

PERCEPTIONS ON THE ROLE OF EVIDENCE: AN ENGLISH ALCOHOL POLICY CASE STUDY

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ABSTRACT

This paper explores the competing influences which inform public health policy and describes the role that research evidence plays within the policy-making process. In particular it draws on a recent English alcohol policy case study to assess the role of evidence in informing policy and practice. Semi-structured interviews with key national, regional and local policy informants were transcribed and analysed thematically. A strong theme identified was that of the role of evidence. Findings are discussed in the context of competing views on what constitutes appropriate evidence for policy-making.

KEYWORDS: Alcohol policy; evidence-based policy; evidence-informed policy, research evidence; England.

EVIDENCE INFORMED POLICY

From the late 1990s, New Labour governments made the contention that public policy should be evidence-based, properly evaluated and informed by best practice (Cabinet Office, 1999). This commitment was operationalised by the creation of public service units and cross-departmental teams working on complex issues (for example, the Social Exclusion Unit). Since then there has been debate on whether the government has adhered to evidence-based policy-making (Bennett & Holloway, 2010). Nevertheless, the rhetoric has survived under the Coalition Government with a slight shift of emphasis from 'evidence-based' to 'evidence informed' policy. The newer term denotes recognition that evidence is only one of many competing influences on policy formation and the policy agenda. In addition, the dynamics of policy-making are also affected by institutional, professional and cultural factors which vary across different policy domains (Head, 2010). However, the requirement for reliable and valid information is generally considered by reformist governments to be one of the foundations for good policy and review processes (Shaxson, 2005).

In practice, the policy-making process has many influences acting upon it, including: the experience, expertise and judgement of decision-makers,

constituting intellectual capital and tacit knowledge; their values, comprising political ideology; engrained political rituals and traditions; the pragmatics of political life and unanticipated contingencies; finite resources; the presence of lobbyists, pressure groups, and consultants; the media and electorate (Davies, 2004). Policy formulation is a complex, contested and iterative process (Martin *et al.*, 2010).

Concordantly, there are a number of prominent models of policy-making (Ritter & Bammer, 2010). The technical-rational model originates from the public administration approach to policy-making and commences from the stage at which an issue is identified. Then the following steps are worked through to achieve the most favourable solution: articulate the problem or issue; identify the causes; develop options; analyse options; select intervention; implement intervention and evaluate (Bardach, 2011). Most commentators report this model as cyclical not linear and sequential as it may intuitively appear. The technical-rational model could be seen as an approach to making rational decisions rather than the reality of how policy is produced (Ritter & Bammer, 2010). Indeed, this structured description of policy-making is in contrast with, for example, the multiple streams model which perceives the policy process as organised anarchy (Kingdon, 2010). In Kingdon's model, three independent streams, namely, problems, politics and policy processes operate in parallel. Policy action occurs when specific events trigger coalescence between the streams (Ritter & Bammer, 2010).

The 'evidence-based policy movement', committed to replacing ideologically-driven politics with rational decision-making, promotes the use of 'rigorous' research and the incorporation of these findings into governmental processes for policy-making (Head, 2010; Sutcliffe & Court, 2005). 'Evidence-based policy' assumes a causal relationship between research evidence and policy development: the reality is much more complex with what constitutes appropriate evidence and the key drivers mentioned previously interacting to inform policy.

Evidence which appears persuasive to researchers is sometimes viewed less favourably by others involved in policy development and implementation. To politicians, policy-makers and practitioners, academic research can seem too abstruse, written in incomprehensible language and not sufficiently focussed on the practical day to day issues that are their main interest (MacGregor, 2010). For research to have an influence, policy-makers have reported that they seek the identification of new approaches to tackling persistent problems that prevent policy from being effective; research which uncovers new issues before they come to the attention of policy-makers; and research which provides accurate information and highlights examples of good practice. Attention also has to be given to the financial and policy implications and to the potential for scaling up initiatives (MacGregor, 2006).

Despite these sometimes competing influences and cultural differences, research evidence can still maintain a role in the policy-making process (Sanderson, 2002). 'Evidence-based policy' has been defined as an approach

which enables people to make well informed decisions about policies, programmes and projects by placing the best available evidence from research at the heart of policy development and implementation (Davies, 1999). In the medical field, emphasis is placed on the practical application of evidence. Sheldon and Chilvers (2000, p.2) provide the following definition of evidence-based medicine: 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients'. However, it is apparent that there is variation in usage of the phrase 'evidence-based', Nutley and colleagues (2007) refer to a spectrum of meaning given to the term from a narrow approach where high quality research is perceived as being systematically translated into guidelines for good practice, to a broader more flexible view of how research can inform people and the types of knowledge that comprise evidence.

The type of evidence utilised by decision makers in the health and public health fields tends to be that which demonstrates both clinical and cost-effectiveness (MacIntyre & Petticrew, 2000). In health research, there is an established hierarchy of evidence to assess effectiveness, with systematic reviews and multi-centre trials at the highest level, ranging through randomised controlled trials, observation studies, uncontrolled trials, before and after studies, non-randomised controlled trials, descriptive studies, case studies, expert opinion and studies of poor methodological quality in descending order (Evans, 2003). With this framework in mind, Cochrane systematic reviews cover diverse health interventions, including a review

group specialising in synthesising drug and alcohol-related research (Armstrong *et al.*, 2006).

In practice, however, there is no clear ruling on what constitutes appropriate evidence for policy-making (Bennett & Holloway, 2010). For example, systematic reviews while providing cost savings for government, struggle to take account of the complexities inherent within the social world and therefore rarely point to unequivocal policy actions (Bulmer *et al.*, 2007). Also although randomised controlled trials can address issues relating to causality they are not designed to address other policy relevant questions such as how or why a policy was effective or how successfully a policy was implemented (Anderson, 2011). Given this, mixed-methods incorporating both qualitative and quantitative approaches are increasingly being applied by analysts and evaluators who seek to explain complex problems and assess complex interventions (Pawson *et al.*, 2005; Woolcock, 2009).

ENGLISH ALCOHOL POLICY

According to health advocates the central purpose of alcohol policies is to impact positively on public health and social well-being through addressing issues such as drinking patterns, the drinking environment and the health services available to treat problem drinkers (Babor *et al.*, 2010). However, the public health perspective has policy rivals. Alcohol has been described as one of the 'wicked issues' (Wildridge *et al.*, 2004) because it is impossible to assign policy responsibility to any one government department. The relevance of alcohol to the business of the Department of Health (DH), the Home Office,

the Department of Culture, Media and Sport, the Department of Trade and Industry and the Treasury (and other government departments) means that policy is constantly faced with juggling competing demands from health, security, and the economy – to name only the main contenders. For instance, policy-makers need to weigh up the evidence of alcohol-related harm in the night time economy against the evidence for city centre regeneration and take account of the diverse pressures for and against policies which impact on that particular area of activity. Policy on alcohol, is, therefore, relevant to and formulated by different government departments and reflects their particular concerns and interests, although cross-departmental collaboration is, in theory, part of the policy system designed to ensure some coherence across the departments.

Under New Labour alcohol policy has evolved through a number of trends. One important shift has been that policy to address problem drinking has slowly moved towards adopting a more public health, population level approach (Thom, 2001). This public health focus led to the development of ‘universal’ approaches including substance use education and public awareness campaigns, and more focused interventions such as community based detoxification and brief interventions (Lloyd, 2010). A second trend, in line with more general policy shifts, was towards the de-centralisation or localisation of policy, first to regional level and then to local level (Perkins *et al.*, 2010). These trends have been accompanied by an explosion of new epidemiological information and other forms of research information designed

to support the development and implementation of evidence-based alcohol policy at local levels.

Therefore, the rhetoric of evidence informed policy from New Labour also coincided with the introduction of numerous laws, regulations, guidance documents and policy statements on alcohol. The major central policy initiatives have been *The Licensing Act 2003*, the *Alcohol Harm Reduction Strategy for England 2004*, *Safe, Sensible, Social: The Next Steps in the National Alcohol Strategy 2007*, and *The Government's Alcohol Strategy 2012*. Another important policy development in this period was the introduction of a Public Service Agreement (PSA) 25 which provided a delivery plan and focussed targets aimed at reducing the harm caused by alcohol (DH, 2007; Hadfield *et al.*, 2009).

Prior to *Safe, Sensible, Social*, the early years of the New Labour administration's national alcohol strategy were largely concerned with anti-social behaviour and public order issues. This policy statement heralded a resurgence of activity focussed on health and came at a time of increasing pressure on policy makers to consider the health and social costs of rising alcohol consumption and related harm.

From the 1960s alcohol consumption in the UK increased steadily over time reaching a peak in 2004: a trend associated with increases in alcohol-related illness and death (British Medical Association, 2008). A 2007 review of the alcohol strategy and the production of *Safe, Sensible, Social* enabled the DH

to ensure that there would be a clearer emphasis on health. The key driver was awareness of how much the burden of alcohol disease was costing the National Health Service (NHS). In the Public Health White Paper, *Choosing Health* 2004, the DH also highlighted that alcohol was a key contributor to health inequalities.

While increasing awareness of the impact of alcohol-related harm on the NHS was undoubtedly an important influence on policy, other forces were also at work. Stakeholder groups – which included researchers, public health professionals, the Royal Colleges, hospital A&E consultants and ‘advocacy’ charities such as Alcohol Concern were busy both producing and disseminating research and epidemiological data to support their demands for alcohol policy to address health issues to a greater extent.

In 2007 a number of stakeholder groups came together as the Alcohol Health Alliance (AHA). Its mission was working together to highlight alcohol-related harms, propose evidence-based solutions and influence decision makers to take action to address alcohol-related harms. The AHA emphasised population level policies such as increased taxation, minimum alcohol pricing and restrictions on marketing as well as recommending dedicated funding for treatment. It exercised its influence through making good use of its links with powerful medical organisations, through media contacts and appearances on the media of charismatic leaders within those organisations, and through producing policy briefings which members were well placed to bring to the attention of relevant civil servants and government ministers. A public health

approach and the evidence to support a health-related policy agenda emerged, therefore, from a complex interactive process which combined the production and use of evidence with powerful advocacy.

However, *The Government's Alcohol Strategy 2012* appears to represent a return to the public order emphasis. It is notable that the most publicised and radical policy it contains, a minimum unit price, is essentially a public health response, although framed in public order terminology (O'Dowd, 2012).

POLICY CASE STUDY: THE ALCOHOL IMPROVEMENT PROGRAMME

The Department of Health's Alcohol Improvement Programme (AIP) is presented as a case study example of the role of different forms of evidence in the formation and implementation of public health policy on alcohol.

Rather than being developed rationally and *ab initio* as a specific programme, the AIP (2008-11) emerged pragmatically, building on prior action. The programme was preceded by efforts to build evidence of alcohol-related harm and by a series of initiatives and guidance directed towards mobilizing Primary Care Trusts (PCTs) and commissioners to address alcohol-related issues and to foster a culture of 'spend to save' in order to reduce the cost of alcohol-related problems to the National Health Service (NHS).

The AIP was a multi-component programme comprising seven main components:

- The Central Policy Team at the DH

- Regional Alcohol Managers/Offices in each region
- The High Impact Changes (HICs)
- The North West Public Health Observatory
- The Alcohol National Support Team
- 20 Early Implementer PCTs
- The Alcohol Learning Centre.

RESEARCH METHODS

Structured telephone interviews were conducted with 44 PCT alcohol leads, four of whom, being in case study areas, were followed up with lengthy semi-structured interviews. Twenty local policy contacts, including Directors of Public Health, were also interviewed in these case study areas. Twenty five semi-structured interviews were undertaken with regional level informants including all Regional Alcohol Managers (RAMs) and staff in the regional offices. Centrally, all 10 members of the DH Alcohol Policy and Alcohol National Support Teams were interviewed. Alcohol policy and strategy documents relevant to national, regional and local levels were also studied in detail. Attendance at and observation of key meetings also took place.

Thematic analysis was utilised to identify themes by their frequency, intensity and extensiveness. This technique is described by Braun and Clarke (2006, p.87) as involving the following stages: the researcher immerses his/herself in the data, reading and re-reading transcripts, making notes and identifying emerging themes to form a coding framework; the data are analysed using

the coding framework, adding new themes as they emerge and linking related items into sub-themes; and an over-arching list of themes is developed.

FINDINGS

The Role of Evidence in Choosing the High Impact Changes

The development process in identifying and selecting High Impact Changes (HICs) for alcohol was conducted by the DH policy team. They examined available evidence in documents such as the Review of the Effectiveness of Treatment for Alcohol Problems (Raistrick *et al.*, 2006); consulted colleagues in allied health fields where HICs had been used to prioritise action (for example, smoking and mental health); and drew on practice examples from areas like Liverpool and Paddington.

Yes a broad notion of evidence base because you are aware some of it has more evidence behind it than others, and some is on the views of experts rather than the evidence, because obviously it's still quite a young field. [Central Policy Contact]

The HICs specified in *Signs for Improvement* (DH, 2009) consisted of seven sub-components chosen as the most effective, 'evidence-based' actions likely to contribute to reducing alcohol-related harm: working in partnership; developing activities to control the impact of alcohol misuse in the community; influencing change through advocacy; improving the effectiveness and capacity of specialist treatment; appointing hospital alcohol health workers

(AHWs); providing identification and brief advice (IBA); and amplifying national social marketing priorities.

It is beyond the scope of the current article to provide a detailed description and appraisal of the evidence base for each of the HICs, however, by way of illustration three of them (AHWs, IBA and social marketing) are examined later in the findings section. Table 1 summarises the evidence which the DH policy team cited to justify inclusion of each of the seven HICs.

Table 1. Evidence cited by DH to inform the seven High Impact Changes

Partnership	Work by Tether, Robinson and colleagues (Tether & Robinson, 1986; Robinson <i>et al.</i> , 1989) and Thom and Bayley (2007) set out the rationale for co-ordinated action at local level.
Control	Local evaluation data from Liverpool and Sheffield Community Safety Partnerships which made use of all existing laws, regulations and controls available to reduce assaults, robbery and antisocial behaviour.
Advocacy	The Community Trials Project (a five component community level intervention that ran from 1991-1996 in California, USA – Moore & Holder, 2003) set a number of key elements in making progress on alcohol harm: community leadership; making local alliances, working with local politics, making the case for additional resources.
Specialist treatment	Models of Care for Alcohol Misusers (MoCAM), the Review of the Effectiveness of Treatment for Alcohol Problems (Raistrick <i>et al.</i> , 2006). The UK Alcohol Treatment Trial (UKATT) showed: treatment saved nearly £1138 per dependent drinker treated and reduced hospital stays; 25% of patients reported no continuing alcohol-related problems at follow-up; 40% of patients reported being much improved, reducing their alcohol problems by 66% (UKATT Research Team, 2005a,b).
Alcohol Health Worker	Local evaluation data indicated that over an 18 month period, the intensive care management and discharge planning delivered by an Alcohol Liaison Nurse in the Royal Liverpool Hospital prevented 258 admissions or re-admissions – about 15 admissions per month. Economic analysis of such an appointment in a general hospital suggested that the post saved ten times more in reducing

	repeat admission than its cost.
Identification and Brief Advice	Much research evidence supporting IBA in Primary Care including 56 controlled trials (Moyer <i>et al.</i> , 2002) and a Cochrane Collaboration Review (Kaner <i>et al.</i> , 2007). Patients who received IBA in A&E made 0.5 fewer visits to the A&E during the following 12 months (Crawford <i>et al.</i> , 2004).
Social marketing	Evidence supporting social marketing exists in areas such as smoking, sexual behaviour and nutrition. But direct evidence concerning alcohol is still emerging.

The first three HICs (partnership, control, advocacy) were enabling actions intended to facilitate intervention. The remaining four HICs (specialist treatment, AHWs, IBA, social marketing) were interventions that could be commissioned and implemented at local level. The HICs were expected to be implemented together, to be complementary and have a synergistic effect greater than the sum of their individual effects.

The Role of Evidence in Raising Awareness of Alcohol Problems

The impact of the various strategies comprising the AIP was measured nationally through PSA 25 Indicator 2. A target was set to reduce the trend of increasing alcohol-related hospital admissions (ARHAs) by a minimum reduction of one percent per year on the projected rate of increase (HM Treasury, 2007). Reflecting this, PSA indicators were introduced in 2008 to monitor progress against this target: National Indicator 39 (NI 39) which was one of the 198 Indicators for English Local Authorities and Local Authority partnerships; and Vital Signs Indicator 26 (VSC 26) for the NHS. As the 'C' denotes, this Vital Sign Indicator was given a third tier priority which meant that it was not coordinated by the Strategic Health Authority (SHA) and it was left to local areas to decide whether or not to include it. Despite not being

mandatory, approximately 100 of the 151 PCTs included VSC 26 in their operational plans.

In addition, the DH alcohol policy team provided practical support on how to make projections about the impact of implementing the HICs, through the development of a modelling tool, the 'ready reckoner', which enabled PCTs to link the HICs to their local level of need and calculate, for example, how many alcohol health workers to employ to model the estimated impact on hospital admissions and associated savings. The UKATT trial (UKATT Research Team, 2005b) and other research was utilised to produce costings for the ready reckoner, which was developed by a DH health economist. Latterly, a more comprehensive systems dynamic modelling tool was developed to allow commissioners to look at the economic impacts of their decisions, although problems were experienced in implementation. This was mainly due to the amount and complexity of information required to set parameters to produce projections.

The modelling tools developed by health economists and used for projecting the impact of HIC initiatives on ARHAs also received some criticism from respondents. While the statistical models produced impressive results and appeared to promise significant savings, some have questioned the reliability of the evidence base that lies behind these calculations:

This was a big issue for us because when we were putting our business cases together and taking it to the accountants - effectively

to try and make a business case for investing in alcohol - the evidence just didn't stack up. The ready reckoner was a tool to help us with that but it just wasn't good enough. [Local Policy Contact]

These are pretty crude tools, but based on the assumptions from the evidence. [Central Policy Contact]

Despite scepticism over the accuracy of the outputs produced, interviewees did recognise what the modelling tools were attempting to do. Having the ability to frame arguments in the language of money and cost savings was a critical factor within the politics of local negotiations around commissioning for alcohol provision.

The Role of Evidence to Inform and Guide Practice

The HICs initiative aimed to provide a framework through which PCTs could concentrate development and action around the 'best evidenced' interventions and compare their provision with other areas. Interviewees, mainly local alcohol leads and RAMs, were generally positive about the alcohol HICs, stating that they were influential by providing a shared language, structure and understanding of these interventions, enabling mapping across PCTs:

...[the HICs] provide an evidence base which has been lacking. It provides the structure, the kind of coordinated approach and also I suppose in some sense, it provides people with something to mark

themselves against, to think right: “we’ve done that, we have put these blocks in place”... [RAM]

[The HICs have] given a very good framework for what was deemed as [best practice] for the interventions to commission locally. It also managed to focus the level of investment based on theoretical or actual return calculations. Without the evidence base, it would have been a slog to get the PCT to invest... [Local Policy Contact]

As the above quotation indicates, the HICs helped to legitimise spending on alcohol with the evidence base providing external validation and reassurance that this investment was justified. For some, the HICs were associated with a new, primary focus on ARHAs. For others, local needs assessments had already taken them in that direction:

The HICs have changed our approach. We have looked at what works, we have been informed by the international research and we know what works. However, there was a needs assessment carried out in 2006 by public health, which told us about the priorities in our area. This was the starting point of the needs, but to focus us on hospital and A&E as the place you can get the most hits, that came from the AIP and the HICs. [Local Policy Contact]

Our commissioning was already focused towards issues related to admissions, we were already there if you like and HICs consolidated it and backed up our approach. [Local Policy Contact]

The first quotation highlights that, although the respondent had awareness of international research, ultimately context specific information was required to guide local policy and practice development. This appears to support the view of Pawson and Tilley (1997) who advocate a realist approach to evaluation which focuses on contextual variables to develop a more nuanced understanding not just of what works but for whom, in what circumstances and how.

There was something of a contrast between the views held at the centre on the value of the HICs and those espoused locally. Some of the central DH policy team were sceptical about the value of some of the HICs:

We should have set up the high impact changes more carefully.
[Central Policy Contact].

A frequent comment from central interviewees was that the HICs were somewhat of a mixed bag in terms of the evidence base available to support them.

If I had my time over again, I would have had three high impact changes which would be the deliverable ones, the commissionable ones - which are the only ones we talk about now - the health workers, IBA and specialist treatment. [Central Policy Contact]

However, both regionally and locally, those HICs with a more substantive evidence base were seen as a crucial aspect of the AIP and very important in bringing about a change in the attitudes of local policy actors; being able to take these 'evidenced' interventions to senior staff helped get 'buy in'. An additional value of the HICs was gaining knowledge and ideas about what could be done in practice as opposed to just being told to 'do something about alcohol': there was a clear structure for what needed to be delivered locally. Whilst being described as adding *external legitimacy* to decisions concerning alcohol interventions, the HICs were also a self-contained body of evidence. Respondents mentioned that having this 'ready to use' source of information helped enable commissioners and other professionals to confidently argue for investment in specialist alcohol services and other interventions.

The HICs formed an important part of the policy language at local and regional levels and proved a major spur to action. However, their credibility is not beyond question. By way of illustration, the next sub-sections highlight three of the seven HICs and the contrasting views on the 'evidence' which informed them.

Alcohol Health Workers in Acute Settings

A recommendation outlined in *Signs for Improvement* was the appointment of Alcohol Liaison Nurses (ALN) or AHWs to deliver specialist interventions to patients admitted with identified alcohol-related health problems. *Signs for Improvement* cited a Royal College of Physicians report (2001) which proposed that each Acute Trust should employ 'one or more dedicated alcohol health workers employed by and answerable to the acute trust, their roles to include: implementation of screening strategies; detoxification of dependent drinkers; brief interventions in hazardous drinkers; referral of patients for on-going support; provision of links with liaison/specialist alcohol psychiatry; and an educational resource and support focus for other health care workers in the Trust'. This influential report also described an audit of the Alcohol Nurse Liaison Service at the Royal Liverpool University Hospital which indicated that intensive care management and discharge planning prevented 258 admissions or re-admissions over an 18 month period, saving the hospital ten times more than its cost.

Although *Signs for Improvement* identified the deployment of AHWs as having 'a predictable medium-term impact on the reduction of alcohol-related hospital admissions', there is a paucity of published research on the effectiveness of the AHW approach (Ryder *et al.*, 2010). What evidence there is suggests that alcohol work in acute settings can have a positive impact on alcohol-related hospital admissions (Crawford *et al.*, 2004). Ryder and colleagues (2010) present evaluation data from a nurse liaison service operating from 2002 to 2007 in Nottingham that indicates intervention by trained staff in a highly

alcohol dependent group with serious physical illness has a substantial impact on alcohol intake and can reduce hospital admissions and bed stays. Also a prospective cohort study by Cobain and colleagues (2011) found that brief interventions given by AHWs led to a decrease in alcohol consumption for patients who received an intervention compared to those in the control group. However, although length of hospital stay and attendance at A&E were also reduced, this did not differ significantly between the groups.

Considerable resources were invested in developing AHW provision. However, local and regional policy contacts described great variation and complexity in the models that were established across the country:

...very different models. Obviously everybody thinks their model is the best. [RAM]

This is corroborated by the findings from an Alcohol Concern report (Ward & Aulton, 2010) which found that AHWs operate on a continuum, with activities such as IBA work at one end and medical interventions like detoxification at the other. Also Ward and Aulton (2010) suggested that the number of AHWs at a local level is a function of local funding, lobbying from providers and support within the commissioning system rather than an assessment of need.

Identification and Brief Advice

The National Institute for Health and Clinical Excellence (NICE), commissioned by the DH, produced a best practice document called *Alcohol-*

use disorders: preventing harmful drinking which recommended that commissioners should ensure their plans include screening and brief interventions for people at risk of an alcohol-related problem and those whose health is being damaged by alcohol (NICE, 2010). IBA is operationalised as an opportunistic case identification, which aims to lower an individual's level of risky drinking through 'one off', 5-10 minute structured sessions delivered across a range of health settings, including primary care and A&E Departments (NICE, 2010).

NICE guidance also states that provision should be made for the likely increase in the number of referrals to services providing tiers two, three and four structured alcohol treatments as a result of screening. These services should be properly resourced to support the stepped care approach recommended in Models of Care for Alcohol Misusers (MoCAM) (DH, 2006). However, this was not always straightforward:

If we put more money into IBAs now, we wouldn't have the capacity in our treatment services to deal with what comes through [Local Policy Contact].

Findings from the AIP evaluation indicate that IBA increased in coverage in line with the best practice guidance which referred to IBA in the following locations: primary care, emergency, hospital and outpatient settings, specialist clinics (e.g. sexual health, pharmacies, dental surgeries, antenatal clinics), criminal justice settings, social services, higher education and other public

services. However, local policy contacts were still most likely to mention the four key locations outlined in *Signs for Improvement* (primary care, A&E departments, specialist clinics and criminal justice settings) when talking about IBA implementation.

While the majority of RAMs focused on developing IBA outside of the conventional GP practice context (implementation in primary care was supported through the Direct and Local Enhancement Schemes), one RAM reported caution about this by stating that “*the main evidence base for IBA was in primary care and Accident and Emergency settings*”. This team had therefore tried to rein-in attempts to develop IBA in other settings, arguing that resources needed to be prioritised for those approaches that had the best evidence base.

Available evidence appears to support this approach. A Cochrane review of 29 randomised controlled trials of brief alcohol intervention in practice-based primary care and accident and emergency departments reported a significant reduction in weekly alcohol consumption at one-year follow-up compared to various control conditions such as assessment only, treatment as usual and written information. Also the review found no significant benefit of increased treatment exposure during interventions (Kaner *et al.*, 2007). However, it should be noted that under the umbrella term of brief interventions a range of treatments were included in the review from structured interventions such as Cognitive Behavioural Therapy and Motivational Interviewing to self-help materials, delivered by practitioners with different levels of training and

professional backgrounds. Also the number of sessions ranged from one to five, and their length varied from one to 50 minutes.

Additionally, some local respondents admitted that they did not trust the evidence base behind the recommendations for an “*industrial roll out*” of IBA to settings other than primary care and A&E. One local policy contact sought academic advice warning that the evidence base for the HIC was not conclusive:

I will say that the industrial roll out of IBAs is not evidence-based. We have a local IBA expert; their advice was that the 5 minute stuff was not worth doing. So the idea that we should roll it out left right and centre was not evidence-based so that is why we have not covered or pushed into different areas... The evidence base for IBAs is pretty confusing; they have chucked together information on 5 minute sessions with 4 sessions of 30 minutes intervention in some of the meta analysis... but it's a completely different animal if you give a 5 minute brief advice compared to 4 sessions lasting half an hour!
[Local Policy Contact].

The view expressed above was in the minority. The majority of local policy contacts did not criticise the industrial roll out of IBA, rather the perceived strength of the evidence was viewed as a reason to prioritise this HIC.

[IBA was prioritised] because of the general body of evidence which made it seem like the thing to do... [Local Policy Contact].

However, centrally the alcohol policy team were aware that there were gaps in the evidence base around IBA and had commissioned the Screening and Intervention Programme for Sensible Drinking (SIPS) project to identify the most effective methods of targeting screening and the best forms of brief advice in various settings (Lavoie, 2010).

I mean there had been 56 controlled trials on brief advice, but many of them used different tools, different intervention techniques, some brief advice it's half hour, some it's five minutes, some it's two sessions or an hour and a half each or something. So the problem with both the word 'screening' and the word 'brief advice' is that they're huge umbrella terms. Which screening tool works best in which setting? That's part of the SIPS investigation and which form of brief advice works best in which setting? [Central Policy Contact]

Recent findings emerging from the SIPS project which comprised randomised controlled trials in emergency departments, GP surgeries and probation offices suggests that IBA is effective and cost-effective in reducing alcohol consumption and related harm in non-treatment seeking high risk drinkers (Drummond & Deluca, 2012). Although brief advice shows promise in terms of reducing drinking behaviour, it was highlighted that implementation in routine practice proved difficult with workload pressures, lack of knowledge and

feeling that there was insufficient alcohol service provision cited by staff as barriers. In emergency departments and in probation settings, failure to implement was the norm and even with incentivised per patient payments, four in every ten primary care practices were unable to implement IBA (Drummond & Deluca, 2012).

Social Marketing

One of the functions of the RAM teams was contributing to local social marketing initiatives for the regions they covered. Social marketing is broadly defined as the “application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of society” (Andreasen, 1995, p.7). DH’s commitment to social marketing was first expressed in 2004 in the *Choosing Health* white paper (DH, 2004). The Department recognised the “power of social marketing” which applies the mechanisms of marketing “to build public awareness and change behaviour.” *Signs for improvement* loosely defined social marketing as the systematic application of marketing (for example, direct marketing materials, wall charts and fact sheets for GPs, self-help booklets), alongside other concepts and techniques, to achieve specific behavioural goals, for a social good. For alcohol, the goal is to reduce alcohol-related hospital admissions by influencing those drinking at higher risk to reduce their use of alcohol to within lower risk levels.

Evaluation findings indicate that over three quarters of localities were involved in some sort of social marketing activities. However, support for social marketing was variable across regions and PCTs. Some of the RAMs were sceptical of the evidence base for social marketing and tended to dismiss its use:

I mean one of the big areas - and this is sort of national - is around social marketing and you know there is no evidence ... there is no evidence whatsoever that social marketing for alcohol has an impact, it just doesn't work. [RAM]

Doubts about the evidence base were not confined to RAMs and regional professionals. A number of PCT contacts were sceptical about the evidence base for the use and effectiveness of social marketing as were some national level policy players:

Well we have not really prioritised that. We don't think that the evidence base is there. [Local Policy Contact]

I think the evidence base was quite clear for IBA. It was very strong and clear, the evidence base for what works in terms of specialist treatment was quite clear. Social marketing, well to be honest, I don't think any of us really believed in it. We thought that the evidence base for social marketing was weak. [Central Policy Contact]

The above comments echo findings from the DH's National Social Marketing Centre which highlighted potential barriers to the uptake of social marketing in English PCTs. Lack of robust evidence and case studies was cited as a key issue, with a strong call from interviewees for evidence to show that social marketing could deliver results. Respondents also talked about the difficulties in generating 'hard' evidence (NSMC, 2009). However, within the alcohol field this evidence is not forthcoming with a review from Jones and colleagues suggesting that social marketing programmes for young people are ineffective (Jones *et al.*, 2007).

The Indicators: Selection of Evidence to Assess Effectiveness

Many of the RAMs and policy contacts emphasised the significance of having a PSA on alcohol and the role of the indicators in moving alcohol up the agenda of competing public health priorities at a regional and local level:

I think the biggest achievement was getting the PSA. I think if this does come to an end with the end of the AIP, I think at least they can walk away and say "well we definitely got alcohol on the agenda."

[RAM]

However, there was a high degree of ambivalence among the interviewees as to the indicators' reliability and importance. This may be due in part to the how the indicators were operationalised and the statistical assumptions underpinning the ARHA calculation reflecting a public health concern which unlike other AIP activities such as the HICs was not based on mobilisation of

the best available evidence. A range of criticisms was expressed. For some, NI39 and VSC26 were too narrowly cast and failed to embrace the broader range of alcohol-related harm implied by the PSA 25 vision. Another issue referred to by many was that as a Tier 3 target, VSC26 was simply too low priority and ignored by SHAs. Other respondents referred to the potential for the indicators to lead to perverse incentives: preventing hospital admissions by “*siphoning people off to GPs*” rather than actually reducing alcohol-related harms.

Notwithstanding this, the main source of frustration stemmed from the indicators’ measurement and the impact of partially attributable hospital admissions, including hypertensive diseases and cardiac arrhythmias. Some interviewees referred to “*wild fluctuations*” in ARHAs at PCT level. The reasons for these fluctuations were often in doubt but one frequent explanation put forward was that other health initiatives for conditions such as hypertension had impacted on alcohol-related disease. For instance, one local policy contact reported that a new ward specialising in hypertensive conditions had been established resulting in an increase in hospital admissions for hypertension, and due to the application of the alcohol-attributable fraction, an increase in the ARHA statistic for this PCT. In some areas, dramatic local fluctuations were put down to changes in the way in which conditions were being coded in particular hospitals. In others there was bemused bewilderment.

A number of RAMs mentioned that the complexity of these targets made the job of explaining them to others very difficult:

The indicator as with any indicator is fraught with problems and difficulties so I'm not saying it's perfect, but the mechanism itself allowed PCTs to look at this issue [alcohol-related hospital admissions]. [RAM]

These issues may explain why the North West Public Health Observatory (NWPHO) who produce ARHA statistics recently conducted a public consultation to review the methodology used to estimate alcohol related admissions.

Reflections on the Role of Evidence within the AIP

Evidence was mobilised in a number of ways in informing and implementing the AIP. The DH alcohol policy team in devising the HICs did look to available evidence to inform them but this was based on a broad conception of evidence which included empirical studies and systematic reviews in the case of specialist treatment and IBA; international research for advocacy; theory based and international models for partnership working and local practice-based evaluation data for AHWs and control. Social marketing appeared not to be based on evidence specifically from the alcohol field and given the competing influences on policy-making described in the introduction to this paper it is telling that:

Ministers were very keen on social marketing. [Central Policy Contact]

Economic modelling tools were developed to provide projections on the impact of HIC initiatives on alcohol-related hospital admissions and associated cost savings. Although economic evidence can play a crucial role in local commissioning negotiations, generally it was felt that the projections estimated were not sufficiently credible. This is a reflection of not having appropriate cost evidence available for the HICs which were not adequately supported by research evidence.

The HICs as a framework for prioritising action around alcohol were generally well received by local and regional informants with the assumed evidence base acting as a lever to promote senior 'buy in' and helping to legitimise spending on 'best practice' interventions. However, in contrast those closer to the development of HICs centrally began to have misgivings about some of the less evidenced HICs such as social marketing.

This view was reinforced by an exploration of the evidence base around social marketing which is lacking for alcohol. When other more evidenced HICs were looked at in detail there were also issues with the evidence base supporting them. In terms of AHWs, although there is emerging evidence of effectiveness for certain activities they perform such as IBA, there are many different models of working which may differ significantly from those which have been independently evaluated. Similarly with IBA even though research

evidence pointed to its effectiveness in primary care and A&E settings, what qualified as IBA was rather broadly defined in systematic reviews. To credit the DH policy team they did acknowledge this issue by commissioning an independent research project to address specific questions on how IBA should be best operationalised in practice.

The use of targets to assess the impact of the HICs provided a spur for action, but respondents reported that by focusing solely on alcohol-related hospital admissions these were too narrow to capture the wider influence of the various initiatives. Also because other health conditions impacted on the calculation of the ARHA statistic, actual improvements in alcohol-related harm may not have been reflected in the overall figure reported. This highlights an issue with target based measures which assume that the complexity inherent in real world issues can be equated with what the chosen metrics indicate is going on (Greenhalgh & Russell, 2009).

CONCLUSION

Williams and Glasby (2010) have challenged the domination of formal research and of data derived from quantitative research with randomised controlled trials as the 'gold standard'. They suggest that there is value in adopting a broader view of evidence which does not privilege some voices over others. A broader approach would include evidence derived from research along with understanding based on theoretical insights and, importantly, on the tacit knowledge of practitioners and the lived experiences of service users. They note that these different forms of evidence are rarely

reconciled. According to Williams and Glasby, the challenges of synthesising different types of evidence (or forms of knowledge) result in the expectation of adherence to 'scientific' knowledge because of the promise of simpler, more 'rigorous' principles on which to base policy decisions rather than because they necessarily result in better decisions or policies. Rigid hierarchies of evidence are, therefore, reinforced. Particularly when considering local level service delivery or policy implementation, experiential evidence may prove more convincing and useful than evidence drawn from international research studies – which are likely to be conducted in very different cultural and geographical contexts and over variable timeframes.

The range of perspectives on the credibility and usefulness of evidence underpinning the AIP illustrate – although not explicitly – the tensions noted by Williams and Glasby between 'scientific' and 'experiential' evidence (or knowledge), the ways in which local policy makers attempt to weigh up the relevance of forms of knowledge in decisions on local policy implementation, and how they try to 'translate' learning from international or national studies to the local context.

This paper examined a case study example of a government backed alcohol harm reduction policy programme which was based on evidence as far as it was available. On examination, this was a loosely defined notion of the term 'evidence' with some of the HICs supported by research evidence and others informed by the views of experts and by experience from practice. How evidence was operationalised in policy and commissioning documents

supports the contention by Petticrew and colleagues who contrasted the 'high concept' notions of evidence assumed by researchers, and the 'mixed economy' of evidence common in policy circles (Petticrew *et al.*, 2004). This is apparent from the policy case study as although the programme marked an important contribution to mobilising evidence and informing targets aimed at reducing alcohol-related harm, what constituted evidence was a much wider conception of the term to include expert opinion and examples of good practice.

The central policy team were committed to utilising 'scientific evidence' to inform the Alcohol Improvement Programme as encapsulated in the following quote:

We have to make a good case and base it on evidence. To get it in place in the first place in the general levers and framework of the NHS and the Department of Health, to persuade ministers that there's evidence behind this, but more importantly to persuade clinicians on the ground as well and PCTs, because they won't work without that. [Central Policy Contact]

Additionally, government funding was used to measure, monitor and disseminate alcohol-related hospital admissions data (evidence of harm and the social costs of alcohol misuse) demonstrating the political use of the production of evidence to activate action in the desired direction.

However, a lack of consensus was also observed between policy contacts whose views differed on the appropriateness and adequacy of the available research evidence: for example, whether international research or systematic reviews conducted in particular care settings were generalisable to inform national policy and practice. Also there were gaps in the evidence base when attempting to implement interventions to address the less evidenced HICs. Therefore, some PCTs conducted local evaluations of pilot initiatives to provide context specific evidence on implementation which was locally appropriate.

Finally, the use of indicators to measure the success of a policy programme assumes that what works is what can be measured (Crawford, 2001). However, a complex public health area such as addressing alcohol-related harm perhaps requires a more flexible approach to informing policy and practice than that based solely on a positivistic conception of research evidence. It may be that the newer concept of 'evidence informed' policy will be better suited to incorporating, and lending credibility to, knowledge and experience drawn from a wider range of sources and to opening up perceptions of what counts as evidence.

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