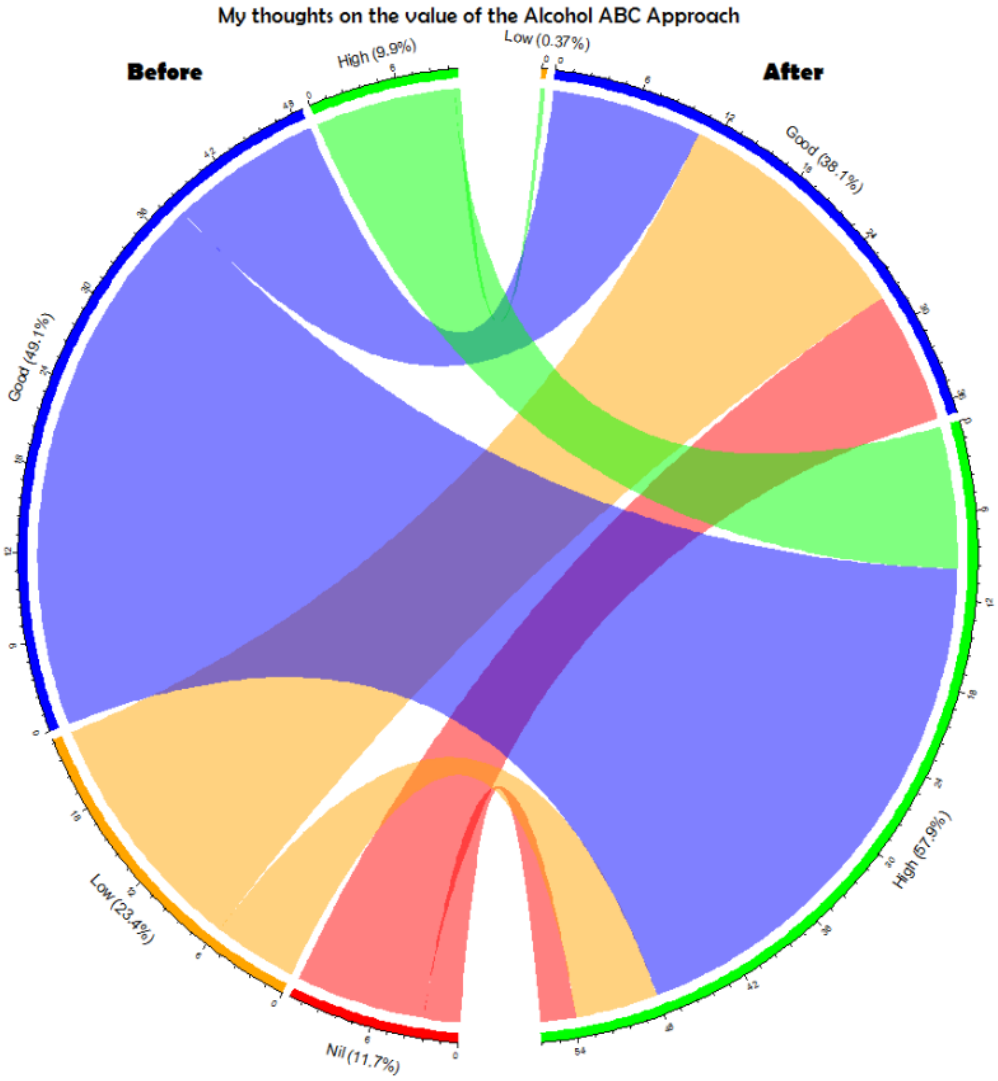


Figure 4: Migration of responses from 'Nil value', 'low value', 'good value' and 'high value' before and after the Alcohol ABC Approach training regarding staff perceptions of the value and importance of Alcohol ABC.

Recognising the value and importance of the Alcohol ABC Approach was identified as a key implementation enabler. Staff participants linked understanding the value and importance of the Alcohol ABC Approach among leaders or managers as critical to ensuring a clinical prioritisation of the Alcohol ABC Approach within their service and protecting staff release time for training and development. Mechanisms for changing perceptions around the importance and value of the Alcohol ABC Approach among staff participants included: participation in Alcohol ABC Approach training, which supported staff to better understand the impacts; observations of alcohol-related harms in their work; strong leadership support and prioritisation of the Alcohol ABC Approach and training; dedicated Alcohol ABC champions or staff to encourage and educate the team; ongoing top up or reflection training opportunities, and; staff hearing examples of the impact conversations have on patients. Notably, there are no formal feedback loops which provide visibility of outcomes associated with assessment, brief advice, or referral to counselling to frontline staff. This is further discussed under 'System failures' on p.70.

A key enabler identified throughout this evaluation is growing staff skills and confidence to approach conversations about alcohol. Staff acknowledged initially feeling nervous or awkward about approaching conversations about alcohol with patients. Consistent with previous research, staff reported concern for patients' discomfort, offence or other patient reactions and deleterious impacts on the therapeutic relationship (Gargaritano et al., 2020; Maynard & Paton, 2012).

> *"I'm trying to think back to when we were first implementing it, it was more just asking the questions. I think it was more learning how to have these conversations and not be scared about people's responses to it. Initially when it was in the piloting stage, and when it first became business as usual, there was a lot of hesitation about, 'what if they're going to get defensive about it'. It was reassuring ourselves that it was okay, that even if they were defensive about it, that we still could fall back on addressing it in a future session"* (S17).

> *"I think before you kind of thought that everyone would be offended if you're asking about it, and that's probably just your own mind-set if you think everyone is going to be quite awkward around it. I guess that's kind of one of those things that when you first started it was a little bit awkward to be talking about, like moral things like drugs or alcohol, smoking and like suicidal thoughts and stuff like that. Those are all kind of what I found when I first initially started nursing, was one of those ones that, kind of like a taboo, touchy subject in certain circles. But yeah, I guess it's more of a nurse onus like thought process rather than actually the patients making you feel like that"* (S09).

The above quotes reflect the journey many staff have taken, from feeling unsure and reluctant to approach conversations about alcohol, to understanding that is okay to ask. Key mechanisms through which staff reported gaining confidence and skills to approach discussions included:

- Alcohol ABC Approach training including initial training sessions but also refresher sessions which supported staff to come back and reflect on their initial conversations for further improvement and assurance.
- Mentoring and support from Alcohol ABC Approach champions and colleagues.
- Having experience and familiarity with approaching conversations which enabled staff to feel less "scripted" and more "naturalistic" in their approach and delivery.

These mechanisms represent core components of SBIRT best-practice (BCCSU, 2019). In particular, evidence indicates that screening rates can decrease over time following training, highlighting the value of ongoing and regular provision of forums for shared practice and educational refresher sessions (BCCSU, 2019; Gargaritano et al., 2020; Mitchell et al., 2017). Repeated training sessions offer an effective method to re-ignite commitment and enthusiasm, and restore and reinforce knowledge and skills (Mitchell et al., 2017; Patston et al., 2017).

> *"I guess everything, when you first start doing something you don't always feel that confident in asking questions and it can be nerve-wrecking having to ask people personal questions about alcohol use and things. For me, doing it more often and becoming a champion and speaking to other nurses in handovers about it and explaining to them how to do it, and also helping people on the floor when I've been coordinating an area and prompting other nurses and giving them a hand in doing it, explaining to them what advice they can give – that's helped me do it better as well. Being able to teach other people how to do it so they can go on to gain confidence as well is the main thing"* (S09).

Alcohol ABC Approach training aimed to support staff to:

- To gain knowledge, awareness and better understanding of alcohol-related harms and hazardous drinking in CM;
- To gain knowledge, confidence, and skill in having conversations about alcohol using the Alcohol ABC Approach (asking using the AUDIT-C tool, delivering brief advice, and knowing when and how to refer patients);
- Gain knowledge, confidence, and skills on how to have patient-centred empathetic conversations with patients that are culturally safe; and
- Champion and support colleagues to have conversations about alcohol.

Overall, the Alcohol ABC Approach training was very well received by staff, who reported it was 'relevant' (N=59, 22%) or 'highly relevant' (N=199, 75%) to their work. Of the 263 people who responded to this survey question, 100 percent stated they would recommend the training to their colleagues (10 staff did not respond).

The training was successful in improving staff knowledge, skills, and confidence to implement the Alcohol ABC Approach within their setting or service. Literature consistently highlights the profound influence of training to build self-efficacy in staff across professional groups (Derges et al., 2017; Mitchell et al., 2017; Patston et al., 2017). Key limitations to staff learning include the ongoing impact of implicit bias which impacts on how staff interact with patients. This was further explored under key theme three. Key learning of training participants is well aligned with training objectives and is summarised on Table 10.

Table 10: Description of key learning from Alcohol ABC Approach training

Theme	Description
Identifying available supports for alcohol	Training participants commonly reported learning about services and resources that were available to the community to support those at risk of alcohol harm. Generally, there was greater range of services or resources available than staff had initially thought (e.g. more than just CADS). As a result of this learning, staff report feeling more confident in their ability to support patients by connecting them with appropriate services: *"The big thing I learnt was CADS referrals, which I didn't know about. . . for me that is a really important tool for people to get support… Just knowing that we can do that ourselves and it's really simple and knowing where to find it"* (S18).
Understanding 'standard drinks'	Training participants were shocked to learn how small a 'standard drink' actually is, and differences in standard drinks across alcohol types such as wine, spirits, beer, and RTDs. With this understanding, participants were better able to understand different levels of alcohol use and inherent risk. Better understanding standard drinks also supports more accurate assessment of alcohol harm: *"Definitely knowing the serving sizes with the different types of alcohol that are out there, that was an eye opener [for me]" (S04).*
Rethinking how conversations are approached with the community about alcohol use	Training participants gained skills and confidence around how to approach conversations about alcohol use, and provide brief advice where indicated. For example, they emphasised the importance of using open-ended questions, being non-judgemental, compassionate, and empathetic in their questioning and advice, and 'planting seeds' for future reflection and change around alcohol use. Participants appreciated gaining skills in motivational interviewing to assist them in identifying and discussing triggers for alcohol use and appropriate responses to these.
Understanding underlying reasons behind alcohol consumption	Training participants reported better understanding why people might drink. Their responses show understanding of what influences people to consume alcohol from various levels and lenses including individual (e.g. feelings and behaviours, self-confidence, sleep trouble, anxiety and/or stress), biopsychosocial, spiritual, community, and societal (e.g. culture of normalisation and social pressure around alcohol use, rife availability to alcohol in local communities). They identified social determinants of alcohol use.

An analysis of responses to simultaneous pre and post Likert scale comments around self-reported confidence and knowledge to assess for alcohol harm, provide brief advice, and refer people to services where needed, show a statistically significant improvement across percentage scores for each statement (Table 11). This improvement is further depicted in migration graphs (Figure 5 and Figure) which show movement in staff responses to Likert scale items.

Table 11: Response percentages to Likert scale comments around knowledge and confidence

Statement	Proportion of 'good' and 'excellent' scores, N (%)		
	Before	After	P-value
My understanding of alcohol and alcohol-related harm for individuals and whaanau	108 (39.6%)	262(95.97%)	<0.0001
My confidence when talking about alcohol with individuals and whaanau	54 (19.8%)	237 (86.8%)	<0.0001
My knowledge of how to assess for alcohol problems	59 (21.6%)	239 (87.5%)	<0.0001
My confidence in delivering alcohol assessments in my work	55 (20.1%)	215 (78.8%)	<0.0001
My knowledge of how to provide brief advice about alcohol	47 (17.2%)	237 (86.8%)	<0.0001
My confidence in providing brief advice about alcohol	52 (19%)	225 (82.4%)	<0.0001
My knowledge of when to refer clients on to other services for help with alcohol	50 (18.3%)	229 (83.9%)	<0.0001
My knowledge of how to refer clients on to other services for help with alcohol	41 (15%)	219 (80.2%)	<0.0001

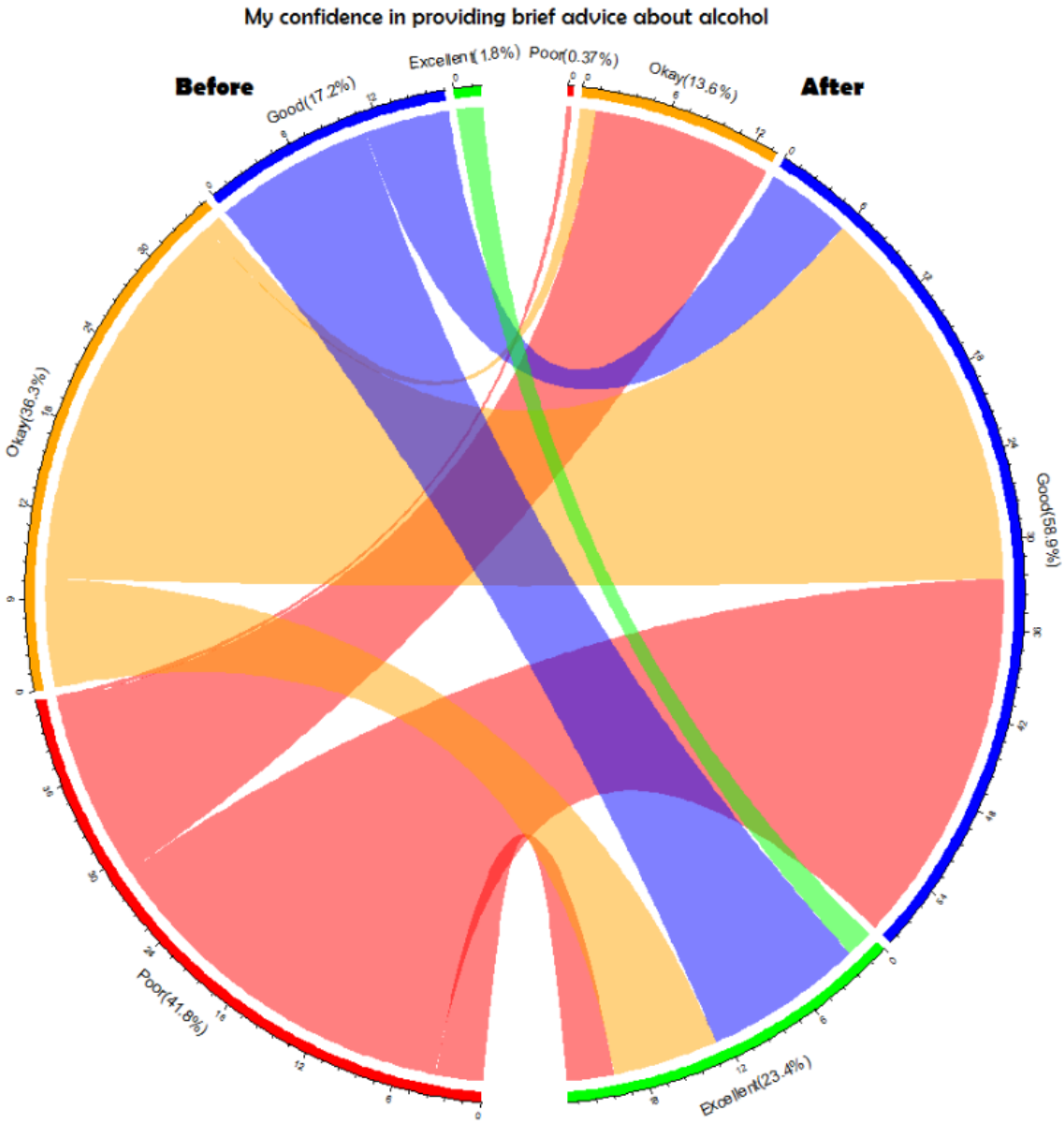


Figure 5: Migration of responses from 'okay', 'poor', 'good' and 'excellent' before and after Alcohol ABC training about staff confidence to provide brief advice about alcohol in their service delivery

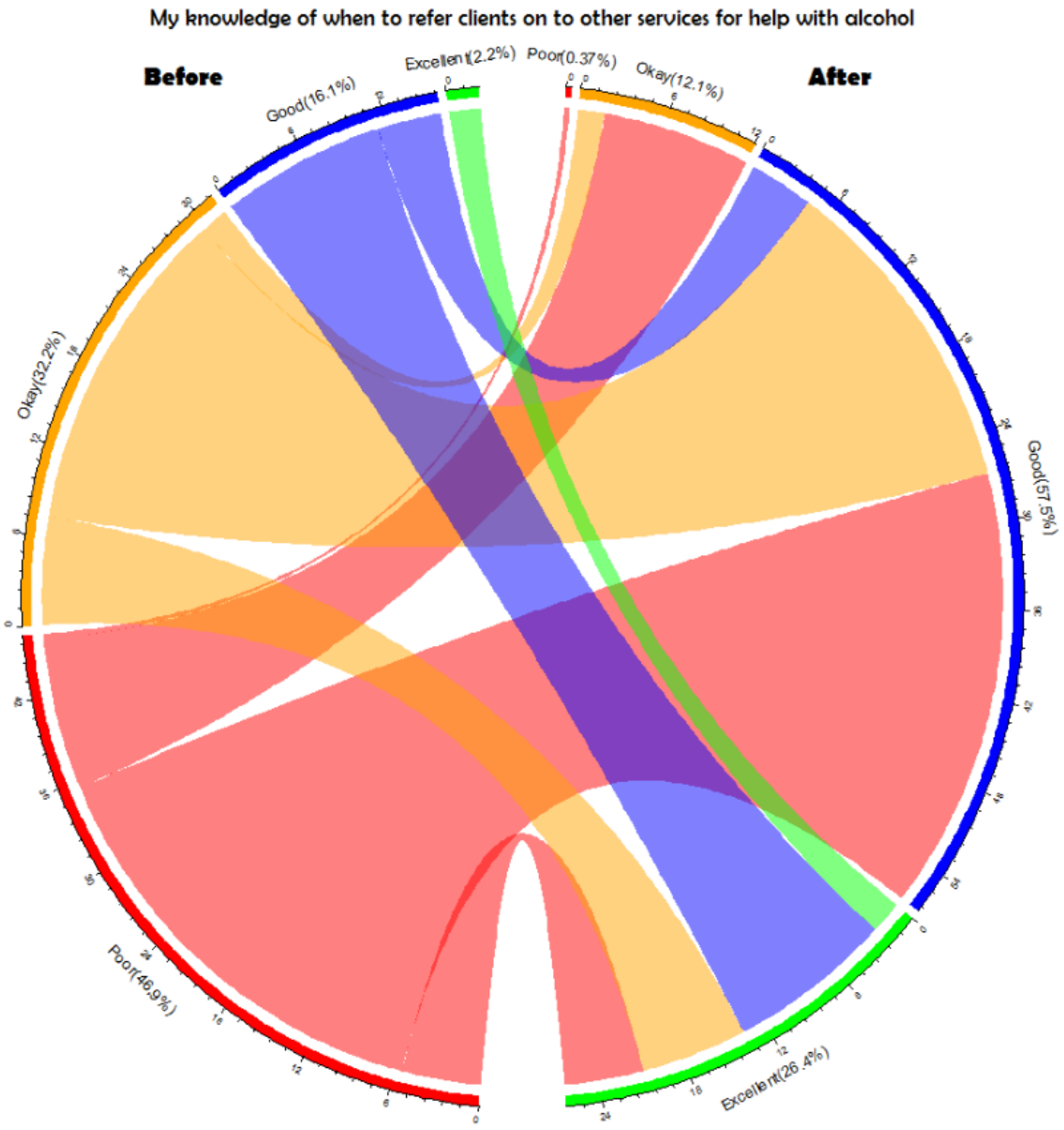


Figure 6: Migration of responses from 'okay', 'poor', 'good' and 'excellent' before and after Alcohol ABC training about staff knowledge of when to refer clients on to other services for help with alcohol

Intention to apply their learning was high amongst survey respondents; 100 per cent of staff who responded to this question responded they would apply their learning to their work (N=255, 9 staff did not respond, and survey data was not available for a further 9 staff). In explanation, staff most commonly described an intention to change their approach to conversations about alcohol. This included, for example, using more open-ended questions, using motivational interviewing skills, listening carefully to why people may be drinking, and being empathic, compassionate, and empowering in their conversations, responses and supports offered. Survey respondents also intend to use the Alcohol ABC Approach more consistently or systematically in their work and recognised the value and impact of doing so.

With their expanded knowledge of resources and services available in CM, survey respondents reported an intention to use support resources or services more frequently in response to the needs of family/whaanau they are screening. Respondents also committed to helping educate their

colleagues around the Alcohol ABC Approach, and assisting their own whaanau to understand harms of alcohol use.

In summary, training survey responses, together with qualitative interview findings, demonstrate a self-reported improvement in knowledge, skills, and confidence of staff to deliver Alcohol ABC Approach, and enhanced perceptions of the value/importance of Alcohol ABC Approach.

(ii) Implementation enablers and success factors

This section presents several success-enabling factors identified by the AHM Team as part of their ongoing programme management between 2016 and 2020, and also by evaluation participants in the course of qualitative interviews (patients, staff, and key stakeholders). For the purpose of this report, 'enablers' are defined as factors that enabled the AHM Programme to progress towards achievement of its aims and/or objectives. Enablers were grouped into three main categories: workforce-related, organisation-related, and programme-related. Please note that these categories are arbitrary and may overlap with one another. Each enabler category is defined in their respective section.

Workforce-related enablers

In this category, enablers relate to workforce involved in the provision of services to a patient population, requiring direct engagement/interactions with these patients. Please see Table 12 for a summary of workforce-related enablers.

Table 12: Summary of workforce-related enablers

Enabler	Examples
Skills and knowledge	1. Some staff already have the skills of motivational interviewing required for the assessment. 2. Availability of staff training, e.g. a training on "Having conversations about alcohol"; training ED staff on Alcohol ABC and referral pathways; creating opportunities and content for online learning; 1:1 orientation for new champions to facilitate their engagement.
Beliefs and motivations	3. Staff eagerness to use a test and learn approach/QI methodology. 4. Staff expressing interest in upskilling in having conversations about alcohol. Such staff can be great role models and advocates. 5. A team with a positive and 'can do' attitude. 6. Using data and evidence about the programme to motivate staff.
Staff availability and prioritisation of AHM work	7. Staff being supported and enabled to attend training, adapt Alcohol ABC Approach to their work setting, and embed into their everyday business-as-usual practice. 8. Identifying staff who can be champions and support other

Enabler	Examples
	staff in their work teams. 9. Creating roles that do not require clinical expertise to aid delivery of the AHM Programme, e.g. changing 'Clinical Champion' role to 'Champion'.
Community reach	10. AHM Team staff work across the sector, facilitating reach into community and primary care as well as the hospital.

Presented below are two examples of how the work-related enablers affected the implementation of the AHM Programme. These examples come from feedback provided to AHM Team by staff involved in implementing the programme.

1) Example 1

"It [Alcohol ABC Approach training] was a good session as usual. I've got over feeling nervous about broaching the subject about patients' drinking now. I gained more from updating on the selection of referral and treatment agencies because often people are reluctant to accept that they could benefit from some help in cutting down or stopping drinking. Maybe because they don't want to take any time off work or think they can cut back to safer levels themselves. Some of them do mention they have cut back later on and often this is reflected in their improved liver function results. I quite often talk about the "4 Ls" and they are worried about their liver being affected" (Email record).

2) Example 2

"[Subject line] Opportunistic screening.
One busy Monday morning I introduced myself to Miss B who was seeing me for a flu vaccine. Miss B was aged 59 years, well dressed, with a huge smile and engaging personality. After I administered the vaccine, I had a few moment to update her patient dashboard. I noticed that no record had been made regarding alcohol consumption. I asked if I could her about this, which she agreed. I used the AUDIT-C tool, which is an Alcohol Consumption Assessment Tool, to enquire about her alcohol status and identify if she was drinking alcohol in a hazardous or harmful way. It became clear that her alcohol consumption was in excess of the recommended guidelines. We talked about what she has tried in the past to reduce this and I offered her a referral to CADS which she declined.

Upon further investigation I came to realise she was using alcohol to mask personal distress in her life to enable her to cope. Whilst Miss B had declined CADS at this stage, she agreed to a referral to our local community psychologist. In preparation to this appointment Mrs B and I met beforehand. We completed an initial mental health screen which showed mild depression and mild anxiety. We also explored the impact her alcohol consumption was having on her wellbeing using the 'Te Whare Tapa Whaa' Maaori Health model and gave her resources on the recommended low- risk drinking guidelines" (Email record).

Literature consistently identifies the knowledge, skills, confidence, and attitudes of staff as fundamental to SBIRT implementation (Gargaratino et al., 2020; Johnson et al., 2013). To support this process and provide continuous reinforcement, best practice recommendations include the establishment and ongoing facilitation of dedicated champions (BCCSU et al., 2019; Gifford et al., 2012; Matua Raki, 2012; Patson et al., 2017; Venkat et al., 2017).

Organisation-related enablers

In this category, enablers relate to interactions within the context of an organisation, both large (e.g. CM Health) and small (e.g. a medical centre). Please see Table 13 for a summary of organisation-related enablers.

Table 13: Summary of organisation-related enablers

Enabler	Examples
IT infrastructure	1. Incorporating alcohol assessment into electronic PMSs. 2. Assistance of data analysts to pull data from different platforms and create reports. 3. Visiting the settings and learning about local IT infrastructure to identify barriers and enablers to implementation of the Alcohol ABC Approach.
Leadership and strategy	4. Management agreeing to providing workforce with the Alcohol ABC Approach training and securing dedicated time for this training. 5. Project leads or champions who demonstrate engagement and support for the AHM Programme. 6. Visibility of leads being seen attending programme-related training, e.g. the 'Having Conversations about Alcohol' training.
Processes and procedures	7. Adaptation of Alcohol ABC Approach processes to accommodate unique project setting environments and constraints. 8. Incorporating Alcohol ABC Approach in standard workflow (so that the patients are routinely asked). 9. Developing resources and making them easily available and visible, e.g. alcohol resources box made and distributed to all areas of ED, and laminated cue cards that serve as guide for triage nurses were placed on all triage computers. 10. Co-designing the processes with champions and other staff from across the different settings. 11. As part of the morning huddle, identification of patients who have not had their Alcohol ABC assessment completed.
Organisational culture	12. One of the participating settings came to the AHM Team and asked to be included in the programme as they had assessed their clients as having issues with alcohol.

Enabler	Examples
	13. Whole-team approach. 14. Promoting awareness among staff, e.g. the Alcohol Harm Summer Campaign to increase awareness about alcohol harm and the Alcohol ABC project in ED amongst staff; or distribution of quarterly newsletter with updates on the AHM Programme. 15. Working with a range of staff groups within the different settings to promote alcohol harm awareness. 16. All new staff attending the Alcohol ABC Approach training. 17. Having alcohol champion presence in settings seemed to increase completion rates of A (as in the Alcohol ABC).

Evidence supports integration of SBIRT resources into the electronic medical record as a primary organisational feature considered fundamental to higher coverage across settings and programme sustainability (McKenna et al., 2013; BCCSU, 2019; Johnson et al., 2013). Furthermore, research indicates that the generation of alerts or electronic prompts was heavily relied on by staff working in busy primary care and ED environments (Gifford et al., 2012; Vipond & Mennenga, 2019). Other CM Health enablers confirmed as important within the literature include: strong buy-in and ongoing support from leadership and senior staff (BCCSU, 2019; Gifford et al., 2012; Johnson et al., 2013) and an inclusive, whole-team approach to planning and implementation (BCCSU, 2019).

Programme-level enablers

In this category, included factors related to managing the AHM Programme, for example human resources, funding, or workforce development.

Table 14: Summary of programme-related enablers

Enabler	Examples
Expertise within the team	1. Recruitment and retention of the AHM Team. 2. A wide range of skills and expertise including population health, Maaori health, project management, clinical, counselling, and others.
Vision and strategy	3. Clearly defined goals and objectives, for example the AHM programme logic. 4. Tracking progress and reviewing goals. 5. Long-term plan for implementation of the programme. 6. Being clear on the purpose of each programme activity, i.e. linking them back to the programme logic.
Professional development of the AHM core team	7. Attended training and developed knowledge and skills in: project management, evaluation, data for improvement, Alcohol ABC training.
Training of workforce across settings	8. Developing training protocols to ensure high quality and consistency; using the same trainers.

Enabler	Examples
	9. Offering follow-up/refresher training. 10. Facilitating sharing of knowledge between settings by organising group meetings, e.g. when one of the PHOs raised difficulties related to onboarding a new champion, another PHO shared their experience, encouragement and approach on how to do this.
Building on existing evidence	11. Underpinned by sound scientific research and a clear rationale; including the dual focus on Alcohol ABC Approach and population health interventions. 12. Learning and adaption of Smokefree ABC from smoking cessation programmes. 13. Proactively seeking feedback from all stakeholders and proposing changes accordingly, e.g. visiting different PHO to seek feedback on implementation of the programme.
Availability of resources	14. Secure funding for continuing the AHM Programme (including staff salaries). 15. Support (improvement, project management and financial) for collaborating general practices. 16. Monitoring of data to identify any organisation-specific inequities. 17. Sustained support of members of the CM Health Alcohol Advisory Group (providing advice and guidance for several years).
Communication and buy-in	18. Presentation to leaders and management in different settings to explain and promote the programme. 19. Proactive communication with key stakeholders, e.g. letting them know about timeframes and next steps in advance. 20. Identifying and discussing alignment with mission and aims of other participating organisations. 21. Developing and maintaining good relationships with staff across all settings.
Relationships and collaborative style	22. AHM Team intention to understand and adapt the programme in response to unique needs and challenges across projects. 23. Genuine commitment to being helpful and supportive in programme delivery and resourcing.

Consistent evidence demonstrates the importance of many of these enablers. Notable in the literature is the profound influence of regular training (specific to clinical setting), availability of adequate resources, and robust monitoring and feedback loops to enable continuous programme modification and improvement (Gargarinto et al., 2020; Geerling et al., 2018; Johnson et al., 2013; Mitchell et al., 2017).

In addition, the discrete bounds of the intervention itself within the context of the implementation landscape are increasingly recognised as crucial (Geerling et al., 2018). These consistently included ease of integration and face validity. Foundational within the Alcohol ABC intervention and arguably part of the success to date at CM Health is the use of the AUDIT-C tool for assessment. Developed for use in primary care by the WHO (2018), and recommended in Aotearoa by The Royal New Zealand College of General Practitioners Guideline (2012), AUDIT-C is consistently viewed as appropriate in content and brevity, including in the most challenging emerging settings like ED (Love & Ehernbery, 2011; Patston et al., 2017). This, however, must be recognised as one component (i.e. the Alcohol 'A') of the Alcohol ABC Approach, which is itself one element of the AHM Programme.

(iii) Implementation risks and issues

This evaluation aimed to explore key risks and issues that arose during the implementation and how these were resolved. As part of AHM programme management, the AHM Team registered a number of events that either resulted in a programme-level issue or were a perceived risk. These events were recorded by the AHM Team. Issues and risks were defined as:

- Risk – an event that has not happened but has some probability of occurring and requires a mitigation strategy.
- Issue – a risk that has happened and requires a resolution strategy.

Following review, the reported issues and risks were grouped into five broad categories: 1) procurement, 2) staff and staffing capacity, 3) data development, 4) unplanned disruptions and, 5) systemic. In the following sections, a narrative summary is provided of issues and risks related to these categories. Risks and issues identified during qualitative interviews are also integrated. Where specific data was available, how these risks and issues were resolved is reported. Finally, a list of learning points and considerations is provided to guide further development of the AHM Programme.

Procurement issues and risks

Multiple issues and risks relating to procurement were identified. Procurement has been defined here as the process of agreeing to terms and acquiring services that are of the desired quality and within the expected timeframes. Issues and risks in this category relate to: 1) stakeholder expectations, and 2) contract management. Both of these issues and risks related to work with the participating PHOs.

Stakeholder expectations

A key part of the support offered by the AHM Team was to assist PHOs with the development of QI Plans to identify PHO specific actions, strengths, issues and needs related to the implementation of ABC Alcohol Approach and monitoring. The development of a QI Plan was a part of contract specifications for this work. However, committing the required resource to the development of high-quality plans was challenging for PHO staff, for an array of reasons related broadly to workloads, COVID-19 disruption, staffing capacity, skills and capability, competing priorities, and for some, underestimating the amount of work involved:

> *"I do find some of the quality improvement planning to be quite labour intensive . . . I remember when I first started in this role, I thought 'oh, my gosh, what have I got to do?' .*

> *. . I know it is a contractual requirement and we have to observe that. But it is time consuming to update and do the progress reporting, it's quite a huge amount of work to do within that, but I know it's a very important project"* (S01).

Over the course of the programme, extensive support from the AHM Team was required to ensure the development of high-quality QI Plans, such as assisting with extracting the baseline data and organising staff from the Health Intelligence and Informatics team (supporting Primary Care) to assist PHOs and transfer over the raw data to a template. This made the team realise that the programme strategy and expectations were potentially exceeding the PHOs capacity and/or ability to deliver on the planning component. In their efforts to ensure high quality QI Plans were completed, the AHM Team needed to be more flexible in the level of support offered and understanding of PHO capacity. This has an impact on implementation costs and therefore needs to be accounted for in future programme planning. Further, the level of work required to support QI planning may need to be considered in the contract type established with PHOs.

Contract management

Managing the establishment of new contacts and re-signing of contracts for 2019-2020 with providers was another area where issues were experienced. These issues included both prolonged contract negotiations, and missing deadlines for returning signed contracts. Prolonged contract negotiations carry the risk of delaying the initiation of the work thereby limiting the programmatic reach in the community. Several delays in the contracting process (e.g. due to delays in confirming lead practices within each PHO) disrupted programme timeframes. However, it appeared that despite some initial internal delays due to DHB contract review processes, PHOs were committed to getting this work underway, and they had put a range of processes in place to ensure the contracts were managed in a timely manner.

Procurement of new services in public-private partnerships is a particularly complex process and carries with it a higher risk than procurement of previously established services. Importantly, the funders' and providers' priorities and expected outcomes are unlikely to be perfectly aligned. To ensure a successful acquisition of new or innovative services, it is crucial to understand the factors contributing to the complexity of this process, both from the funder and the provider perspectives. Notably, in some circumstances a success of one stakeholder, may lead to a loss for another one. Thus, evaluators recommend specifically focusing on understanding the service providers' priorities, expected outcomes, and also their capacity and resources available to them.

Several strategies and leverage points to support timely contract completion were identified, including (i) ensuring no contract payments would be made while draft contracts outstanding and (ii) targeted liaison and communications with each of the PHOs separately to ensure responsivity to the unique needs and circumstances of each PHO. The AHM Team drew on senior leaders to communicate to the relevant high-level PHO management and contract managers (the contract managers are often separate to the PHO Champions who drive the work and attend the meetings).

Similar action was also taken to ensure the distribution of funds from PHOs to practices to ensure reimbursement for work undertaken at a practice level. Adequate financial compensation for Alcohol ABC Approach implementation within primary care has been identified as fundamental to

programme sustainability within Aotearoa (Adams et al., 1997; Gifford et al., 2012). Letters of Agreement between PHOs and practices were introduced to clarify how PHOs would support practices to deliver the Alcohol ABC Approach, and specify the roles, expectations and resourcing more transparently.

Staff and staffing capacity issues and risks

The issues and risks in this category relate to challenges with programme staff capacity, turnover, and retention. Across all settings, staff reported having limited capacity or lack of time to complete Alcohol ABC with attending clients/patients. This challenge is well-established in the literature (Geerling et al., 2018). The AHM Team explored a range of options to address this, for example, using text recalls for alcohol assessment, running competitions for patients while they were in the waiting room to complete a paper survey including AUDIT-C, and using AUDIT-C as a requirement for Wi-Fi connectivity in waiting rooms. Although in many instances lack of time or understaffing may be the key reason behind this issue, the role of each setting's culture and prioritisation of tasks may also play an important role here, i.e. considering the Alcohol ABC as an additional task versus one of the priorities. Staff and staffing capacity issues and risks are explored in more detail related to their unique setting and project as follows: 1) ED projects, 2) PHO champions (previously 'clinical champions'), and 3) AHM Team.

ED project

The amount of effort and resources to implement the Alcohol ABC Approach within ED was higher than expected. CM Health ED is a busy setting. Adding a new activity (i.e. Alcohol ABC Approach) to an already overburdened service was a challenge. At times when ED was at full capacity, alcohol assessments had to be halted. The negative impact of high patient numbers on screening rates within ED settings is also evident within the literature (Patston et al., 2017).

Funded positions (by the AHM Programme, Population Health Directorate) for clinical nurse alcohol leads have been critical for facilitating engagement and buy-in in ED and for making progress with implementing Alcohol ABC Approach in this setting. Temporary vacancies in these roles over the programme duration resulted in loss of programme momentum and programmatic experience from key workforce. Regular communication with senior ED staff through the Secondary Care Advisor was needed to strengthen buy-in during vacancies.

PHO champions

The PHO alcohol champion is the lead person in each PHO, responsible for driving activity within the collaborating general practices and across their PHO, in line with the actions listed in their respective QI Plans. Turnover for this role has been high (all five PHOs have now had new champions). This resulted in a higher transactional cost (as the AHM Team needed to spend time orientating new staff) and lost productivity (due to the position being vacant or staff being new to the role).

It appears that most of the reasons for high turnover were unique to the organisations and were difficult to mitigate as PHOs nominated champions using their own internal processes. However, the AHM Team also noted an increased enthusiasm for the programme and this role with the new PHO champions coming on board, who were eager to work collaboratively and share their learnings.

AHM Team staff

One of the main risks and issues to the success of the AHM Programme related to the AHM Team's capacity and sustainability. The AHM Programme was a new initiative, and consequently initially most staff were employed on fixed term contracts. A proposal to change the contracts of the AHM Programme from fixed term to permanent was proposed to transition from pilot to permanent programmatic efforts. This proposal was approved and took effect in March 2019. While not many funding-related issues were reported by the AHM Team, it is important to note that funding continuity is integral to ensuring the success of the AHM Programme.

Due to the small size of the AHM Team, staff turnover or changes in capacity pose significant risks to programme continuity and meeting expected timeframes for milestones. Workforce turnover or recruitment challenges within the AHM Team means that prioritisation of tasks, monitoring timelines, and robust handover documentation have been required and completed.

A related issue raised during the course of evaluation interviews, is the importance of and need for Maaori workforce participation and leadership across the AHM Programme. Cultural loading on members of staff who identify as Maaori is an important consideration in any CM Health programme. While the AHM Programme staff recognise that genuine working relationships with Maaori are integral to this work, further work is needed to ensure the continuity of relationships in the event of workforce changes:

> *"They've really done amazing work, working to engage and work with Maaori on this issue. . . . I think you want to set up a process that isn't reliant on amazing staff who have particular skills or background. I just think it would be more sustainable"* (KS01).

Data development

The AHM Team and project staff worked closely together to develop IT infrastructure to enable collection, recording, and output of Alcohol ABC Approach data. Prior to the establishment of the AHM Programme, there were no standardised, structured data capture and reporting systems for Alcohol ABC Approach in any project settings, therefore development of these was a key challenge.

In the GP setting, during the development of this infrastructure, particularly as general practices transitioned to different PMSs, the accessibility and quality of data reporting were affected. Some PHOs experienced issues with their PMS databases, for example difficulties extracting the correct data, which meant no data was available for extended periods of time (many months). As PHOs have been at different stages in the development of alcohol data reporting capability across the duration of the programme, this has prevented the AHM Programme from pooling data for DHB wide reporting requirements. This is a risk to long term monitoring and accountability.

The AHM Team made efforts to actively manage data-related issues together with PHO champions, including private contracting to develop an alcohol pop up box in MedTech PMS to better support the Alcohol ABC Approach. This was supported by PHO staff being open and transparent, keeping the AHM Team in the loop regularly about data issues and quality:

"Counties paid for the electronic[8] improved pop-up form. . . At the beginning we just couldn't capture much. I can't remember what it looked like, [but] I know that with my practice we could only get only get the A part reliably, which is good, that we can get the A part. But you really need the B and C, you know, particularly the B get a full picture of what's going on . . . I think it was the C part at the beginning that we couldn't capture on the electronic [form], so I think once we got that, it was helpful. So we can see the full picture, [because] in order to make improvements, you need to know how you're doing. So it was really important to get" (S11).

In the ED setting, audits conducted to monitor progress with implementation of Alcohol ABC Approach have shown relatively low completion of AUDIT-C assessments by staff, for patients screened at triage and reported to have an alcohol-related presentation to the ED. The main reason for the low completion rate was reported as being due to a lack of alignment between the administrative IT system at triage and the paper-based systems for recording patient-related data in ED. With no availability of electronic data capture in the ED setting, the AHM Team, together with project staff from these services, had to be creative and flexible in their attempts to create improved processes for Alcohol ABC Approach.

While being a key challenge, the development and improvement of data capture systems, and the establishment of some Alcohol ABC Approach monitoring is also identified as a key programme success. This is further reflected under the Implementation enablers section.

Unplanned disruptions

The COVID-19 pandemic inadvertently impacted the AHM Programme activities. First, three AHM Team members were redeployed to support the regional response to COVID-19. As the team were asked to prioritise supporting COVID-19 response, many of the programme activities had to be put on hold. One of the examples is this evaluation, which was originally scheduled for completion by September 2020 and was significantly delayed. The evaluation methodology had to be adapted to incorporate remote interviewing of patient and staff participants – as earlier detailed in the Methodology.

At the time of commencing writing of this report, the pandemic was still developing, vaccine roll out was in its first stages, and its impact on the AHM programme and the healthcare system in general were not clear. Recognising this event as a *force majeure* and adapting to the 'new normal' may be the most appropriate mitigation strategy.

System failures

Staff and patient participant narratives highlight of range of systemic failures to ensure effective, consistent, and accessible referral pathways and support services to those patients referred to counselling. While the AHM Team are not part of the provider arm with responsibility over AOD services, these participant experiences highlight the value of increased integration and relationship

[8] Form names have been removed to de-identify evaluation data.

building between the programme and AOD services. Examples from participant narratives are summarised on Table 15.

Table 15: Description of systemic failures alcohol support services

Issue	Description	Example from patient participant quote
Lack of service integration and continuity for alcohol harm support	Boundaries of practice and support scope were unclear for staff and patient participants when navigating across services. Fragmentation of services resulted in inappropriate positioning and burdening of patients and whaanau as 'messengers' between healthcare staff across services to resolve issues.	*"She [my doctor] expected more from CADS, but CADS said it was like they sort of flipped off a bit to go, go and tell me what your doctor says. What does your doctor think, oh ok then when I got to the doctor was saying 'no it should be CADS giving you that'. So I was a bit confused sitting there with that. So maybe they need to agree with each other or something because I just got confused that [they gave me different advice]… CADS told me one thing and she told me another, so I was a bit confused"* (PP02).
Poor organisational health literacy	Patient participants reported experiencing inappropriate burdening of service access and navigation on themselves or whaanau. For example, where participants had to be very proactive in following up about working with services rather than referring healthcare staff.	*"I think it would have been valuable if they were chasing me, if they knew I had a bit of an alcohol problem. I think it would have been really helpful if they would have been chasing me to give me something. I'm not trying to put the blame on them. . . If they had followed up and said, 'hey, look, just touching base to see how you are', you know what I mean? And trying to dig a little deeper, especially knowing that I expressed my concern about the alcohol . . . But it was nothing more after that"* (PP02).
Failure to deliver care	Across a range of evaluation sources, gaps in equitable delivery of alcohol assessment and brief advice to patients have been identified. Potential loss of patients to follow up is a risk for low-risk drinkers who may benefit from repeated conversations, or those who are provided with information about a service but not direct referral.	*"Some of our GPs – they have their concerns about what happens once we refer patients to the CADS because then they lost the touch, there is no follow up with the GPs once they've the patient with the feedback, this is one of the concerns of GPs have – what happens after the referral?"*

Poor visibility of service actions and efficacy	Staff report poor visibility of service access and efficacy for patients they refer for counselling. This can impact on the confidence and willingness of staff to refer patients to support services where clinically indicated.	*"We also give the 1737 card. . . We think, 'actually do you want this number to give them a call?'. My questions would be, how connected are we to 1737, like do we get feedback from them about people who have talked to them about their alcohol? Or what is the relationship like there? Do we know that we're referring to a credible source? And what happens at that point really, what alcohol providers do they then refer them off to and how do they do that? I'm now just remembering a case in the very early days of somebody that we'd asked to go and call 1737 because of their drinking, and he didn't get a great response, which has led us all to thinking, 'gosh we need something internal', and he was left to it. . . But I mean, maybe some confidence around where we're referring or who we're referring to, or even if it's just about the homecare medical line – 1737" (S10).*

These challenges are symptomatic of fragmented health and care services with poor organisational health literacy. The risk of Alcohol ABC conversations being a discrete and isolated event is evident in the above quotes.

Though the development of supportive and functional referral pathways is a component of best-practice, there remains a paucity of evidence to demonstrate successful referrals following alcohol screening (BCCSU, 2019; Dzidowska, 2020). There may be numerous barriers to successful referral, such as stigma, lack of specialist services and long waiting periods; however, there is evidence to suggest that a focus on role clarity for staff will enable more effective engagement (Adams et al., 1997). It is important to note, however, that challenges can arise where expectations or responsibilities are perceived by healthcare staff to exceed professional boundaries (Maynard & Paton, 2012).

Similarly, for those identified as exceeding 'low-risk drinking' guidelines but not meeting thresholds for referral, emerging evidence indicates that follow-up by phone can improve the effectiveness of a single SBIRT interaction (Gormican & Hussein, 2017). This type of active follow-up approach, where appropriate and consented, may also minimise the burden on patients and whaanau in seeking further support by offering an additional opportunity for engagement.

(iv) Process evaluation: Summary of key learning points and considerations

The process evaluation aimed to understand perceptions and experiences of Alcohol ABC delivery among patients and staff, staff experiences of AHM Programme implementation, key risks and issues that arose during the implementation and how these were resolved, and key implementation enablers and success factors. High quality evidence indicates that implementation strategies targeting multi-level factors, including organisational and workforce context, for duration of more than 12 months are most effective (Dzidowska, 2020; Gargaritano et al., 2020). Findings from this process evaluation demonstrate that the CM Health AHM Programme has been generally successful in leveraging this type of approach.

Participants' narratives demonstrate that service experiences of early intervention from alcohol harm are impacted by perceived acceptability of alcohol use. Qualitative findings, supported by existing literature, highlight that participants' perceived acceptability of their own alcohol use is entrenched in social norms around binge drinking and heavy alcohol use in Aotearoa communities. Importantly, participants sought to describe their own alcohol use as being socially acceptable and therefore not problematic. These interpretations may differ from clinical and physiological definitions of hazardous alcohol use, and impact on feelings of personal readiness for change and treatment of consumption behaviours. Participant insights highlight the importance of early interventions that support the de-normalisation of hazardous alcohol use, which is integral to the Alcohol ABC Approach.

Understanding and acknowledging the impact of broader social norms of alcohol use on patient experiences of early interventional conversations around their alcohol use is critical to ensure that conversations are approached and delivered with compassion and care to support a positive experience by the patient. Staff engagement in the tikanga of whanaungatanga and manaakitanga were described as potentially protective for participants and facilitated safer, non-judgemental conversations around their alcohol use. Such practices are a cultural imperative for addressing equity and Te Tiriti o Waitangi commitments mandated in healthcare settings (Wilson, et al., 2021).

Despite the opportunity to explore prejudices, stereotypes and assumptions around alcohol use, and users of alcohol in Alcohol ABC Approach training, the manifestation of these biases related to sex, age and ethnicity were evident in staff narratives. Ethnic biases are a form of racism and determinant of health (Bloomfield, 2019). Addressing implicit bias is critical to ensuring future conversations around alcohol are culturally safe; this requires staff to thoroughly examine their own culture and better understand how their culture impacts on their interactions with others (Curtis et al., 2019). Though this evaluation has demonstrated significant improvement in staff skills to deliver Alcohol ABC conversations, addressing implicit bias requires structured and ongoing intervention to identify and disrupt biased behaviours, as well as develop empathetic relationships and health improvement interventions. This requires that staff are supported to: (i) understand what implicit bias is and how it occurs (i.e. capture experiences of bias – including how biases manifest in interactions among peers and colleagues); (ii) understand the nature of biases – how they are developed and when they are mostly likely to be activated; and (iii) understand adverse outcomes of implicit bias in the health service context. Recommendations to support teams in monitoring the manifestation of implicit bias in staff behaviours are included in this evaluation. Appropriate interventions that reduce the opportunity for bias (i.e. strengthen the processes of prioritisation and

approach so there is less room in bias in treatment and screening) against this manifestation is paramount.

Process evaluation findings show that both staff and patient participants think the Alcohol ABC Approach is a valuable and important practice, though how staff are able to prioritise and operationalise the approach in their work differs across settings and in response to changing work dynamics on a daily basis (e.g. leadership support, workload, staffing levels, and COVID-19 disruptions). Alcohol ABC Approach training successfully increased skills and confidence among staff to initiate conversations about alcohol with patients as well as to provide brief advice. Staff also highlighted the value of refresh and 'top up' training sessions to discuss initial experiences and challenges having conversations about alcohol post implementation of Alcohol ABC Approaches in their services. Tailoring training for different services was appreciated by staff and demonstrated valuing and commitment to acknowledge and accommodate unique needs and constraints across services.

Key enablers of programme implementation were identified through qualitative interviewing and document review. Enablers related to workforce (e.g. existing skills such as motivational interviewing, availability and prioritisation, and community reach), organisation (e.g. IT infrastructure, organisational culture, leadership and strategy, and processes and policies) or programme (e.g. resourcing, vision, communication and buy-in, relationships and collaborative style).

Upon review of the programme-level risks and issues reported by the AHM Team, two key areas that stood out were procurement and staffing capacity. Procurement risks and issues were related to establishing and managing contracts with stakeholders. Their key impacts included additional costs, delays in achieving programme milestones, and roll out to new settings. Disparate stakeholder expectations pose a major risk to the programme's success. The risks and issues relating to staff capacity resulted mainly from difficulties with employing and retaining staff. The consequences included lost productivity, less progress with programme activities, and ultimately are a major risk to the programme's success. Furthermore, it appeared that lack of appropriate IT systems in many settings may act as a barrier to embedding the Alcohol ABC Approach.

(2) Outcome evaluation findings

The outcome evaluation aimed to answer the following evaluation questions:

1. How successful was the programme in increasing delivery of the Alcohol ABC Approach in the priority settings (GP, hospital, and community)?
    - 1.1 How successful was the programme in increasing delivery equitably?
2. How successful were the programme activities in increasing the three programme 'domains' of influence on the determinants of hazardous drinking and alcohol-related harm?:
    - 2.1 How successful were the programme activities in increasing CM Health's leadership for action on alcohol in the DHB setting?
    - 2.2 How successful were the programme activities in increasing advocacy to reduce hazardous drinking and alcohol-related harm?
    - 2.3 How successful were the programme activities in increasing the development and provision of data, intelligence, and evidence-based advice on alcohol?

Outcome evaluation findings are presented in three sections covering: (i) Delivery of Alcohol ABC Approach in project settings (outcome key evaluation questions 1 and 1.1), (ii) Programme 'domains' of influence (outcome key evaluation questions 2.1, 2.2, and 2.3), and (iii) Outcome evaluation summary of key learning points and considerations.

(i) Delivery of Alcohol ABC Approach

In this section, indicators of delivery of Alcohol ABC Approach are described for five projects, i.e. GP, Middlemore Hospital ED, CM Health LSFS, CM Health Maternity Service, and Hand Therapy Outpatient Service at Manukau Health Park. Brief overviews of these projects are available in the Background chapter of this report. As also described in the Background, indicator and data systems have been developed for each project setting. Implementing and improving these systems is an ongoing process. In this report, data are described up to the end of December 2020, with various starting time points depending on the individual project timelines and data availability in each project setting. As Alcohol ABC Approach indicators are adapted for each project setting, there are some differences between settings in the definitions of the indicators, which are outlined in Appendix E. Alcohol ABC Approach data are summarised in graphs throughout this section, to complement the written narrative.

Statistical data and analysis provide vital information creating a range of population health pictures. The way data are presented can also create a powerful narrative. It is crucial therefore for data to be sourced, collected, presented, and interpreted in the most accurate and meaningful way. For the purposes of this section, graphs of Alcohol ABC Approach delivery by ethnicity include 'Maaori', 'Pacific peoples', and a comparator of 'NMNP'. This was deliberate equity action by the AHM Team designed to: (i) reflect the organisational strategic equity priority focus on Maaori community and Pacific community; (ii) provide a deeper equity delineation by addressing the potential for Pacific health statistics to negatively skew the non-Maaori statistics when comparing Maaori and non-Maaori health; (iii) provide an ethnicity level comparison of systemically privileged groups and underserved groups.

The project team acknowledges the Tiriti partnership between Mana Whenua and CM Health within the CM region. Due the data collection systems at CM Health, they were unable to provide data information or analysis at iwi level to honour this relationship.

General Practice Project

Eleven practices and their PHOs have collaborated with CM Health to support embedding the Alcohol ABC Approach since the beginning of the project in 2017/18, with a further eight practices joining at various time points up until the end of December 2020. The aim of this work is that all patients aged ≥15 years be involved in a conversation with their GP provider asking about their alcohol use (at least once in a three-year period) and be provided brief advice and referral for counselling or other help if indicated. It is acknowledged that the capacity of the collaborating practices to carry out alcohol assessments was significantly impacted during 2020 by COVID-19.

Percentages of alcohol assessments (Alcohol 'A' indicator) are described by PHO below. It is not the intention to compare across PHOs, or within PHOs, to compare collaborating practices with other non-collaborating practices (these are identified in Figures 7 to 11 as 'Other Practices'). No PHOs showed ethnic or sex disparities for Alcohol 'A' coverage in the collaborating practices. Four of five PHOs showed gaps in Alcohol 'A' coverage by age group, with younger age groups tending to have lower coverage than older age groups.

Across all collaborating practices in all PHOs, brief advice (Alcohol 'B' indicator) was provided to a high percentage of people with drinking considered to be above the 'low-risk drinking' guidelines. As outlined in the Methods section, Alcohol 'C' for GP was not included in this evaluation.

Alliance Health Plus PHO has supported two practices as part of the collaborative project since 2017/18, with a further practice (Practice 3 in Figure 7) joining during the quarter ending December 2019. All practices show relatively low and steadily rising percentages of enrolled patients who have been assessed for alcohol use in the last three years (Figure 7). This change in percentages may not be due to project activity. A more likely explanation is that this is due to a change in the PHO's data warehouse provider in early 2019 which resulted in loss of historic data and therefore in percentages that only count alcohol assessments done since April 2019, rather than 'within the last three years' as per the 'Alcohol A' indicator definition for GP. This explanation is supported by the fact that baseline estimates of percentages in June 2018 for the 'Alcohol A' indicator, based on data collected during the first phase of development of Alcohol ABC Approach indicators, were 68 percent for Practice 1 and 65 percent for Practice 2.

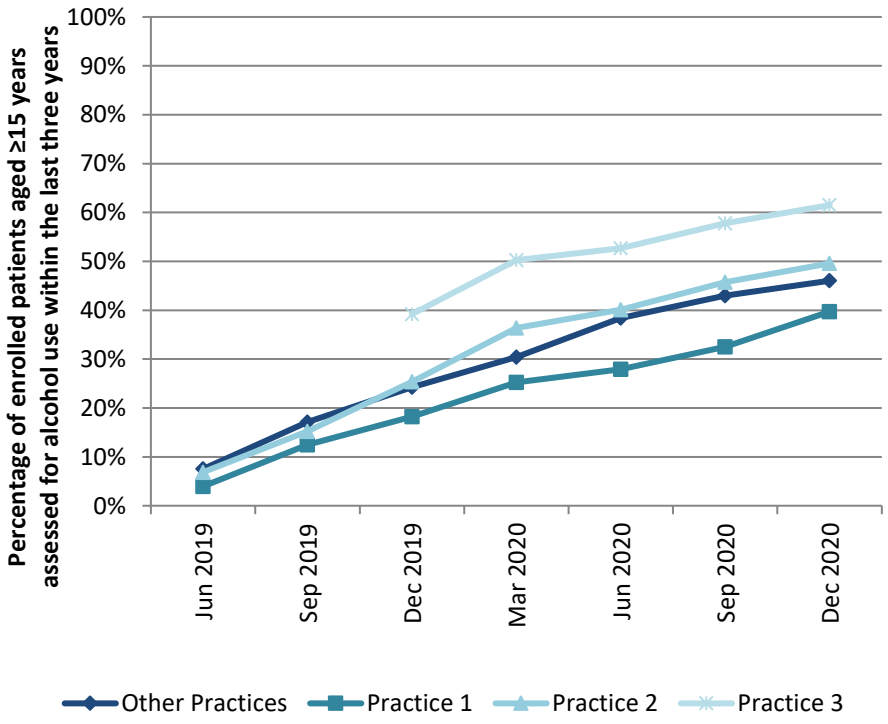


Figure 7: Percentage of enrolled patients aged ≥15 years assessed for alcohol use within the last three years for Alliance Health Plus PHO (practices located in CM Health area)

Data source: MADSF Healthsafe data repository; data were extracted, modified where applicable to align with agreed data specifications, and analysed by CM Health staff

East Health Trust PHO has supported two practices as part of the collaborative project since 2017/18, with a further practice (Practice 3 in Figure 8) joining from January 2020. Over time the three collaborating practices show increases in the percent of enrolled patients who have been assessed for alcohol use in the last three years from 44 and 52 percent to 56 and 60 percent for Practice 1 and 2 respectively, and 54 to 56 percent for Practice 3 (Figure 8).

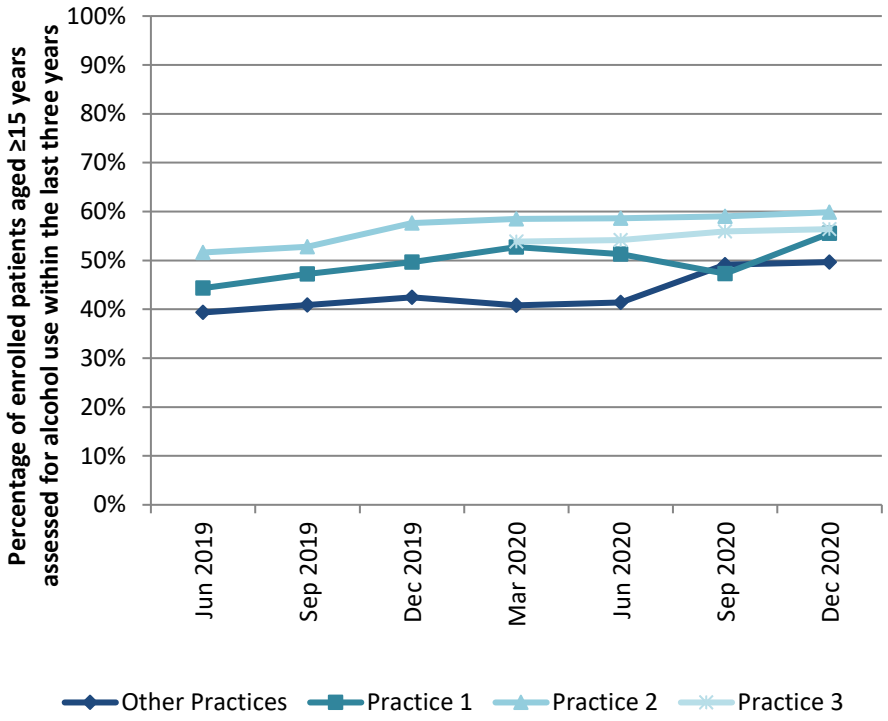


Figure 8: Percentage of enrolled patients aged ≥15 years assessed for alcohol use within the last three years, East Health Trust PHO, practices located in CM Health area

Data source: MADSF Healthsafe data repository; data were extracted, modified where applicable to align with agreed data specifications, and analysed by CM Health staff

National Hauora Coalition PHO has supported one practice as part of the collaborative project since 2017/18, with a second practice (Practice 2 in Figure 9) joining from February 2020. The percentage of enrolled patients in Practice 1 assessed for alcohol use in the last three years reduced during 2019 and the first half of 2020, likely exacerbated by the impact of COVID-19, but increased during the second half of 2020 from 34 to 44 percent (Figure 9). Practice 2 shows a small increase of 4 percent in alcohol assessments from March to December 2020, from a relatively low baseline of 33 percent.

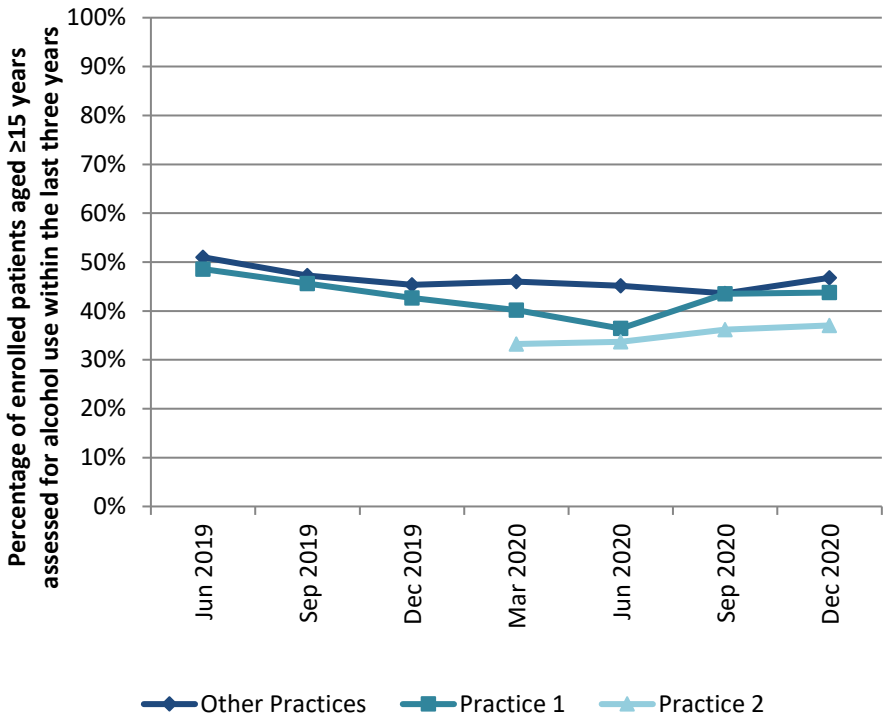


Figure 9: Percentage of enrolled patients aged ≥15 years assessed for alcohol use within the last three years, National Hauora Coalition PHO, practices located in CM Health area

Data source: MADSF Healthsafe data repository; data were extracted, modified where applicable to align with agreed data specifications, and analysed by CM Health staff

Procare PHO has supported three practices (Practices 1, 2, and 3 in Figure 10) as part of the collaborative project since 2017/18, with Practice 4 joining in July 2019, Practice 5 joining in September 2020, and a further three practices joining during the quarter ending December 2020 (these three are not shown in Figure 10). There are missing data points for Practice 1 (quarter ending December 2019) and Practice 3 (quarters ending December 2019 and March 2020). The percentage of enrolled patients assessed for alcohol use in the last three years shows differences between practices. Three practices show increases overall, across the period of time reported, in the percent of patients assessed for alcohol use (i.e. Practice 1 increased from 80% in June 2019 to 91% in December 2020; Practice 2 increased from 56% in June 2019 to 64% in December 2020; and Practice 5 increased substantially in one quarter from 59% in September 2020 to 67% in December 2020). Two practices show decreases overall (i.e. Practice 3 reduced from 68% in June 2019 to 64% in December 2020; Practice 4 reduced from 68% in September 2019 to 57% in December 2020).

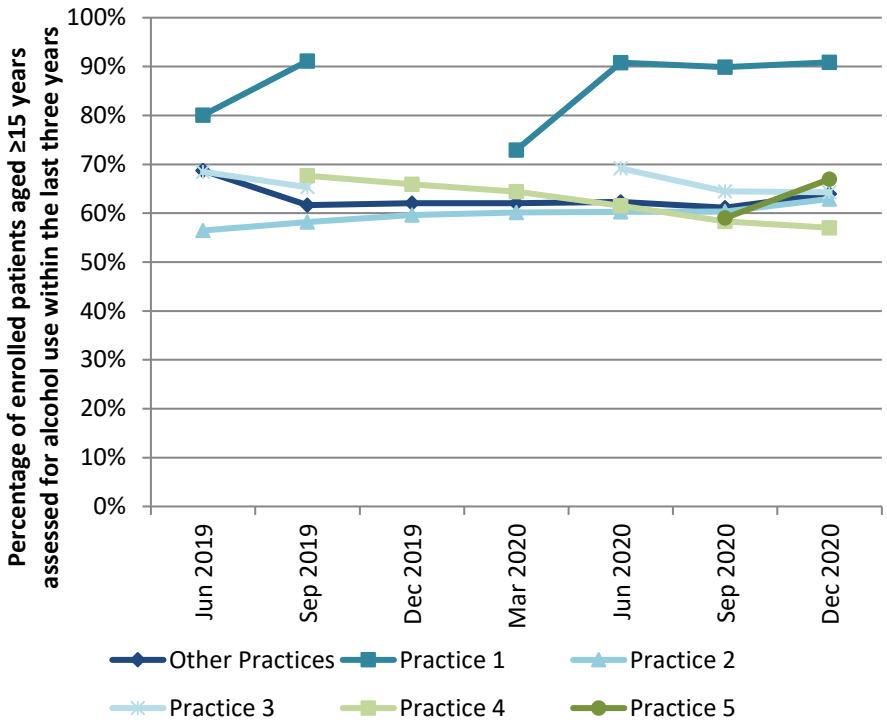


Figure 10: Percentage of enrolled patients aged ≥15 years assessed for alcohol use within the last three years, Procare PHO, practices located in CM Health area

Data source: MADSF Healthsafe data repository; data were extracted, modified where applicable to align with agreed data specifications, and analysed by CM Health staff

Alcohol ABC Approach was supported by the development of electronic prompts for assessment in PMSs in this PHO. In staff interviews, these electronic prompts and integration and flow of alcohol assessment in existing PMS were identified as key enablers in programme implementation.

Total Healthcare PHO has supported two practices (one of which has two separate clinics in different locations) as part of the collaborative project since 2017/18, with a further practice (Practice 3 in Figure 11) joining from September 2019. All practices show a relatively high baseline and, overall across the period of time reported, show small decreases in the percentages of enrolled patients who have been assessed for alcohol use in the last three years (Figure 11). A drop in Alcohol ABC Approach delivery over 2020 in 'Other practices' visible on Figure relates to the closure of some practices as they refocused their service delivery as Community Based Assessment Centres for COVID-19.

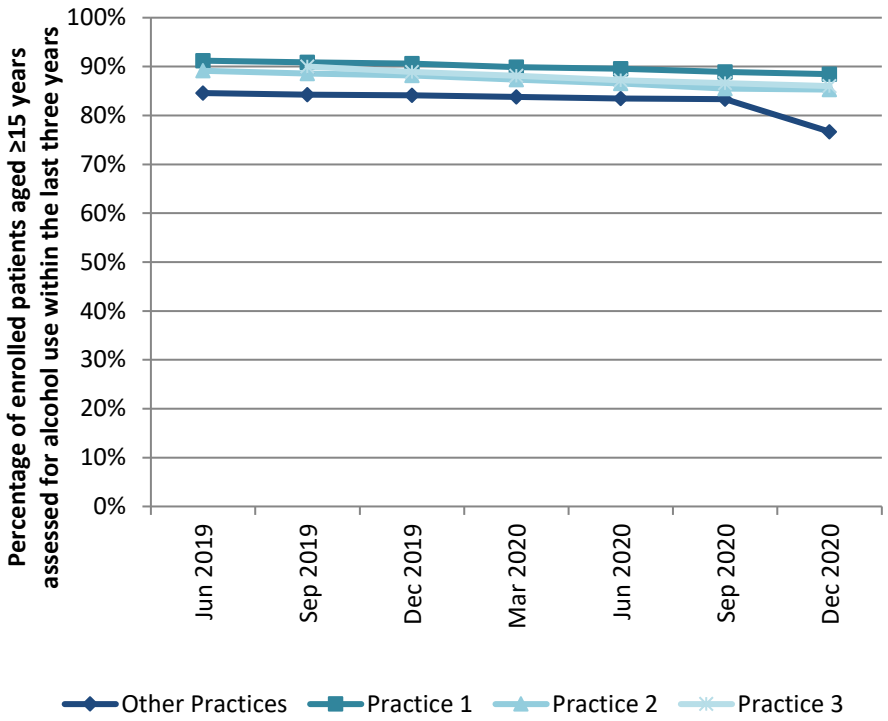


Figure 11: Percentage of enrolled patients aged ≥15 years assessed for alcohol use within the last three years, Total Healthcare PHO, practices located in CM Health area

Data source: MADSF Healthsafe data repository; data were extracted, modified where applicable to align with agreed data specifications, and analysed by CM Health staff

Differing uptake of Alcohol ABC Approach across primary care practices resembles trends in the literature. For example, Rose et al. (2008) describes screening coverage rates spanning 41 to 95 percent over a two-year period across ten primary care practices. Although there are limited published examples from within Aotearoa, one Whanganui based pilot involving 14 primary care clinics reported achieving 43 percent coverage of enrolled patients aged 15 years and older over an eight-month period (Gifford et al., 2012) with a single practice reaching 74 per cent coverage. Differences between practices were attributed to electronic medical record capacities, leadership quality, competing organisational priorities, staff motivation and whether the practice held an existing holistic approach to service delivery and protected nursing time for health screening (Rose et al., 2008; Gifford et al., 2012).

Middlemore Hospital ED

Electronic data capture of Alcohol ABC Approach is not currently available in ED. Instead, the findings of manual audits of clinical records from June 2019 to December 2020 are used to estimate the uptake of the Alcohol ABC Approach in ED. Each audit examined a non-random sample of records from one week of each month. Audits included clinical records of patients seen in the ED with alcohol-related presentations, and included only those hard copy clinical records that were available (i.e. that could be retrieved at the time). Alcohol-related presentations were identified based on responses, entered in the administrative data system at triage, to the question “Is alcohol associated with this presentation?”

From October 2019, the project aim was that 25 percent of patients with alcohol-related presentations would receive an assessment for alcohol use using the AUDIT-C tool. The percentage of patients with alcohol-related presentations who were assessed for alcohol use was low across the whole time period reported (Figure 12), but did exceed the 25 percent target on 3 samples: 32 percent in September 2019, 38 percent in April 2020 (although note that this was a very small sample and occurred during the COVID-19 lockdown period), and 27 percent in September 2020. Apart from April 2020, months showing higher uptake coincided with project activities or campaigns to support nursing staff in having conversations with patients about alcohol. Although not representative of the demographic distribution of all patients with alcohol-related presentations cared for in the ED, aggregated data of patients whose records were audited in 2020 show disparities for alcohol assessment completion by ethnic and age groups. Nine of 129 (7%) Maaori patients, 26 of 130 (20%) Pacific patients, and 33 of 189 (17%) NMNP patients received a documented AUDIT-C alcohol assessment. Younger age groups had lower alcohol assessment completion, i.e. 24 of 166 (14%) aged 19-29 years, 14 of 89 (16%) aged 30-39 years, 6 of 49 (12%) aged 40-49 years, 10 of 51 (20%) aged 50-59 years, and 12 of 45 (27%) aged 60 years or more. Percentages of alcohol assessment by sex were about the same.

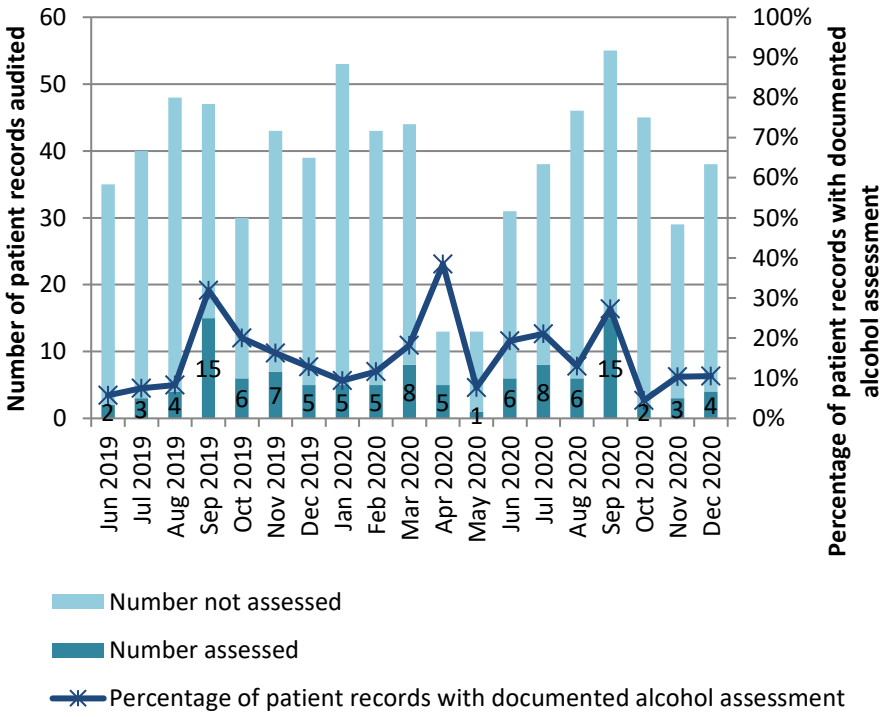


Figure 12: Number and percentage of patient records with documented alcohol assessment

Data source: Manual audits of clinical records by CM Health staff

While the percent of assessments documented were low, brief advice was provided to a very high percentage (usually 100%) of clients who received an AUDIT-C assessment and were assessed as drinking above the 'low-risk drinking' guidelines. Of the 440 patients whose records were audited in 2020, 78 (18%) were referred for specialist alcohol counselling or other help (such as mental health or social work services).

Existing literature highlights that ED settings are complex environments in which to introduce alcohol assessments and delivery of brief intervention (Maynard & Paton, 2012). Barriers to delivery of Alcohol ABC Approaches include extremely high workload volumes/demands in ED, many patients being severely unwell at the time of presentation, large numbers of nursing staff requiring training in the Alcohol ABC Approach, and relatively high staff turnover. The Alcohol ABC Approach needed to be adapted to these unique demands and pressures.

CM Health Living Smokefree Service (LSFS)

Data are reported by quarter from the start of implementation of Alcohol ABC Approach by the LSFS in January-March 2018. Data are reported separately for LSFS clients who are pregnant and 'general' service clients (i.e. males and non-pregnant females). The LSFS aims for all clients to have an alcohol assessment as part of routine care.

For pregnant women seen by the LSFS for smoking cessation, the percentage of women who were asked about alcohol reached 99 percent by July-September 2019 and remained consistently high (Figure 13) with no differences by ethnic group (Figure 14). There were no differences by age group. Brief advice was provided to all pregnant women who reported drinking alcohol (i.e. 70 women from Jan 2018 to Dec 2020). Seven referrals were made for alcohol counselling or other help. Feedback from the LSFS indicates that most clients preferred to receive help from the LSFS rather than be referred to a separate service. As staff are trained and experienced in motivational interviewing and coaching skills, they are able to provide help for alcohol for many clients and only refer those who wish to be referred or for whom specialist AOD services are indicated.

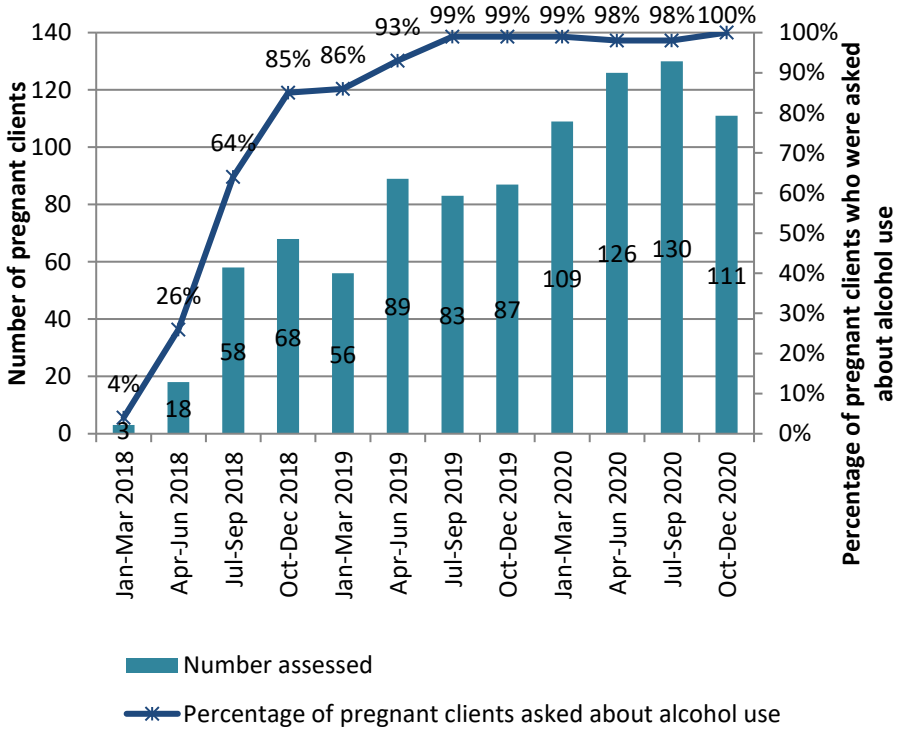


Figure 13: Number and percentage of pregnant women, seen by the LSFS, who were asked about alcohol use

Data source: CM Health LSFS database

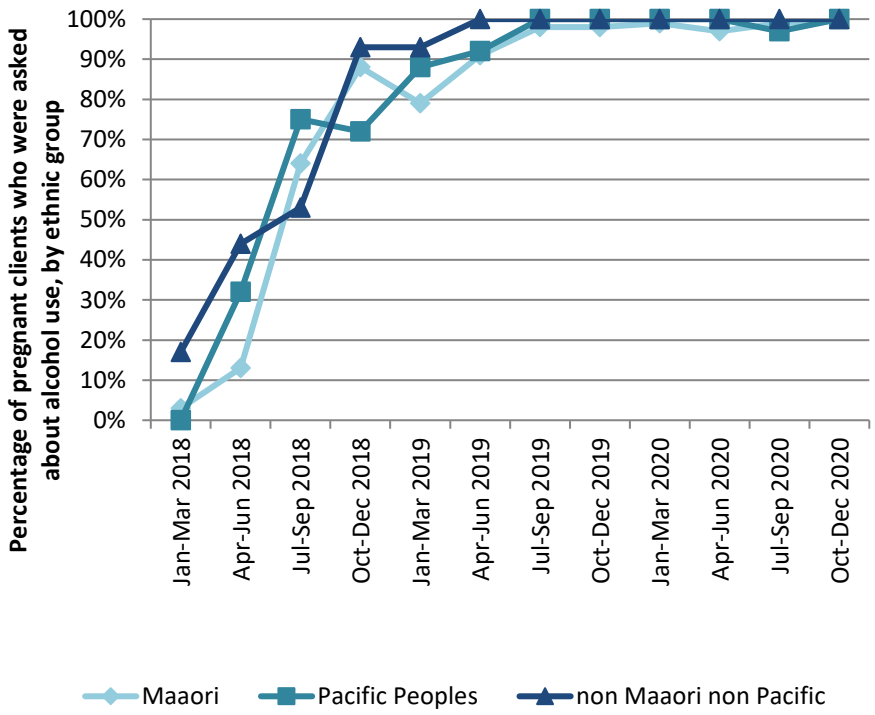


Figure 14: Number and percentage of pregnant women, seen by the LSFS, who were asked about alcohol use

Data source: CM Health LSFS database

For other non-pregnant clients seen by the LSFS for smoking cessation, the percentage of clients who were asked about alcohol improved over the first two years of implementation from 88 percent to 92 percent in 2020 (Figure 15). A disparity for Pacific peoples was evident during the first 18 months of implementation. However, for the second 18-month period, both Maaori and Pacific percentages tracked above the NMNP ethnic group percentages (Figure 16). There were no differences by sex or age groups. Brief advice was provided to a very high percentage of clients assessed as drinking above the 'low-risk drinking' guidelines. Percentages reached 100 percent in 8 of the 12 quarters reported and never fell below 96 percent during 2019 and 2020. During the three years reported, sixty-two referrals were made for clients to access specialist alcohol counselling or other help.

High coverage by the LSFS of Alcohol ABC Approach may reflect the confidence and skill of staff familiar with 'ABC' programming and motivational interviewing techniques through core smoking cessation work. This type of previous experience has been found as an enabler in a previous evaluation of ABC implementation within Aotearoa (Gifford et al., 2012).

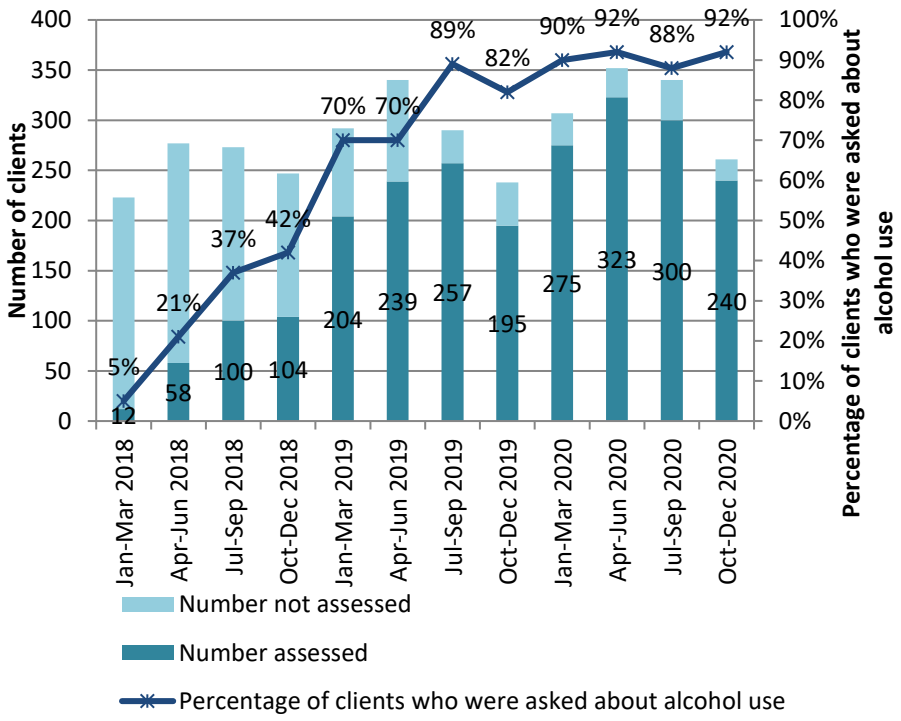


Figure 15: Number and percentage of non-pregnant clients, seen by the LSFS, who were asked about alcohol use

Data source: CM Health LSFS database

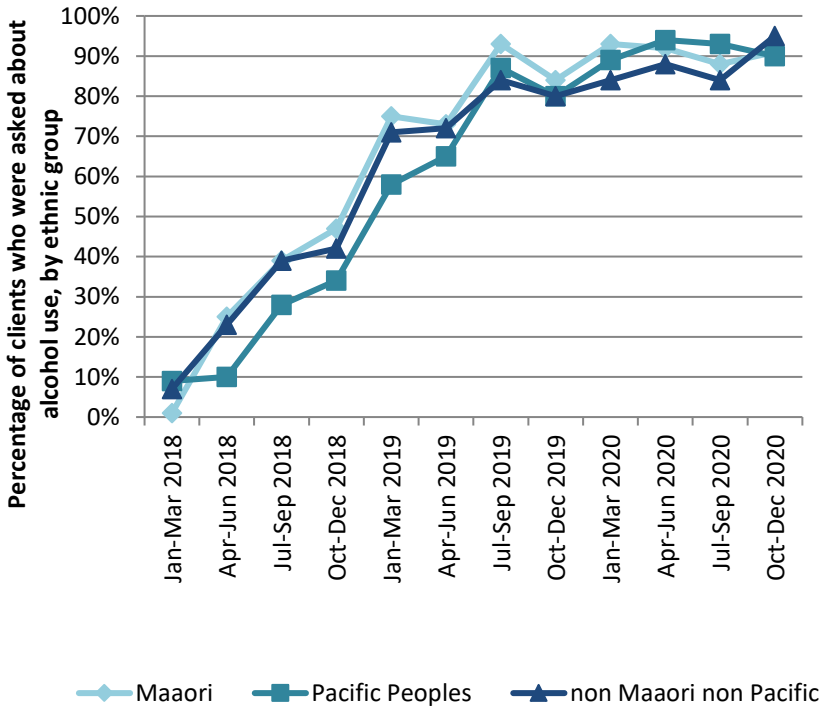


Figure 16: Number and percentage of non-pregnant clients, seen by the LSFS, who were asked about alcohol use, by ethnic groups

Data source: CM Health LSFS database

CM Health Maternity Service

Data describing Alcohol ABC Approach delivered by CM Health-employed midwives are reported from August 2019, which is when the service started supporting midwives to access Alcohol ABC Approach training and resources. There was no specific aim for this project, however, best practice is that all pregnant women should be asked about alcohol as part of their antenatal care.

The percentage of maternity clients who were asked about alcohol at their booking appointment was consistently high overall across the whole time period reported, ranging from 84 percent to 93 percent (Figure 17). Percentages of alcohol assessment for younger women (<30 years) and older women (aged 30 years or more) were about the same (88% and 90% respectively) for the 17-month time period. There is a disparity evident, with (averaged over the 17 months reported), 83 percent of Maaori women, and 88 percent of Pacific women, compared to 94 percent of NMNP women having been asked about alcohol at a booking appointment (Figure 18). Earlier studies undertaken in Aotearoa in maternity settings indicate that not having an established relationship or rapport can be a barrier to staff asking about alcohol use in first appointment (Wouldes, 2009). However, MoH guidelines (2010) for Alcohol ABC Approaches with women who are pregnant or planning pregnancy highlight that there is no known safe level of alcohol use at any stage during pregnancy. Having conversations early are critical to reducing the risk of fetal damage resulting from alcohol use. A monitoring focus on the delivery of Alcohol ABC Approach early during maternity care is therefore important.

A small number of women were recorded each month as drinking alcohol (i.e. range one to five per month, a total of 53 documented over the period August 2019 to December 2020) and data indicate that overall, three-quarters of these women were delivered brief advice; conversely, one quarter of women eligible for brief advice did not receive it. A small number of referrals to counselling or other help for alcohol were made each month (i.e. range one to five per month, a total of 42 referrals documented over the period August 2019 to December 2020).

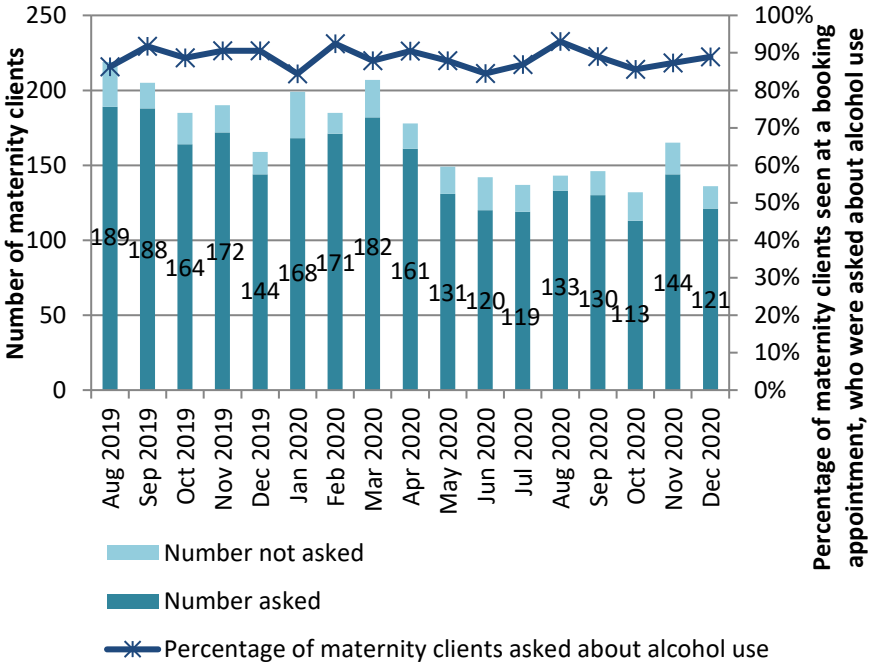


Figure 17: Number and percentage of maternity clients seen at a booking appointment, who were asked about alcohol use

Data source: MCIS, extract by Health Intelligence and Informatics Team. Data are related to care provided by DHB employed midwives (i.e. this analysis does not include care provided by independent community-based Lead Maternity Carers).

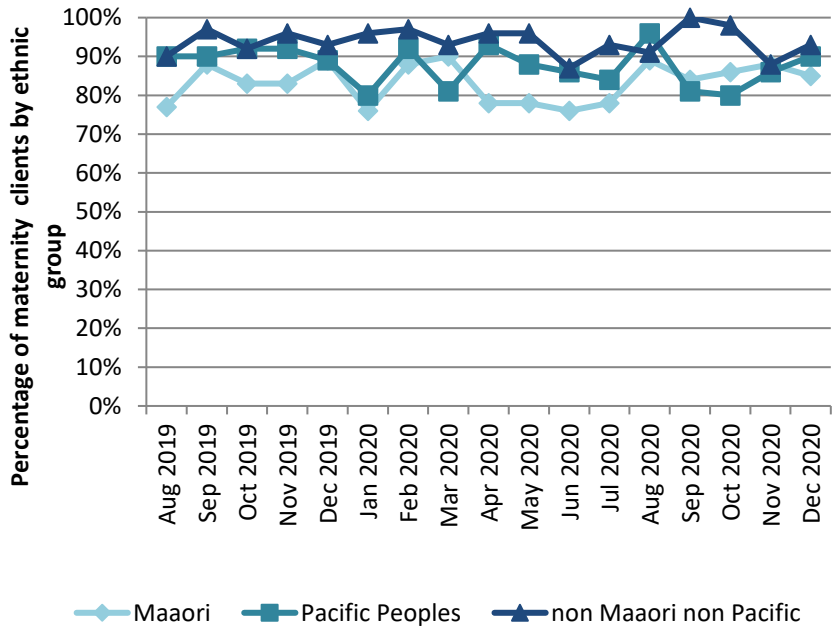


Figure 18: Number and percentage of maternity clients seen at a booking appointment, who were asked about alcohol use, by ethnic groups

Data source: MCIS, extract by Health Intelligence and Informatics Team. Data are related to care provided by DHB employed midwives (i.e. this analysis does not include care provided by independent community-based Lead Maternity Carers).

Hand Therapy Outpatient Service at Manukau Health Park

Data describing the Alcohol ABC Approach in the Hand Therapy Outpatient Service has been available since January 2019. Following initial uptake by the team in early 2019, alcohol assessments were paused during COVID-19 lockdowns, and were subsequently restarted with the percent of hand therapy outpatients assessed for alcohol use recovering to 59 percent by October (Figure 19). Of note is a disparity for Maaori outpatients, which was substantial in the months of July, September, and October (Figure 20). Percentages of alcohol assessment were very similar for males and females. There were some differences by age groups, but no clear pattern of disparity was evident.

Brief advice was provided to a high percentage of outpatients assessed as drinking above the 'low-risk drinking' guidelines. Percentages ranged from 79 percent to 97 percent across the last six months of 2019. Referrals for counselling or other help for alcohol were not made by the team during 2019 due to time constraints, referral process barriers, and other priorities. Streamlining processes to enable referrals to AOD services is a current focus of improvement work.

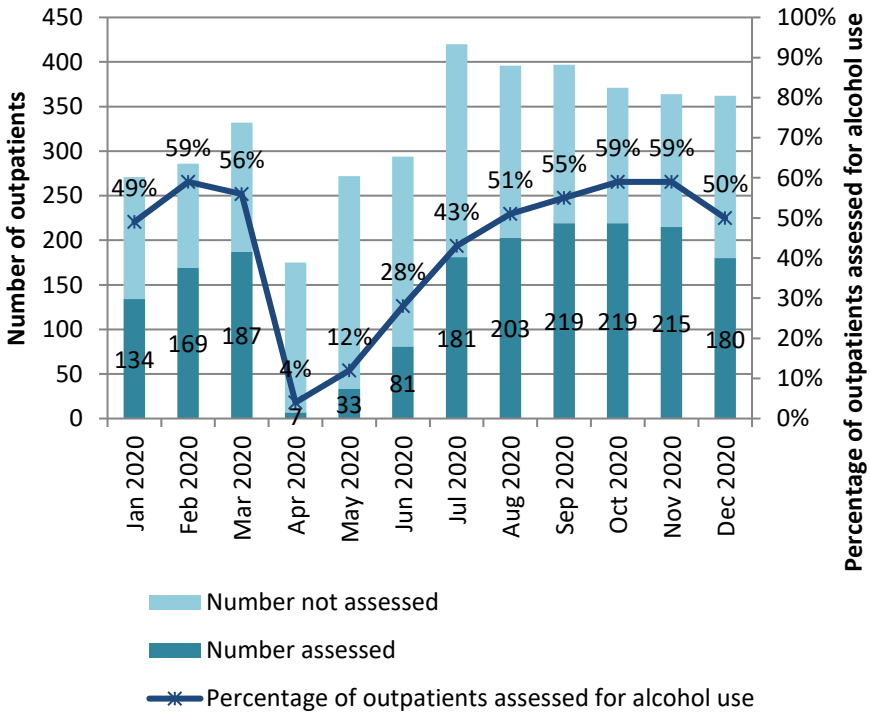


Figure 19: Number and percentage of hand therapy outpatients assessed for alcohol use

Data source: CM Health data from Forms On Line, output by Health Intelligence and Informatics Team.

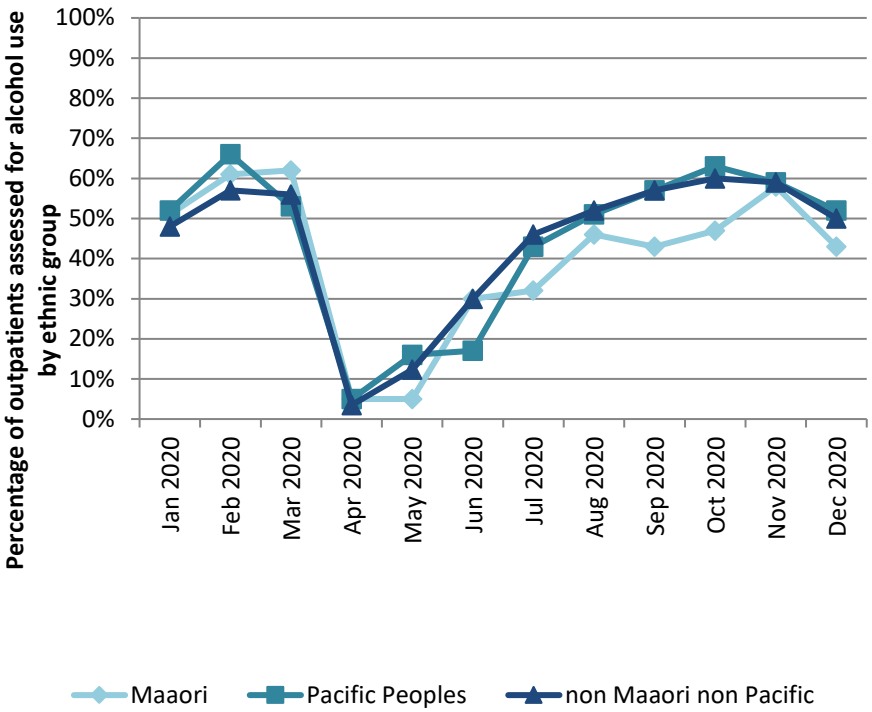


Figure 20: Number and percentage of hand therapy outpatients assessed for alcohol use, by ethnic groups

Data source: CM Health data from Forms On Line, output by Health Intelligence and Informatics Team.

(ii) Increasing domains of influence on the determinants of hazardous drinking and alcohol-related harms

This evaluation aimed to understand how successfully the programme increased 'domains' of influence on the determinants of hazardous drinking and alcohol-related harms. These domains were identified by the AHM Team as **leadership** for action, **advocacy** to reduce hazardous drink and alcohol-related harms, and the **development and provision of data**, intelligence and evidence-based advice on alcohol. Although the AHM Team provided an interpretation of these domains for use by evaluators (Table 16), examples from the participant narratives of staff and key stakeholders frequently overlap and may be relevant across all areas. For example, the development of data to describe the problem was a common point of discussion, as was the utility of this data to support delivery of evidence based messages, enable community action (advocacy), drive for results and create change (leadership). Please accept that examples from evaluation participants transgress across leadership, advocacy and data development and therefore some examples could be relevant in multiple reporting domains.

Table 16: AHM Team definitions of leadership, advocacy and data development and provision

Leadership	Advocacy	Development and provision of data
• Ensuring clarity of goal (the what & why), strategy (the way), and actions (the how to); • Delivering the AHM Programme and driving for results; • Working collaboratively & in partnership; • Supporting innovative approaches; • Creating change.	• Delivering clear & consistent evidence-based messages to staff and the CMH community; • Supporting and enabling Community Champions to take actions. • Developing data to describe the problem, burden, and cost to the health system; • Developing & providing data outputs/products; • Providing evidence-based advice to support policy change;	• Providing a clear vision and plan for data development and provision activities; • Developing data to describe the problem, burden, and cost to the health system; • Developing & providing data outputs/products; • Providing evidence-based advice to support policy change; • Providing evidence-based advice to support policy change; • Bringing an equity focus to data activities.

Since its beginning in late 2016, the AHM Programme has achieved several key milestones. This is not an exhaustive list but an overview of the achievements to date, organised by programme objectives.

Objective 1 & 2

Focus area 1: Pursuing equity in access to high quality and culturally safe healthcare services, particularly the Alcohol ABC Approach. Objective 1: 'Implement or further develop a systematic, sustainable, and equitable Alcohol ABC Approach in three key health settings', and; Objective 2: 'Strengthen integration between the Alcohol ABC Approach and mental health and AOD services'

1. Establishing Alcohol ABC Approach projects and working to embed the Alcohol ABC Approach in key settings: - GP, ED, LSFS, GP, Maternity Service, and Hand Therapy Outpatient Service;
2. Procuring and contracting with primary healthcare providers since 2017 to deliver services which have enabled routine monitoring of data on Alcohol ABC Approach that was not previously available;
3. Working with over 20 collaborating GPs across the five CM PHOs to embed the Alcohol ABC Approach, trial innovative projects, and apply QI methodologies;
4. Setting up and coordinating regular Alcohol ABC Approach training sessions for CM Health and GP staff (training 287 staff in 'Having Conversations about Alcohol'), and;

5. Setting up a team of advisors and champions to drive the work in the AHM Programme, with an advisor leading work in each of the key settings. This includes 0.2FTE of an ED nurse time as the clinical lead in ED.

Objective 3 & 4

Focus area 2: Working with communities and intersectoral partners to influence the social determinants of hazardous drinking and alcohol-related harms.

Objective 3: 'Support and enable communities/groups to take actions on alcohol harm reduction', and;
Objective 4: 'Support and enable inter and intra-sectoral collaborative work aimed at alcohol harm minimisation'.

1. Working with health sector partners to influence the determinants of hazardous drinking and alcohol-related harms. For example, working alongside Alcohol Healthwatch to advocate for best-practice pregnancy warning labels on alcohol;
2. Championing innovative youth-focused health promotion interventions such as the Youth Peer Crowd programme of work – 'The Movement' – alongside health sector partners HPA, CAYAD, Healthy Families, Sport New Zealand, and the New Zealand Drug Foundation;
3. Hosting the first ever national Waipiro Symposium in 2019 at CM Health alongside partners Haapai Te Hauora, HPA, Kookiri ki Taamakimakaurau Trust, and the National Hauora Coalition, attended by over 40 delegates from across the country;
4. Being selected by health sector partners such as HPA to partner on projects and localise national health promotion campaigns so that they were more targeted and relevant to the CM population. An example of this is the HPA's 'Pre-Testie Bestie campaign', and;
5. Publishing two data reports 'CM Health Alcohol-Related Harm Profile' and 'Alcohol-Involved Emergency Department Encounters and Hospital Admissions at Middlemore Hospital in 2018' that have been used by community members and health sector partners in their objections to off-license applications.

Across all AHM objectives, key achievements include:

1. Being the first DHB in the country to implement an alcohol harm minimisation programme such as this with a whole-of-system approach, from clinical settings in secondary and primary care right through to the community;
2. Creating a position statement for alcohol for CM Health. This is the first position statement for CM Health and was the first position statement to be adopted and published of any of the three Auckland-metro DHBs;
3. Creating a logic model and action plan to guide this work, which is used by CM Health REO as an example of best practice;
4. Taking a strong equity approach across the programme, such as implementing a population-based formula for funding and creating equity specific targets with lead practices within the primary care contracts, and;
5. Creating and delivering a range of communications activities. This included the creation of personas that have been used when developing workforce development training videos for staff; working with social media influencers on targeted campaigns; health promotion

activities; community activation events; the development of a Creative Foundation and AHM branding.

Leadership

The dual focus on both Alcohol ABC Approach delivery in service settings, as well supporting the development of public health interventions to minimise alcohol-related harms was identified as a key strength of the AHM Programme. Though individual-level interventions are crucial, a public health approach aimed at population-level interventions has been consistently found to be the most rapid, effective, and cost-effective data to mitigate the burden of alcohol (The Lancet Public Health, 2020). While participants also recognise the public health aims might be ambitious within the current programme resourcing, they supported this focus. Participants recognised the dual focus as comprehensive, evidence informed and courageous in comparison to the positioning and prioritisation of approaches to address alcohol-related harms across other DHBs in Aotearoa:

> *"What Counties has shown is the commitment to work right across the spectrum. Their plan, and their position statement talks about advocacy, it talks about data collection. It's really important that other DHBs see their role in alcohol beyond their day to day service delivery. That's why Counties Manukau position statement is so strong, because it is just so evidence based. I think other DHBs are looking at the work they're doing, and going, 'why aren't we working right across the spectrum in relation to this?'"* (KS01).

> *"[The AHM Programme is] really good on a range of levels and so whether it is about the work that you're doing in [your service] with brief intervention or screening and whether it's data collection that you're doing or whether it's work in the communities to prevent harm for young people. A range of things like it's robust and it's comprehensive and it's data or evidence based"* (KS02).

In the last decade, accumulating evidence has consolidated recommendations to focus on three particular public health measures: increasing taxes on alcohol to raise the purchase price, restricting availability and access to retailed alcohol, and comprehensive bans on alcohol advertising across different mediums (Loring, 2014; WHO, 2018). These public health interventions form the basis of the WHO's most recent 'SAFER' initiative, along with SBIRT interventions for individuals, and drink-driving counter measures (WHO, 2019). Similarly, such measures have been strongly recommended specifically within an Aotearoa context by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry, and recent Mental Health and Addictions Inquiry (Government Inquiry into Mental Health and Addiction [Government Inquiry], 2018; Walker, 2019). Programme documents and focus group discussion with staff illustrate efforts to drive for change in these areas.

Since the AHM Programme conception, there have been a number of opportunities for the team to contribute to the development or refinement of health promotion campaigns. Programme activities highlight significant programmatic effort on localising a national health promotion campaign for improved engagement of health promotion messages (e.g. Pre Testie Bestie). As these campaigns were outside of the scope of this evaluation, it is not possible to comment on the effectiveness of this work. However, it is important to note that "Primary prevention programs that have used exclusively educational approaches have received mixed results. Increasing effectiveness has been

associated with prevention programs that have utilized a multi-component approach and have included educational initiatives with environmental changes" (Kelly-Weeder et al., 2011, p.29). While the AHM Programme maintains a focus on upstream determinants of alcohol use and related harms, for future work there is opportunity to be more intentional about increasing alignment of programmatic activities with public health interventions that have the most compelling evidence of effectiveness and scope to address the inequitable burden of alcohol harm (outlet density, retail environments, advertising and taxes) (Roche et al., 2015; Seigfried et al., 2019; WHO, 2019). This work had value for actions that can be achieved now, to support community understanding of issues surrounding alcohol use, given that influencing upstream determinants is a long-term commitment.

Staff and key stakeholders were appreciative of the collaborative approach taken by the AHM Team both internally, and inter/intra sectorally. Staff and key stakeholders identified strengths of their collaboration style as follows: a collegial approach, active listening, flexibility with implementation processes, solution-oriented attitudes and thinking, offering clear opportunities to feedback on the development of resources and approaches, responsivity to unique organisational constraints, and characteristics, and accepting a piloting to learn approach. For one member of staff at CM Health, this approach was identified as unique to other programmes at CM Health, and fundamental to staff and key stakeholder engagement in training and Alcohol ABC Approach implementation:

> *"I think it worked well because there was more of an exploratory approach. They changed my mind from thinking, 'oh, well, this is the next new flavour' through to saying 'oh in actual fact this is backed up with resources it's backed up the ability to tell staff what we're expecting and to train them and to make it, make them able then to try and achieve what the DHB wants us to achieve'. A lot of the time we get asked to do stuff with absolutely no resources, with lots of criticism, we've got to try and make it up as we go along, then we get blamed for not doing that well. But what we didn't get any help in the first place, and it's really hard working in that environment. . . At least with the alcohol [team] they came and did the exposure stuff, saw where the gaps were then came and talked to us about the gaps without blaming us for them. So that that was really helpful" (S06).*

Beyond CM Health, the collaborative approach taken by the AHM Team has resulted in them working alongside individuals from a range of organisations from PHOs, Alcohol Healthwatch, New Zealand Drug Foundation, FSM, NZ Police, Auckland Council, Curative, HPA, Auckland Regional Public Health Service and more. Because of the reach of alcohol-related harms beyond health and the complex intersection of social determinants in perpetuating alcohol-related harms, multi-sector government, NGO and civil society collaboration within a system-wide approach is vital (Government Inquiry, 2018; Roche et al., 2015; Stockings et al., 2018; WHO, 2018, 2019).

Social media campaigns that involved the development of personas to communicate with key demographic groups around alcohol harms were the most frequently cited examples of innovative approaches in staff and key stakeholder interviews.

The diverse health settings in which the AHM Programme has been implemented to date is one example of innovative leadership. A growing body of literature supports expansion into other settings beyond primary (Kaner et al., 2018; WHO, 2019), notably EDs (Patston et al., 2017; Vipond &

Mennenga , 2019;), maternity and reproductive health services (WHO, 2010, 2019) and hospital inpatient wards (Gargaritano et al., 2020), however, these are still emerging areas. Evidence is still strongest for application of SBIRT within primary care (WHO, 2019). By drawing on international evidence supporting SBIRT and leveraging local context, the AHM Team have created a comprehensive approach that reflects CM Health strategic priorities and service delivery, engaging with patients at numerous points of connection. This type of approach has been found to increase the likelihood of effective and sustainable implementation (Geerling et al., 2018).

Advocacy

Multiple measures were taken to ensure clarity of AHM goals, strategy, and action through documentation, including the development of CM Health's position statement on alcohol, programme aims, programme logic and Alcohol Action Plan. This information was integral to the ability for other staff and key stakeholders to understand the programme and provide support as part of their own roles:

> *"For me, this is one of the more organised programmes in the organisation. They're very structured, was good for me when I started working with the team that they had some foundation documents and some very clear goals and objectives. So it's much easier to formulate [other aspects] for a programme that really has worked through what it is they're trying to achieve"* (KS04).

> *"I think that people who have read the position statement are a lot clearer around where the DHB sits and the people who use the position statement to be able to advocate for other things like, um, around licensing and stuff like that, or whether a new premises should be open or not in the area. So that's all been made possible or made a lot easier to happen because of that position statement that has clarity of where the DHB sits"* (KS03).

Development and provision of data

The development and provision of data supported the AHM Programme with both the operational delivery of Alcohol ABC conversations, and advocacy to progress public health interventions for alcohol harm reduction. Auditing of Alcohol ABC coverage and visibility and feedback of Alcohol ABC data to services undertaking the Alcohol ABC Approach was key in facilitating staff buy in and identified as a key enabler of this programme.

> *"What also worked well was the feedback that they got from the auditing . . . The expectation is you will make the effort and ask every single [patient] this question and you will record whether you have a conversation or not, you record whether you give a brief advice, you'll record whether you couldn't ask it for any reason or whatever. And then once that was audited and feedback, it's. . . just like a positive reinforcement loop. So once they get, 'oh look 96 percent of you asked the question', it reinforces people to carry on doing it, rather than saying, you know, over 20 percent of you are not asking it, No, 80 percent of you are doing really, really well and a 20 percent of cases there may be an issue or a reason that they couldn't be asked ad then we can look at that and feedback and we can redo what we*

are doing, so I think that was also really important and that had a good impact on staff" (S06).

The above quote highlights how visibility of data can influence staff behaviour and buy in for the Alcohol ABC Approach. Evidence points to the effectiveness of training with audit and feedback for supporting behaviour and practice changes among healthcare staff (Chauhan et. al., 2017). As well as supporting the operational delivery of Alcohol ABC Approach, the development and provision of alcohol data has been integral to building a more complete picture of alcohol harm in CM. Key stakeholders provided examples of the utility of this previously unavailable data from ED and GP settings to advocate around public health interventions aimed at reducing alcohol-related harms.

> *"I was in a hearing all day yesterday, where I relied on emergency department presentation data. Because Counties and Auckland have got such good data, you're able to use it to actually inform day to day licensing decisions in policy. But unfortunately, the rest of the country doesn't have the same quality of data, some areas do but… The efforts that they have put into ED data collection will have huge payoffs in terms of programme planning, in terms of targeting, in terms of policy decisions, in terms of licensing decisions. I can't congratulate them enough. We've been watching ED data for decades, and we're now in a position in CMDHB where we've got good data, good quality that we can rely on for policy making. I think it's just fantastic, it's amazing what they've done . . . It's absolutely compelling to be able to show that the local community is experiencing alcohol-related harm, ED data is excellent source of information on that. Because the other problem is that for most of our alcohol harm indicators, we can't get local information, everything is either at a local board level or a DHB level. But ED data is available at the census area unit level, so for the first time we've got some local data we can bring to local licensing decisions"* (KS01).

The AHM Team have been instrumental in supporting the development of processes and systems to collect, record, and output Alcohol ABC Approach data (largely through their collaborative approach, but also resourcing and funding of analysts to support the development of data infrastructure). However, as outlined in the evaluation limitations and audit data, significant work still needs to be undertaking in supporting consistency and quality of reporting across settings.

> *"That's been a challenge for some practices changing systems, yeah, it's been challenging, but we're getting, it's improving with a more collective approach collection through the wider group, Through Counties collecting it through their systems . . . Well, there's been a programme that's been as a pop up, being encouraged for consistently across the practices, but as we say, it's being challenged by different IT functions of particular practices, that's has been a challenge, but we've got a more unified approach gotten out of it, and the DHB has been the lead in a coordinated process finally. And so we've requested question for many times a long time now that the data can be collected from the DHB perspective and the collective as opposed to the individual and that seems to be a more seamless approach through the network. And finally, they can just get that data and we don't get involved as such" (S02).*

Persisting gaps in data to support advocacy includes prevalence data for alcohol attributable diseases. One participant identified a case study in Scotland and Ireland which achieved significant policy reform on the basis of liver disease rates which demonstrated health burdens of harmful alcohol use*: "I haven't been able to get anything like that in NZ"* (KS01).

(iii) Outcome evaluation: Summary of key learning points and considerations

The first section of the outcome evaluation aimed to determine how successful the programme was in increasing delivery, including from an equity perspective, of the Alcohol ABC Approach in priority settings. Delivery of Alcohol ABC Approach has been described for five of the original eight projects; as noted in the Background section, two projects were considered out of scope as they were evaluated separate to this report, and another project (Project 7: Middlemore Hospital Plastics Ward) was paused while awaiting IT system enablement of alcohol assessments.

Varying degrees of success of Alcohol ABC Approach delivery have been seen across projects. For example, the CM Health LSFS has successfully integrated Alcohol ABC into their core business, and indicates what is potentially possible with the Alcohol ABC Approach work. This success has been enabled by a number of factors including pre-existing skill, experience, and confidence in motivational interviewing and the 'ABC' approach which underpins both alcohol and smokefree programmes; strong leadership and a culture of innovation within the team; and a service which has a focus on being client-focussed and holistic. While no disparity across key equity groups is apparent in Alcohol ABC monitoring for this service, patient experiences are also central to achieving equity in the delivery of Alcohol ABC – see evaluation conclusions for further information.

Large gains have also been seen in the Hand Therapy Outpatient Service, despite set-backs to the project during COVID-19 lockdown periods. The focus for the service currently is on continuing to increase uptake of the Alcohol ABC Approach, ensuring equitable delivery of the Alcohol ABC Approach, and working on referral pathways for Alcohol 'C'. This latter aspect is an important consideration across all projects. Where data capture allowed assessment of this component, small numbers of referrals for counselling or other help for alcohol were seen overall and this should be a focus for further development of the programme.

The CM Health Maternity Service and some GPs show relatively high and stable delivery of Alcohol ABC Approach. However, many of the GPs collaborating in this project have relatively low coverage of Alcohol ABC, and in some cases, coverage is declining. It must be acknowledged that recent times have been very challenging for GP, for example, due to the impact of COVID-19, and numerous competing priorities. Of the project settings described, ED is understandably the most challenging setting for delivery of Alcohol ABC Approach, as evidenced by relatively low uptake of Alcohol ABC and the ethnic inequities suggested by the audit data, despite the denominator only including patients who came to the ED with an alcohol-related presentation. Disparities in Alcohol 'A' coverage by age group were evident in GP, Middlemore Hospital ED, and Hand Therapy Outpatient Service. Disparities by ethnicity have occurred over several projects and service settings including Middlemore Hospital ED, CM Health Maternity Services and Hand Therapy Outpatient Service. Four of five collaborating PHO's showed gaps in Alcohol 'A' coverage by age group, with younger age groups tending to have lower coverage than older age groups.

All projects require further development and support for Alcohol ABC Approach data capture. This is particularly evident for the 'C' component, i.e. capturing data on whether a referral was made for counselling or other help for alcohol, and which organisation a patient/client was referred to. For the GP setting, standardisation of Alcohol ABC online forms/tools, data recording in PMSs, and output to HealthSafe, would contribute to improving the coverage and quality of Alcohol ABC data.

The second part of the outcome evaluation focused on how successful the programme activities were in increasing CM Health's leadership for action on alcohol, advocacy to reduce hazardous drinking, and the development and provision of data, intelligence and evidence-based advice on alcohol. Findings from qualitative interviews suggest that in many instances the AHM Team have exceeded expectations in their demonstrated leadership, advocacy, data, intelligence and evidenced based actions. While the goals and objectives of the AHM Programme were identified by some participants as "ambitious", they have simultaneously identified the work and related goals and actions as worthwhile, evidence based, and of value to key partners. Significant work still needs to be undertaken to support consistency and quality of Alcohol ABC Approach monitoring across all settings.

Conclusions

The AHM Programme commenced in 2016 and since then has achieved considerable progress towards the programme goals and objectives. Notably, staff who have completed Alcohol ABC Approach training demonstrate a self-reported improvement in knowledge, skills, and confidence to deliver the Alcohol ABC Approach, and enhanced perceptions of the value and importance of the Alcohol ABC Approach. Literature consistently highlights the profound influence of training to build self-efficacy in staff across professional groups (Derges et al., 2017; Mitchell et al., 2017; Patston et al., 2017). Training also engaged staff in critical reflection of stereotypes they may hold about groups of people and alcohol use. However, ongoing disruption of prejudices, stereotypes and implicit biases is fundamental to the equitable delivery of the Alcohol ABC Approach. Appropriate interventions that reduce the opportunity for bias (i.e. strengthen the processes of prioritisation and approach so there is less room for bias in treatment and screening) against this manifestation is paramount.

The Alcohol ABC Approach is evidence based and best practice and should be continued, however, implementation outcomes have varied across programme settings. Disparities in Alcohol 'A' coverage by age group were evident in GP, Middlemore Hospital ED, and Hand Therapy Outpatient Service. Disparities by ethnicity have occurred over several projects and service settings including Middlemore Hospital ED, CM Health Maternity Services and Hand Therapy Outpatient Service. Presence of these disparities in Alcohol ABC Approach monitoring data or audits, contextualised with qualitative insights from staff (e.g. implicit bias findings), demonstrate the current inequitable delivery of Alcohol ABC Approach across CM communities. While this evaluation has highlighted the need to disrupt implicit biases held by staff, particular attention to eliminating racism is critical to creating services that meet the rights and needs of Maaori communities.

While there has been increasing coverage of the Alcohol ABC Approach in GP, further development of data infrastructure is needed to support: (i) integration of Alcohol ABC Approaches within PMSs; (ii) consistency of monitoring across practices and PHOs for regional monitoring; and (iii) improvement of data capture for referral to counselling ('C'). Low uptake of Alcohol ABC and the ethnic inequities evident in audit data in Middlemore Hospital ED suggests further consideration should be given to the feasibility of the current model of Alcohol ABC delivery in the ED and whether there are alternative options that may be more successful in enabling uptake of Alcohol ABC Approach.

Overall, several findings in this evaluation point to the need for decolonised[9] approaches to alcohol harm reduction. Drawing particular attention to: (i) colonised constructs of acceptable alcohol use and models of readiness for change and treatment, which influence feelings of personal readiness, self-blame and victim-blaming around hazardous alcohol use; (ii) the strength, value and cultural imperative of engaging in tikanga of whanaungatanga and manaakitanga to facilitate mana-enhancing conversations about alcohol use, and staff needs for enhanced understanding and

[9] "Decolonisation is both an individual and collective process of revealing and analysing the historic and contemporary impact of colonisation, and institutional racism, combined with political commitment to recognition of indigenous sovereignty" (Came, Warbrick, McCreanor, Baker, 2020, p.103).

practice of this tikanga; (iii) the impact of ethnic bias/racism in delivery of Alcohol ABC Approach by staff; (iv) need for improved Maaori leadership and governance within the AHM Programme; and (iv) inequity in coverage of Alcohol ABC assessment across settings and projects. Decolonising health and care systems in Aotearoa are clearly aligned with health equity rights and aspirations of Maaori communities (Came et al., 2020), Te Tiriti responsiveness and strategic priorities of CM Health.

It is clear from existing evidence that the most rapid, effective, cost-effective alcohol harm reduction comes from public health measures, notably pricing, availability, and advertising of alcoholic beverages. Continued focus in these domains is imperative to achieve equity of outcomes, and requires the collective impact of various inter and intra sectorial partners. Programme staff have demonstrated an ability to work collaboratively with these partners, in a manner which builds mutual trust and respect.

Recommendations

Listed below are a range of recommendations for the next phase of AHM Programme development and implementation. This evaluation report largely focuses on the implementation and outcomes of the Alcohol ABC Approach. Please note that while this attention is reflected in the evaluation recommendations for the AHM Programme below, strategic focus, resourcing and activities aimed towards influencing the social determinants of hazardous alcohol use is a critical focus of the AHM Programme which should be retained.

Continue and retain:

1. A dual focus on Alcohol ABC Approach delivery and public health interventions to progress towards addressing hazardous alcohol use and alcohol-related harm.
2. Delivery of Alcohol ABC Approach training with consideration to:
    a. Engaging more staff across participating services;
    b. Facilitating ongoing and repeated training opportunities (tailored to clinical setting and roles of participating healthcare staff);
    c. Increased focused on culturally safe practice, particularly focused on continued disruption of implicit biases and tikanga practices around whanaungatanga and manaakitanga;
    d. Leveraging champions for mentorship, support and role modelling of Alcohol ABC Approach in everyday practice settings.
3. Investment and development of data infrastructure to support future monitoring of Alcohol ABC Approach delivery in CM communities, with a particular focus on:
    a. Maintaining visibility of equity (access, delivery, and outcome).
    b. Incorporating a measure of deprivation (e.g. NZ Dep index) in the analysis of Alcohol ABC Approach data to eliminate deficit framing of ethnicity analyses.
    c. Standardising data across GPs to support regional monitoring.
    d. Increasing data capture and standardisation of referral to counselling (i.e. ‘C’) indicators.
    e. Electronic prompting and data capture of Alcohol ABC assessment.
4. Monitoring and sharing of Alcohol ABC Approach data with partners for dual purposes, including for long term monitoring of the Alcohol ABC Approach (with an emphasis on equity of service delivery) and for advocacy purposes to support evidence informed public health interventions.
5. Collaborative working style with partners and services across CM Health and externally.
6. Leadership engagement both internally at CM Health and across the health and social sector to support collective impact on public health interventions.
7. Monitoring and evaluation activities to facilitate programme adaptation and improvement, with a particular focus on:
    a. Equity of outcomes.
    b. Privileging Maaori voice and lived experience.
    c. Long term outcome and impact monitoring.

Strengthen or improve:

8. Te Tiriti compliance with Maaori as equal partners and decision makers within the AHM Programme to ensure accountability of Te Tiriti o Waitangi commitments and sustainability of partnerships with Maaori.
9. Alignment of alcohol assessment frequency and monitoring in GP settings for the Alcohol Harm Minimisation Programme with Aotearoa guidance (The Royal New Zealand College of General Practitioners, 2012): annually for patients between 15 and 25 years of age and annually for patients of any age if their alcohol use is defined as hazardous (until their status changes).
10. Sustainability of Alcohol ABC Approach training model, to support increased participation of staff, continued availability of repeated or refresher training, and accommodate regional training needs.
11. Issue and risk monitoring and management to include a detailed description, rating of severity, mitigation strategy used, and outcome.
12. Follow up and reflection training to support ongoing disruption of implicit bias and understanding the role biases, particularly racism, play in shaping interactions between healthcare staff and patients in conversations around alcohol use.
13. Alignment of resourcing and advocacy work around public health interventions in the domains of pricing, availability, and advertising.
14. Opportunities for more universal coverage and early identification of hazardous drinking within the bounds of the unique clinical setting.

Create, establish, or enable:

15. Programmatic policies, systems, and processes to address implicit and explicit biases among staff who deliver Alcohol ABC Approach, including:
    a. An anti-racism programme position statement, addressing implicit and explicit racial biases (as a form of racism), microaggressions, white privilege, cultural safety, stereotypes, and prejudice.
    b. An anti-racism service dashboard as an accountability framework for cultural change/ institutional change that is both (i) outwards facing (to critically challenge ourselves about ourselves, who is benefiting from current work/ programmes and who isn't), and; (ii) inward facing (to assess internal structure, power, voice, decisions and process).
    c. Improved engagement of the structural and social context where decisions and interactions occur e.g. Tiriti based leadership position, Maaori workforce recruitment strategies to decolonise the dominant discourse and biases, and uphold Maaori rights to health as guaranteed in Te Tiriti o Waitangi.
    d. Improved understanding of the predictive brain model through Implicit Association Tests (as part of cultural safety training).
16. Improved duty of care for those patients referred to counselling, including:
    a. Supporting the development of monitoring/feedback systems that capture whether referrals were received, and extent to which patients and whaanau utilised services.
    b. Active follow-up protocols to ensure continuity of service for patients who do not respond to service referrals.

    c. Evidence to understand the efficacy of services to address hazardous alcohol use for referred patients. This is important for ensuring referral behaviours do not contribute to poor access, experiences, or outcomes of service use for patients and whaanau, and staff confidence to refer.
17. Pandemic planning to consider how Alcohol ABC Approach delivery can be supported during alert levels that inhibit face-to-face contact; given that isolation and lockdown may exacerbate stressors that lead to alcohol use among patients and whaanau.
18. Protocols and systems to support monitoring of the burden of alcohol attributable disease in the CM Community.
19. Publication of programme implementation strategy and lessons learnt to build body of evidence (with particular relevance for settings outside primary care).
20. A celebration of programme achievements to recognise the work of staff and partners.

Appendix A: Background information on Alcohol ABC Approach

A multi-pronged approach is required to prevent and reduce the harmful use of alcohol. More effective regulation is needed to turn the tide of Aotearoa's harmful drinking culture. Alongside this, the health and social systems have important roles to play in facilitating access to services for people with hazardous and harmful drinking patterns. In summary, the evidence-based strategies recommended include to (Babor, 2010; Anderson, Chrisholm & Fuhr, 2009; World Health Organisation, 2010; New Zealand Law Commission, 2010):

- Raise alcohol prices.
- Raise the purchase age.
- Reduce alcohol accessibility.
- Reduce marketing, sponsorship, and advertising of alcohol.
- Increase drink-driving counter-measures.
- Increase access to SBIRT for people with hazardous and harmful drinking patterns.
- Increase treatment opportunities for people with alcohol dependence and problems.

There is a large body of literature investigating the effectiveness of SBIRT in a wide range of healthcare settings, including GP and the ED. In CM Health, the Alcohol ABC Approach is used for delivery of SBIRT.

For the GP setting:

- There is robust evidence that brief alcohol interventions are effective at reducing hazardous and harmful drinking (O'Donnell et al., 2014).
- A systematic review of 22 Randomised Controlled Trials assessing 5,856 patients found brief intervention reduced the quantity of alcohol consumed in those receiving brief intervention, compared with controls, by 38g per week (about 4 standard drinks) on average at one- year follow-up (Kaner et al., 2018).
- Further evidence has shown that screening followed by very brief advice involving simple feedback and information is just as effective as more intensive brief intervention strategies (Kaner et al., 2018).

For the ED setting:

- The evidence for the effectiveness of SBIRT has been ambiguous.
- However, a recent large meta-analysis of 28 Randomised Control Trials including 14,456 patients found evidence for small effects of brief intervention. Small but significant reductions were found in the quantity of alcohol consumed per week, the intensity of alcohol consumed (e.g. amount of alcohol consumed per occasion), and the number of binge-drinking occasions (Schmidt et al., 2016).
- Other studies focussed on injuries have shown SBIRT in emergency care settings to be effective in reducing injury recurrence and other alcohol-related harms (Neilsen et al., 2008).

- Further evidence has shown that more intensive interventions do not show benefit over shorter approaches (i.e. screening with very brief advice/feedback) (Drummond et al., 2014).

Appendix B: Interview guide for staff

This interview schedule provides examples of the type of questions or prompts that will be used. Interviews will take a form of a 'guided conversation' with a focus on following up points raised by participants.

Introduction:

- Introduce self, including
    - Who you are,
    - What you do,
    - Who you are working on behalf of.
- Introduce evaluation
    - We are evaluating an alcohol harm minimisation programme being delivered by Counties Manukau DHB. We will meet with patients/families, staff, and key stakeholders to investigate how well the programme is doing and how it may be improved. Here is some more information on the evaluation (go through consent).
- Go through Participant Information Sheet and consent form.
- Approval / decline of consent (give koha and begin interview / thank for time and end interview).

START RECORDING

Part 1: Prelude – context and role details

1. Where do you work?

2. What is your role and involvement in Alcohol ABC? [Is it a patient-facing role?; if not please specify/describe]

Part 2: Perceptions of the ***implementation process*** of Alcohol ABC Approach

This set of questions relates to your perceptions about the implementation process of Alcohol ABC Approach.

3. What were your experiences and involvement in the implementation of the Alcohol ABC Approach? Are you able to share any examples?

4. What aspects of the implementation process do you think worked well?

5. What aspects of the implementation process did not work so well?

6. What improvements do you think could be made to the implementation of Alcohol ABC Approach in your setting or workplace?

Part 3: Experiences of having conversations about alcohol with the CM population

7. How did you approach having conversations with people about their alcohol consumption?
    a. Can you share an example of a time this conversation went well? What worked?

b. Can you share an example of a time this conversation did not go well? Why didn't it?
c. What would you change about your approach to these conversations?

8. How did you take into consideration people's cultural needs when having these conversations?

9. Thinking about your knowledge, skills, and/or confidence to deliver Alcohol ABC Approach over the time you have been involved with this work:
    a. Have they changed? How? Please provide an example.
    b. Why have they changed?
    c. What helped? Any examples?
    d. What didn't help? Any examples?
    e. What could be improved to help with this?

Part 3: Perceptions of the ***Alcohol ABC Approach*** itself

*This set of questions relates to your perceptions about **value and importance** of Alcohol ABC Approach.*

10. How important do you think the Alcohol ABC Approach is? Why?
    a. Have your perceptions of the value and importance of Alcohol ABC Approach changed over the time you have been involved with the Alcohol ABC Approach work? Are you able to share some examples?

11. What were the things that enabled you to carry out Alcohol ABC Approach work?

12. What were the main challenges for you carrying out Alcohol ABC Approach work?

Part 4: Concluding questions

I am going to ask you a few questions about your age, sec and ethnicity which we use to demographically describe our participant sample in the final report.

13. Do you have any **additional comments** that you would like to make? We appreciate your input on any and all aspects of this work.

14. What is your age-group?: 20-39 / 40-59 / 60+

15. What is your sex?:

16. Ethnicity (use standard ethnicity question from Census): (PTO)

END RECORDING

Nga mihi nui, Thank you for taking part in this evaluation.

Appendix C: Training survey

Thank you for attending today's training. We would appreciate if you could complete this survey about your experience. Please do not write your name and all your answers will be kept confidential. Please give your completed form to [staff member] at CM Health before you leave.

1. On the table below, please:
   - Circle a response which best describes your thoughts and understandings **before this session**
   - Then circle a response which best describes your thoughts and understandings **now** after the session, so you can compare your answers.

Statement	***Before*** *the session*				***After*** *the session*			
1. My understanding of alcohol and alcohol-related harm for individuals and whaanau	Poor	Okay	Good	Excellent	Poor	Okay	Good	Excellent
2. My confidence when talking about alcohol with individuals and whaanau	Poor	Okay	Good	Excellent	Poor	Okay	Good	Excellent
3. My knowledge of how to assess for alcohol problems	Poor	Okay	Good	Excellent	Poor	Okay	Good	Excellent
4. My confidence in delivering alcohol assessments in my work	Poor	Okay	Good	Excellent	Poor	Okay	Good	Excellent
5. My knowledge of how to provide brief advice about alcohol	Poor	Okay	Good	Excellent	Poor	Okay	Good	Excellent
6. My confidence in providing brief advice about alcohol	Poor	Okay	Good	Excellent	Poor	Okay	Good	Excellent
7. My knowledge of *when* to refer clients on to other services for help with alcohol	Poor	Okay	Good	Excellent	Poor	Okay	Good	Excellent
8. My knowledge of *how* to refer clients on to other services for help with alcohol	Poor	Okay	Good	Excellent	Poor	Okay	Good	Excellent
9. My thoughts on the value of the Alcohol ABC Approach	Nil value	Low value	Good value	High value	Nil value	Low value	Good value	High value
10. Likelihood that I will use the Alcohol ABC Approach in	Nil	Low	High	Definite	Nil	Low	High	Definite

my day to day work								

If you would like to provide further information on your above responses, please do so here:

_____

2. What were the key things you learnt from this session?

_____

_____

3. What could we have done better or would you like us to change?

_____

_____

4. What other information would you like to know?

_____

_____

5. Will you apply learning from today within your work? *(please tick one response then explain your answer)*

☐ Yes, how? ☐ No, why not?

_____

_____

6. What other support will you need to deliver Alcohol ABC ongoing in your workplace?

_____

_____

7. To what extent did you find this session relevant to your work? *(please tick one response)*

☐ Not at all relevant ☐ Of little relevance ☐ Relevant ☐ Highly relevant

8. Would you recommend this session to your colleagues? *(please tick one response)*

☒ Yes ☐ No, why not?

_____

_____

Appendix D: Patient participant interview guide

This interview schedule provides examples of the type of questions or prompts that will be used. Interviews will take a form of a 'guided conversation' with a focus on following up points raised by participants.

Whakawhanaungatanga
Introduction (guidance for the interviewer):

- Introduce self, including:
    - Who you are,
    - What you do,
    - Who you are working on behalf of,
- Introduce evaluation
    - We are evaluating a programme being delivered by Counties Manukau DHB which looks at reducing alcohol harm in the community. We will be talking to hospital staff, GP staff and families/whaanau to investigate how well the programme is doing and how it may be improved. Here is some more information on the evaluation (go through consent).
- Go through Participant Information Sheet and consent form.
- Approval / decline of consent (give koha and begin interview / thank for time and end interview).

START RECORDING

Part 1: Experience of being asked about alcohol

*This set of questions focuses on your experience of having a conversation about alcohol when you last visited [**NAME OF SERVICE**]. Please feel free to respond however you like and to ask questions at any time.*

1. Tell me about when you were asked about your alcohol use at (select one: at your GP/ at the ED/ in the hospital/ at hand therapy/ at the Living Smokefree Service/ as part of your pregnancy care/), how did this happen?

2. How did you feel about being asked about your alcohol use? Why?

3. Thinking back, how did you feel about the conversation and any advice/help you received at [restate setting]?
    a. What were the things you liked?
    b. What could be done better for you or others in the future?

4. What are your thoughts about the value and importance of being asked about alcohol and having conversations about alcohol? Why?

Part 2: Current alcohol use

This set of questions relates to your perspectives on any potential impact/s your recent alcohol conversation may have had on you.

5. Has your alcohol use changed since your conversation about alcohol?
   If so, how? (Eg. amount, frequency, type, occasion, place). What was it before? If no, why not?

6. What has this meant for you?

Part 3: Experience of alcohol-related harms

This set of questions seeks your perspectives on harm from alcohol use. Please share as much or as little detail you are comfortable with.

7. What harm caused by alcohol have you observed in your life or the community (if any)?

8. Has the alcohol conversation you recently had helped you or your whaanau in any way? How? (allow free response then prompt for any reduction in alcohol-related harm e.g. physical, mental, emotional, violence, relationship, finances, legal things)

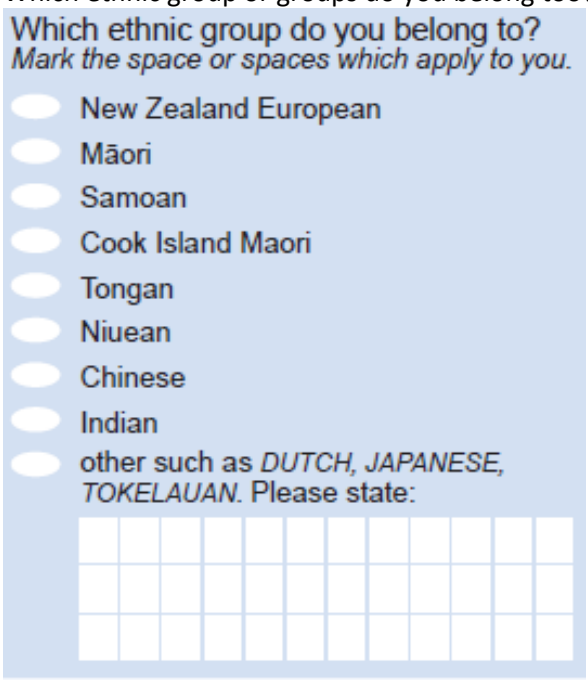
9. What do you think could be done to reduce alcohol-related harms for you and/or for your whaanau and community? Are you able to share any examples?

Part 4: Additional comments

10. Do you have any **additional comments** that you would like to make?

Part 5: Study ID number: [two-digit number to be assigned]

11. Which age range do you fall within? 20-39 / 40-59 / 60+
12. What is your sex?
13. Which ethnic group or groups do you belong too?



END RECORDING

Nga mihi nui, Thank you for taking part in this evaluation.

Appendix E: Alcohol ABC Approach indicators

Project	A: Ask/Assess alcohol use	B: Provide Brief advice	C: Refer for Counselling or other help	Comments
General Practice				
Indicator	Percentage of enrolled patients aged ≥15 years who have had their alcohol status assessed in the last three years	Percentage of enrolled patients aged ≥15 years, who have had their alcohol status asked/assessed in the last three years showing alcohol use above the 'low-risk drinking' guidelines, and have been provided brief advice	Number of enrolled patients aged ≥15 years who have had their alcohol status asked/assessed in the last three years and been referred for counselling or other help for alcohol use	Framework for Alcohol 'A', 'B', and 'C' indicators was guided by the Royal New Zealand College of General Practitioners' *Implementing the ABC Alcohol Approach in Primary Care* Clinical Effectiveness Module Indicators have a rolling three-year time frame Measured quarterly
Numerator	Number of enrolled patients aged ≥15 years who have had their alcohol status assessed in the last three years	Number of enrolled patients aged ≥15 years, who have had their alcohol status asked/assessed in the last three years showing alcohol use above the 'low-risk drinking' guidelines, and have been provided brief advice	As above	
Denominator	Number of enrolled patients aged ≥15 years	Number of enrolled patients aged ≥15 years, who have had their alcohol status asked/assessed in the last three years showing alcohol use above the 'low-risk drinking' guidelines	-	
Middlemore ED				
Indicator	Percentage of patients, with an alcohol-related presentation to ED, who have had their alcohol status assessed in ED	Percentage of patients with an alcohol-related presentation to ED, who have had their alcohol status assessed in the ED showing alcohol use above the	Number of patients with an alcohol-related presentation to ED, who have been referred for counselling or other help for alcohol use	Indicator definitions were adapted to apply only to those patients with alcohol-related presentations, due to this being the focus of

		'low-risk drinking' guidelines, and have been provided brief advice		the project; Measured monthly through manual audit of clinical notes Alcohol assessment involves use of the 3 question AUDIT-C tool, resulting in a score out of 12 An AUDIT-C score ≥5 indicates drinking at a level considered above the 'low-risk drinking' guidelines
Numerator	Number of patients, with an alcohol-related presentation to ED, who have had their alcohol status assessed in ED	Number of patients with an alcohol-related presentation to ED, who have had their alcohol status assessed in the ED showing alcohol use above the 'low-risk drinking' guidelines, and have been provided brief advice	As above	
Denominator	Number of patients with an alcohol-related presentation to ED	Number of patients with an alcohol-related presentation to ED, who have had their alcohol status assessed in the ED showing alcohol use above the 'low-risk drinking' guidelines	-	
Living Smokefree Service – service for pregnant women				
Indicator	Percentage of pregnant clients seen in the service each quarter who were asked about alcohol	Percentage of pregnant clients seen in the service, who have had their alcohol status assessed showing alcohol use, and have been provided brief advice	Number of pregnant clients seen in the service, who were asked about alcohol and referred for counselling or other help for alcohol	Any alcohol use in pregnancy is harmful and therefore is defined as being 'above the low-risk drinking guidelines'
Numerator	Number of pregnant clients seen in the service each quarter who were asked about alcohol	Number of pregnant clients seen in the service, who have had their alcohol status assessed showing alcohol use, and have been provided brief advice	As above	
Denominator	Number of pregnant clients seen in the service each quarter	Number of pregnant clients seen in the service who have had their alcohol status assessed showing alcohol use	-	
Living Smokefree Service – general service				
Indicator	Percentage of pregnant clients seen in the service each quarter who were asked about alcohol	Percentage of clients seen in the service, who have had their alcohol status assessed showing	Number of clients seen in the service, who have had their alcohol status assessed, and	The Alcohol ABC Approach model was adapted to the LSFS workflow. The

		alcohol use above the 'low-risk drinking' guidelines, and have been provided brief advice	been referred for counselling or other help for alcohol use	indicator for 'A' has been defined as asking a client whether they drink alcohol. If a client responds 'Yes', an AUDIT-C alcohol assessment is carried out at the next LSFS follow-up visit.
Numerator	Number of pregnant clients seen in the service each quarter who were asked about alcohol	Number of clients seen in the service, who have had their alcohol status assessed showing alcohol use above the 'low-risk drinking' guidelines, and have been provided brief advice	As above	
Denominator	Number of pregnant clients seen in the service each quarter	Number of clients seen in the service who have had their alcohol status assessed showing alcohol use above the 'low-risk drinking' guidelines	-	
CM Health Midwifery Service				
Indicator	Percentage of maternity clients seen in booking appointments each month who were asked about alcohol	Percentage of maternity clients who responded that they drink alcohol and were provided brief advice (measured monthly)	Number of maternity clients who were asked about alcohol and referred for counselling or other help for alcohol (measured monthly)	Any alcohol use in pregnancy is harmful and therefore is defined as being 'above the low-risk drinking guidelines'
Numerator	Number of maternity clients seen in booking appointments each month who were asked about alcohol	Number of maternity clients who responded that they drink alcohol (when asked during their booking visit), and were provided brief advice (measured monthly)	As above	
Denominator	Number of maternity clients seen in booking appointments each month	Number of maternity clients who responded that they drink alcohol when asked during their booking visit (measured monthly)	-	
Hand Therapy Outpatient Service				
Indicator	Percentage of hand therapy patients seen each month who have had their alcohol status assessed	Percentage of hand therapy patients seen each month who have had their alcohol status assessed showing alcohol use	Number of hand therapy patients seen each month who have had their alcohol status assessed, and been referred for	Alcohol assessment involves use of the 3 question AUDIT-C tool, resulting in a score out of 12

		above the 'low-risk drinking' guidelines, and have been provided brief advice	counselling or other help for alcohol use	An AUDIT-C score ≥5 indicates drinking at a level considered above the 'low-risk drinking' guidelines
Numerator	Number of hand therapy patients seen each month who have had their alcohol status assessed	Number of hand therapy patients seen each month who have had their alcohol status assessed showing alcohol use above the 'low-risk drinking' guidelines, and have been provided brief advice	As above	
Denominator	Number of hand therapy patients seen each month	Number of hand therapy patients seen each month who have had their alcohol status assessed showing alcohol use above the 'low-risk drinking' guidelines	-	

Appendix F: Key Stakeholder interview guide

This interview schedule provides examples of the type of questions or prompts that will be used. Interviews will take a form of a 'guided conversation' with a focus on following up points raised by participants.

Introduction:

- Introduce self, including
    - Who you are,
    - What you do,
    - Who you are working on behalf of.
- Introduce evaluation
    - We are evaluating an alcohol harm minimisation programme being delivered by Counties Manukau DHB. We will meet with patients/families, staff, and key stakeholders to investigate how well the programme is doing and how it may be improved. Here is some more information on the evaluation (go through consent).
- Go through Participant Information Sheet and consent form.
- Approval / decline of consent (give koha and begin interview / thank for time and end interview).

START RECORDING

Prelude:

14. What is your role in your organisation? [Is it a patient-facing role?; if not please specify/describe]
15. What has been your role with the Alcohol Harm Minimisation Programme?

Part 1: Perceptions about CM Health's **leadership for action on alcohol** in the DHB setting

This next set of questions relates to your perspectives about CM Health's leadership for action on alcohol.

1. What are your views on the role the DHB should in preventing and reducing hazardous alcohol use and alcohol-related harm?

2. What are your views on CM Health's leadership for action on alcohol? Can you think of any examples?

3. Thinking about the AHM Programme in general:
    a. What are your thoughts on the programme?
    b. Has the programme created change related to action on alcohol?
    c. What improvements could be made?

4. This Programme, including the Alcohol Action Plan, aimed to ***provide clarity*** about the role the DHB should play in preventing and reducing hazardous alcohol use and alcohol-related harm.
    a. How successful (or not) do you think this has been? Why?

b. Do you feel that achieving equity has been a clear focus of programme activities? Why?

5. Thinking specifically about the Alcohol Action Plan:
    a. Are you familiar with this document? Has it helped providing clarity about direction of the programme? What could be improved?
    b. Do you think it is focusing on the right actions?

6. To what extent did the programme team and activities display collaborative working and partnership? What about supporting innovative approaches? Are you able to provide any examples?

Part 2: Perceptions about CM Health's **advocacy to reduce hazardous drinking and alcohol-related harm.**

*The next series of questions is going to explore your perspectives about CM Health's **advocacy** to reduce hazardous drinking and alcohol-related harm.*

7. What are your thoughts on CM Health's advocacy relating to reducing hazardous drinking and minimising alcohol-related harm?
    a. What do you think worked well? Are you able to share any examples?
    b. What do you think could be done to improve it further?

8. How successful (or not) have the programme activities been in delivering clear and consistent evidence-based messages to staff and the community? Why?

9. To what extent have the programme activities supported/enabled our community champions to take action on alcohol? Are you able to share any examples?

Part 3: Perceptions about CM Health's **development and provision of data and evidence-based advice on alcohol**

*The next series of questions is going to explore your perspectives about CM Health's **development and provision of data and evidence-based advice** on alcohol.*

10. Are you aware of any alcohol-related data activities carried out as part of this programme?

11. To what extent has the programme provided a vision and plan for data development and provision?

12. How successful (or not) has the programme been in developing data and/or providing data outputs to describe the problem, burden and cost to the health system? Why?

13. Do you believe there has been a sufficient focus on equity in data-related activities in this programme? Why?

Part 4: Additional comments

14. Do you have any additional comments that you would like to make? We appreciate your input on any and all aspects of this work.

Part 5: Details about the stakeholder

I am going to ask you a few questions about your employment, age, gender and ethnicity which we use to demographically describe our participant sample in the final report.

16. What is your age-group?: 20-39 / 40-59 / 60+
17. What is your gender?
18. Ethnicity (use standard ethnicity question from Census):

END RECORDING

Nga mihi nui, Thank you for taking part in this evaluation.

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