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Working with the police service and homeless services in North West England to reduce alcohol harms: A feasibility study of a tailored Blue Light approach

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ABSTRACT

Introduction: Deaths caused by alcohol are increasing in England and 80 % of people with alcohol use disorders (AUDs) are not in treatment. The Blue Light approach (Alcohol Change UK) is an initiative to support people with AUDs who are not in treatment. This study aimed to tailor the Blue Light approach (combined with alcohol identification and alcohol brief interventions [ABI] training) for police officers and homeless service staff in North West England, and to qualitatively evaluate the feasibility and acceptability of the training.

Methods: The Blue Light approach was tailored using co-production activities, based on Transdisciplinary Action Research. Full-day and half-day training sessions were delivered to the police (full-day $N = 14$, half-day $N = 54$) and homeless service staff (full-day $N = 11$, half-day $N = 32$), in local police stations and online (four half-day sessions). Semi-structured interviews ($N = 23$) were conducted to evaluate implementation and integration, analysing the qualitative data in line with Normalisation Process Theory.

Results: Four themes were identified, each with two to three sub-themes, reflecting: (i) the importance of training for working practice, (ii) implementation of the interventions, (iii) changes to relationships within and between organizations, and (iv) recommendations for further changes to the training. Differences in findings across the organizations (police versus homeless services) and by training type attended (full-day versus half-day, in-person versus online) are presented.

Conclusions: There is evidence to suggest that the training has provided worthwhile knowledge and intervention techniques that can become embedded into working practices. Nevertheless, structural barriers were apparent, primarily within the police service, with clear disparities between recognising the value of the training and what is achievable in practice, given the competing demands.

Introduction

In the United Kingdom (UK), 20 % of patients in hospital use alcohol harmfully and 10 % are alcohol dependent (Roberts et al., 2019). The direct costs of alcohol to the National Health Service (NHS) are estimated to be £3.5 billion annually (Williams et al., 2020). The recent Black review (Black, 2021) outlines the urgent need for better support and provision for people with alcohol and drug problems, highlighting years of funding cuts and a reduction in services. The impacts of these reductions will be even greater in areas of higher deprivation

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(Blackwood et al., 2021; Public Health England, 2020). Interventions differ depending on the individual's level of alcohol use, and alcohol identification tools, such as the Alcohol Use Disorder Identification Toolkit (AUDIT) (Babor et al., 2001), can be used to determine whether someone has a lower severity alcohol use disorder (AUD, i.e., hazardous use) or higher severity AUD (harmful or dependent use). Those with a lower severity AUD require prevention through alcohol brief interventions (ABI) (Heather et al., 2013), whereas those with higher severity AUD require more in-depth support (e.g., multi-agency working, harm reductions) and referral to specialist treatment services.

The police are often the first point of contact for alcohol-related injuries or crimes as approximately half their workload is alcohol-related (Institute of Alcohol Studies (IAS), 2015) and rates of AUD are high among users of homeless services (Fazel et al., 2014; Fountain et al., 2003). Individuals working in these services therefore have opportunities to deliver ABI and provide referrals to appropriate services. Findings from exploratory feasibility studies suggest that criminal justice settings are acceptable for delivery of ABI (Addison et al., 2018; Brown et al., 2010; Coulton et al., 2012). Yet many services in contact with individuals with AUDs, such as the police, do not have the relevant training or the appropriate networks to provide support which would consequently reduce the number of emergency admissions.

Alcohol Change UK developed the Blue Light approach, which is unique in providing a clear protocol for the provision of support for people with high severity AUDs who are not in contact with treatment services (described in supplementary materials, Table S1), including training professionals in harm reduction techniques and setting up multi-agency working (Alcohol Change UK, 2014). In this feasibility study, we tailored the existing Blue Light approach, combined with additional alcohol identification and ABI training (targeting those with low severity AUDs), towards non-healthcare organizations who have frequent contact with people with both low severity and high severity AUDs (i.e., the police service and homeless services), in North West England. We conducted a process evaluation, using quantitative data (sign-ups and attendance) and qualitative data from interviews with participants, using framework analysis and applying Normalisation Process Theory (NPT) (May & Finch, 2009). NPT can be used to understand how interventions become embedded in working practices, through four generative mechanisms: coherence (individually or collectively making sense of the work), cognitive participation (relational work to build and sustain new working practices, e.g., ensuring participants believe it is right for them to be involved), collective action (operational work to establish working practices, e.g., working with others to implement practices), reflexive monitoring (appraisal work to assess and understand new practices). These mechanisms promote or inhibit the normalisation of a practice in its contexts to generate outcomes (May & Finch, 2009; Murray et al., 2010).

This feasibility study aimed to (i) use co-production techniques with police officers, staff from homeless services and people with lived experience of AUDs to tailor the existing Blue Light approach; (ii) assess the feasibility of rolling out the Blue Light approach to police officers and representatives from homeless services to assess uptake of the training and acceptability; and (iii) examine the implementation and mechanisms of impact of the Blue Light approach, using NPT.

Methods

Design

We present a feasibility study of a tailored Blue Light approach (Alcohol Change UK, 2014), through four work packages (WP) involving the following activities: (i) tailoring the existing Blue Light approach for police and homeless services, (ii) delivering the training, and (iii) assessing the feasibility of this approach by conducting a qualitative evaluation and examining the acceptance rate for booking and attending the training. Fig. 1 presents an overview of each WP.

Context

We tailored the Blue Light approach for staff working in the Police

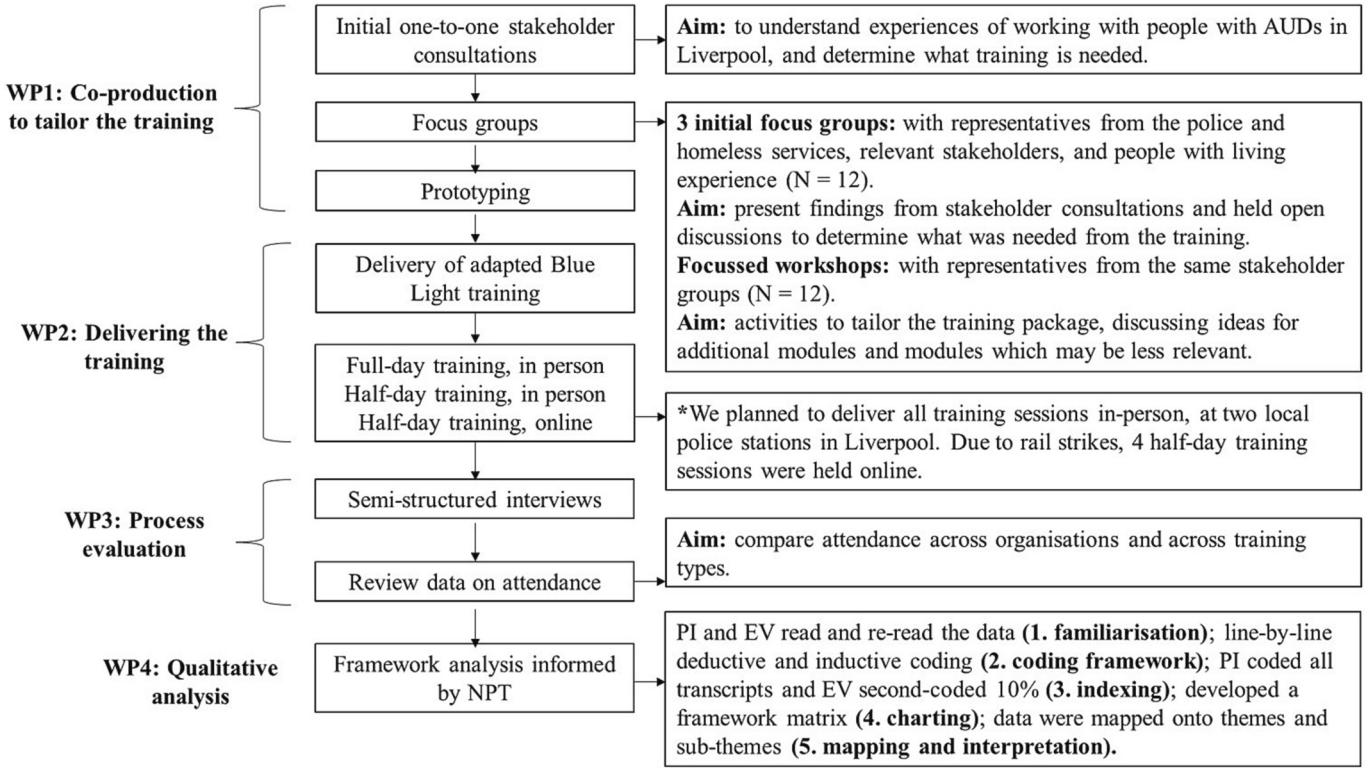

Fig. 1. Flow diagram presenting an overview of each stage of the feasibility study.

Service and three homeless services in North West England. WP1 involved three stages of (i) consultation, (ii) co-production and (iii) prototyping, based on the concept of Transdisciplinary Action Research (TDAR) (Hawkins et al., 2017). When developing the feasibility study, we held initial one-to-one stakeholder consultations to understand the current context and any existing initiatives (e.g., multi-disciplinary teams) with key representatives from relevant organizations, such as Merseyside Police Service, Liverpool City Council, clinical commissioning groups, and local drug and alcohol services. Co-production activities are described in Fig. 1, with focus groups and workshops being held between March–May 2022. Members of the research team reviewed the updated training materials (prototyping) and provided feedback.

Implementation plan

WP2 involved the delivery of the tailored training to representatives from the police and homeless services. Informed by WP1, we aimed to train police officers from key roles, such as response and neighbourhood policing, who may have more opportunities to implement training techniques. We sought to deliver full one-day training (which involved half a day of alcohol identification and ABI training, and half a day of the Blue Light approach) to approximately 50 people and to deliver half-day training (reduced version of the full-day training) on a larger scale to approximately 150 people, informed by the stakeholder consultations, as not all staff members would require the in-depth full-day training, and the half-day training would enable a greater number of people to attend. Consultations identified the need for a sustainable approach. We therefore organised a train-the-trainer session with a small number of representatives from police and homeless services who completed the training, to ensure the intervention techniques will be rolled out long-term by key representatives. A senior consultant from Alcohol Change UK delivered the training.

Process evaluation

We conducted a process evaluation for WP3, assessing the outcomes described in Table 1, in accordance with the Bowen framework (Bowen et al., 2009), as well as the processes involved in achieving these outcomes, aligning to NPT (May & Finch, 2009; Murray et al., 2010). Both the Bowen framework and NPT informed the development of the semi-structured interview schedules (available in supplementary materials). We assessed the outcomes from the quantitative data (demand – number of people who signed up and attended the training) and qualitative data obtained from staff from the police and homeless services who completed the training and senior representatives who implemented the training. NPT overlaps with the Bowen framework, as NPT seeks to identify and explain the mechanisms that promote the implementation and integration (two outcomes of the Bowen framework) of interventions, through coherence building (also relating to acceptability), cognitive participation (relevance to practicality), collective action, and reflexive monitoring (linked to adaptation). The study invited participants who attended the training and consented to further contact via email to participate in the interview. The study used convenience sampling at first, followed by purposive sampling to ensure sufficient inclusion of participants from both organizations. However, the interview sample may have been biased as a greater proportion of staff from homeless services volunteered for the interviews (33 % of those who attended training) than police officers/staff (13 % of those who attended training), despite the use of purposive sampling. Two female early-career researchers (PI, EV), with experience conducting qualitative interviews conducted interviews online via Microsoft Teams or Zoom (approximately one hour). With consent, we audio-recorded the interviews and transcribed them verbatim (PI, EV, ZG). Participants had the opportunity to review the transcript and received a £20 voucher.

Table 1
Description of outcomes (adapted from Bowen et al., 2009).

Acceptability	Interviews will assess practical aspects of attending the training, e.g., venue, timing, impact on other demands and responsibilities, as well as experiences of the training and usefulness/relevance to role.
Demand	Data collected on number of people who signed up and attended the training to assess acceptance rate for booking and dropout rates.
Implementation	Interviews will assess whether and how training techniques have been implemented.
Integration	Interviews will assess whether and how training techniques have been integrated into working practice and procedures.
Practicality	Interviews will determine whether the training fits within schedules and whether it is feasible to roll-out the training on a larger scale.
Adaptation	Interviews will determine if any further adaptations need to be made to the content or delivery of the training.
Expansion	Interviews and consultations with senior representatives will understand how similar approaches can be delivered in other regions.
Limited-efficacy testing	Consultations with senior representatives to see if there have been any changes to practice.

Analysis

For WP4, we analysed the qualitative data using framework analysis (Ritchie & Lewis, 2003), in NVivo 12, described in Fig. 1. Framework analysis is a commonly applied approach to health policy research, enabling the exploration of a priori and emergent codes to answer targeted questions in specific populations. We identified the coding framework using line-by-line deductive and inductive coding of an initial sample of transcripts. We applied NPT to the coding framework (May & Finch, 2009), as deductive codes were obtained from the NPT coding manual, e.g., cognitive participation - legitimation, coherence building - internalisation (May et al., 2022). We developed inductive codes through open coding (e.g., relevance to role). Given the overlap between NPT and the Bowen framework, many of the codes (both inductive and deductive) related to the outcomes of the Bowen framework (e.g., practicality of attending training). We resolved any disagreements in coding between PI and EV through discussions with a senior researcher (LG). PI and EV summarised the data from each transcript against each of the codes (charting) to produce a framework matrix (supplementary materials).

Ethics

Lancaster University's ethics committee provided ethical approval (FHM-2022-0691-RECR-2). Participants provided informed consent to attend the training and those who consented to further contact were invited to participate in the interview. Participants completed a separate consent form before completing the interview.

Results

Developing the intervention (WP1)

The stakeholder consultation highlighted a lack of existing training to support people with AUDs, particularly for police officers. The focus groups identified content for modules that were deemed the least relevant (e.g., legal powers) and additional modules or content that were needed (e.g., harm reduction approaches, co-occurring mental health problems, language around alcohol use and stigma). As this WP identified a need for alcohol identification and ABI, we expanded existing content relating to these topics and they became the focus of the first half of the training. In addition, we produced a document listing the AUDIT-C (Bush et al., 1998), 12 questions on physical harms, and relevant organizations for referrals (e.g., drug/alcohol services, mental health services). The research team developed three lived experience

videos using scripts from interviews with people with lived experience to supplement the modules. Informed by the co-production activities, we separated the training into two halves: (i) alcohol identification (i.e., using alcohol identification tools to determine an individual's level of alcohol use) and ABI, and (ii) Blue Light approach. An overview of the tailored training is in the supplementary materials (Table S2).

Delivery of intervention (WP2)

Senior representatives from the police service and homeless services worked with their organizations to invite staff who they perceived to work in relevant roles to attend the training, including police officers/staff with frontline roles and homeless services staff who frequently work with people with AUDs. We delivered the training between May–June 2022 to 68 members of the police service and 43 staff from homeless services (Table 2). We invited those who attended the full-day training to attend the train-the-trainer session, which was delivered in-person in July 2022 to six police officers (including one person who had not attended the initial training, which resulted from organizational challenges within the police service) and two staff from homeless services.

Process evaluation of intervention (WP3 & 4)

Researchers completed a total of 21 interviews (9 police officers/staff and 14 staff from homeless services) with participants who attended the training (PI $N = 16$, EV $N = 5$), in addition to two interviews with senior representatives (one from the police service and one from a homeless service) who helped to implement the training (both conducted by PI). We conducted the interviews during July and August 2022. Interview participant characteristics are in Table 3. We identified five themes from the data, each with two or three sub-themes, referring to the acceptability and importance of the training, changes in working practices following the training and potential challenges, and recommendations to adapt the training (Table 4). The themes and sub-themes are described below, with reference to relevant the components of NPT, and evidenced with quotes.

Theme 1. Importance of training for working practice

This theme relates to 'coherence building' (NPT), whereby participants make sense of the interventions in relation to their role (May, 2006). For participants who work in homeless services, the training was described as relevant to their roles and useful for their working practice, though many were already aware of a lot of the intervention techniques (e.g., incentive schemes) as the training aligned with their working practice.

> It was really interesting. It was a refresher for me, because I probably haven't done any of that training for about 8 years. It was really good to go over it and a lot of the information has changed from when I used to do it. (P5, female, homeless service).

> It's important because we have quite a core group [who]are running into significant, serious health issues. So, it's really important that we have strategies to work with that group. (P22, female, senior representative, homeless service).

For participants who work in the police service, there were varied responses about the relevance to their role and usefulness to working practice, depending on the team they worked in. One participant commented, 'I was quite surprised to be put on it initially… The training was interesting and eye opening, but not role-specific to the role that I am doing.' (P6, male, police service). Whilst others felt this training was beneficial to their role, 'I think any information in relation to that is always going to be useful because ultimately our patrols are going first at scene at incidents where people have got an addiction to alcohol.' (P23, female, senior representative, police service).

Training content preferences

This sub-theme outlines which of the two halves of the training (alcohol identification and ABI versus the Blue Light approach) were perceived as more important. The interventions surrounding alcohol identification and ABI were more relevant to police employees than the Blue Light approach, due to competing demands limiting their ability to

Table 2
Number of sign-ups, number of people who attended, and attendance rate for each training type, by organization.

Training type	Organization	Signed up	Attended	Attendance rate
Full-day (N = 3)	Police service	16	14	87.5 %
	Homeless service	13	11	84.6 %
Half-day (in-person) ($N = 4$)	Police service	40	32	80.0 %
	Homeless service	19	16	84.2 %
Half-day (online) (N = 4)	Police service	40	22	55 %
	Homeless service	22	16	72.7 %
Train-the-trainer [a] ($N = 1$)	Police service	8	6	75.0 %
	Homeless service	2	2	100.0 %

[a] Participants who attended the full-day training were invited to attend a train-the-trainer session. One participant from the police service attended the train-the-trainer session despite not attending the full-day or half-day Blue Light training.

Table 3
Participant characteristics and training attendance.

Participant characteristics		N	%
Gender	Male	7	30.4
	Female	16	69.6
Age	18–24	3	13.0
	25–34	3	13.0
	35–44	8	34.8
	45–54	5	21.7
	55–65	4	17.4
Organization	Police service	9	39.1
	Homeless services	14	60.9
Training type [a]	Full day (in person)	9	39.1
	Half day (in person)	7	30.4
	Half day (online)	5	21.7
	Implemented training	2	8.7

[a] The N/% of participants for full day (in person) training includes 1 participant who also attended the train-the-trainer session. The 'implemented training' refers to the one senior representative from the police service and one senior representative from a homeless service who helped to implement the training and were also interviewed.

Table 4
Summary of themes and sub-themes.

Themes	Sub-themes
1. Importance of training for working practice	Training content preferences 'I can see the value in this' vs 'This is what we should be doing'
2. Implementation of interventions	Intervention techniques that have been implemented Challenges to implementing interventions Changes in norms, attitudes, and stigma
3. Relationships within and between organizations	'Singing from the same hymn sheet' Changes in organizational working Further organizational support needed
4. Recommendations for further changes to training	Changes to implementation of training Changes to training content

engage regularly and follow up with people with severe AUDs. However, there were contrasting perceptions regarding whether the people they come into contact with are suitable for alcohol identification and ABI.

> We've got the night time economy in the city centre. I know it was said that people generally do lie about things like that, but it kind of gives you a better idea if you can work out how much someone has had, even if you just find them, like paralytic on the streets… you can try and work out how many units they've had. (P11, female, police service).

> The assessment of how much you drink, I think is a very rare sort of thing that we'd ever actually encounter… We don't really get the chance to do those sort of assessments with people. (P19, male, police service).

In contrast, staff who work in homeless services found the Blue Light approach relevant, as these organizations already use a lot of the intervention techniques. Whereas alcohol identification and ABI are less relevant to those who mainly work with service users with long-standing AUDs.

> I felt like the second part of the training, like the first part was obviously brief advice and that was amazing. But the second part, I felt it was really tailored towards what we actually do. (P16, female, homeless service).

'I can see the value in this' (coherence building) vs 'This is what we should be doing' (cognitive participation)

Understanding the importance of interventions, i.e., 'coherence building', can contrast with perceptions that organizations can or should actively participate in implementing the interventions, i.e., 'cognitive participation' (May, 2006). Across the interviews with police officers/staff, it was apparent that the training was worthwhile knowledge, and appeared helpful in reducing stigma, by providing a better understanding of why someone is in frequent contact with the police and how to handle situations better. However, participants also stated that police officers/staff may not be best placed to deliver the interventions.

> You have a little bit of power in the fact that there's a possibility that with how you speak to them, how you interact with them, they could make a positive change. Even if it's not 100 % lasting, even to get someone thinking is the important message because it's then in their hands. (P14, female, police service).

> It was quite interesting, but I think that would be more useful for intervention charities or organizations rather than the actual immediate intervention that you get from the police. (P18, male, police service).

Staff from homeless services recognised the value of the training, as it was tailored towards the people they work with, and it helped to reduce stigma and increase empathy (particularly within the police service). In addition, they think the interventions are what they should be doing in their working practice.

> I think that was so powerful to then build the empathy, especially for maybe police that don't get to hear that side so much, so that when they met somebody in the future that maybe they've previously thought there's no hope or there's no change in it, that might help build their empathy to think why they're in that position. (P7, female, homeless service).

> The training helped me to remember what I'd already done in the past and confirmed that what we are doing is being done in other services or asked to be done through the training. (P1, male, homeless service).

The senior representatives from both organizations saw the value of the training for improving the skills of their workforce to reduce alcohol harms and believed that the intervention techniques should be implemented into their working practices.

> I think we need to make it core rather than making it sort of something you can choose to dip into, I can't think of a role where you won't get exposed. (P22, female, senior representative, homeless service).

Theme 2. Implementation of interventions

The second theme demonstrates the implementation of the intervention techniques from the training, along with the challenges to implementing interventions. This theme also provides evidence of 'outcomes' resulting from the interventions, such as the changes in norms, attitudes, and stigma. This theme as a whole is reflective of 'cognitive participation' and 'collective action', as it demonstrates the work being done to enable the intervention to be put into practice.

Intervention techniques that have been implemented

There were mixed findings regarding the implementation of alcohol identification and ABI from police officers/staff. Many had not yet had opportunities to implement the intervention techniques due to their role (sub-theme 2.2), though some police officers/staff (usually police community support officers) were trying to implement ABI.

> I've used the brief advice, I've not yet used the AUDIT, but I have used the brief advice more. I think because we've been given a specific structure, I think it's a lot easier to then tailor to the different members of the community in need. (P14, female, police service).

There was evidence that participants from homeless services have been implementing the alcohol identification and ABI with new clients or people who have just started drinking harmfully, more so than before the training.

> I've had one person who's just started to misuse alcohol, so bringing that person back and being able to use the brief advice has been really helpful. Because I think if I hadn't done the training, we would be in a completely different situation to what we are now. (P16, female, homeless service).

Participants from the police service had more difficulties implementing the Blue Light approach due to the nature of their job being demand-generated and having less opportunities to sit down with someone or engage with people frequently/consistently (sub-theme 2.2). In contrast, participants from homeless services found the Blue Light approach easy to implement as this strongly aligned with the work they currently do, and they have implemented techniques (both individually and collectively with colleagues) such as incentive schemes, harm reduction approaches, and motivational interviewing. There was evidence that the training increased confidence and has already resulted in positive outcomes.

> I know it's helped me because I know even one of my clients already, I've moved them away from the strong beer to wine and that's a big plus, because he's not getting nowhere near as many units as he was. (P8, female, homeless service).

This finding was supported by the senior representative from a homeless service, who was aware of the training techniques being implemented and disseminated.

> One of my managers is [implementing interventions] and she works in the harm reduction service. She said that that she was going to then have team sessions specifically around what she learned. (P22, female, senior representative, homeless service).

Challenges to implementing interventions

Participants described the challenges to implementing intervention

techniques taught in the training. Police officers/staff from various roles (e.g., response and resolution, neighbourhood policing) described not having opportunities to implement the interventions due to the training techniques not being relevant to their role. Reduced resources mean that officers/staff often go from job to job and need to prioritise responding to crimes. There were also issues regarding referrals, as it is often unknown what happens to the person once they have been referred or whether they actually get seen by the service. This sub-theme corresponds with 'coherence building' and 'cognitive participation' (NPT), as participants try to understand whether they are able to implement the interventions within their role.

> It's just quite difficult because although we might see that person five times over because of the nature of our job, we go there probably because someone called to complain about them more than anything, so we've got to be mindful that we're trying to get them moved off the property for the person who's complained. (P11, female, police service).

The perspectives from police officers/staff demonstrate their challenges, but there is a broader drive to take a more preventative approach, as outlined by a senior representative from the police service.

> I think definitely response and resolution because they're the people that first go out. So, they're the people that first go to the job and then they would do referrals from there… I think there's still value in sending officers from local policing and early help teams. (P23, female, senior representative, police service).

Challenges for staff from homeless services stem from wider organizations or other frontline services not using the same intervention techniques. In addition, there are now reduced services meaning resources are stretched, and services are often quick to dismiss service users if they do not engage. It was commonly reported that it would be helpful for other services to receive the training, and there is a need for better partnership across organizations. This sub-theme aligns with the 'context' aspect of NPT, i.e., the environment shaping the ability to implement interventions.

> I think if we received a little bit more support from mental health services and GP services, and I know they are sort of strained with the things they have to do, but I think it would benefit the people that we work with. (P1, male, homeless service).

Changes in norms, attitudes, and stigma

Participants reported that the training resulted in increased empathy, changes in terminology and a better understanding of how to interact with people and how to use language effectively across both organizations.

> I think that people will decide to use different terminology, even if it was to come down to that, because I've never been told to not call someone an alcoholic. That's what I thought was the terminology to be used. (P3, female, police service).

For staff from homeless services, the training provided a better understanding of barriers to engagement, the benefit of harm-reduction approaches, and highlighted the importance of perseverance and consistency.

> We know they have got motivation, but they can't put it into action, but I wasn't always really sure why and because it's laid out very clear - all the contributing factors - so that's really made me think about it and I actually used that in arguments about a service user at an MGT meeting to say this is the reason why this person's not turning up for those appointments. (P5, female, homeless service).

Theme 3. Relationships within and between organizations

The training created changes in relationships across staff within one organization and across wider organizations including, for example, better partnership between the police service and homeless services. However, it was apparent that further support was needed from either participants' own organization or other organizations.

'Singing from the same hymn sheet'

This sub-theme relates to 'collective action', an NPT mechanism whereby people work together to enact the interventions (May, 2006). The phrase 'singing from the same hymn sheet' was repeated across interviews, to ensure interventions are being implemented across services. The benefits of organizations using the same tools allows transferability as service users engage with various organizations.

> If different services use different tools, I think things can be lost in translation. So, I think everyone singing from the same hymn sheet, everyone using the same tool, it makes it easier for communication… I think in the long run it's going to work out much better for people accessing the services. (P4, female, homeless service).

Senior representatives reiterated this finding and believed that the interventions should be embedded within their working practices, as should the partnerships with other organizations.

> Any sort of collaboration and partnerships where we're looking at preventative early help for people where it doesn't escalate, it basically can reduce our demand and what would become maybe a high-demand generator. (P23, female, senior representative, police service).

Changes in organizational working

Changes in organizational working were inconsistent across police officers/staff, as some believed the training was not relevant to their role. However, positive changes in working practice were clear among others, for example, gaining a better understanding of what the other organizations do, and establishing connections with key representatives across organizations. The training highlighted the need to work more closely with other organizations to build positive relationships with service users.

> It was interesting to look at the different ways that people would tackle it. It was interesting for us to put our input in and be like, well, we'd look at it like this. Then for people from outreach to be like, well, actually, we probably do it like this. (P11, female, police service).

Similarly, for homeless service staff, the training was useful for networking and creating links across police and homeless services in the area. Collectively, people thought that the interventions aligned with their working practice and highlighted the benefits of harm-reduction. Participants have disseminated information with other services that they work closely with, and supervisors have encouraged supervisees to implement the intervention techniques.

> We went off into groups at one point, doing little different ways of learning, in different mini teams, sort of thing. That was a good opportunity to meet different people and work with different services. Kind of network a bit, learn how they operate, how we operate. (P12, male, homeless service).

Further organizational support needed

Despite the positive changes in working practices and relational restructuring, for some, further organizational support was needed (corresponding with the 'context' component of NPT). For police officers/staff, there was still a lack of awareness of where referrals go and what services exist for people. They highlighted lack of time and

resources as a key barrier to implementing the training techniques, 'Realistically, it's just the time, I think that's the biggest thing' (P18, male, police service).

> The only sort of thing that we were all chatting and said, "well, where do they get this treatment?"… "Who do we ring and say we've got this problem person can you help them?" And then it's like, it's just the usual services with extra training. (P19, male, police service).

The training highlighted a lack of provision in the area for homeless staff and one participant said,

> I think this is where the all-systems approach comes in, that it can't just be down to one organization, they can't provide that level of intense support. (P9, female, homeless service).

Theme 4. Recommendations for further changes to training

As this is a feasibility study, we were interested in whether further adaptations to the training are needed. This theme aligns with the 'context' component of NPT, i.e., the systems and structures within and between settings which make up the implementation environment (May et al., 2016).

Changes to implementation of training

Some participants from the police service stated that the training was not relevant to their role and that in the future it should be more 'role-specific' (P6, male, police service), i.e., targeted towards those who have regular contact with the same people. However, the senior representative who helped implement the training selected participants to attend based on the relevance to their roles. These contrasting perspectives reflect a dissonance between what is considered important within the police service and what is achievable in practice, given the demanding nature of the role.

> We've got a lot of local policing teams that look at a lot of preventative policing. We try to mix it as well with sort of response and resolution, who are the first responders to jobs and people from early help teams as well. (P23, female, senior representative, police service).

Homeless services staff were enthusiastic of the training being rolled out to their organization and to other organizations, including organizations one may expect to have sufficient alcohol training.

> I would like them all to do that training because I think there isn't one service out there that couldn't take something away from that training. (P5, female, homeless service).

The senior representative from the police service faced more challenges in implementing the training than the senior representative from a homeless service, whose main challenge was allocating people to the different training types ('Working out who would benefit and actually then utilise the training.', P22, female, senior representative, homeless service).

> I think that one of the biggest challenges was because of the nature of the police is trying to get all of those people in one place at that time without there being any prior engagements or things that will pull resources away (P23, female, senior representative, police service).

Changes to training content

This sub-theme communicates 'reflexive monitoring' (NPT) as participants appraise the intervention components and offer suggestions for beneficial changes. Regarding the training content, participants from homeless services provided positive feedback with few suggestions for changes, except for additional group work, case studies, and lived experience. Similarly, participants from the police service had minimal suggestions for changes to the training content, though some expressed that the videos of lived experience portrayed the police service in a negative light.

> If we had done a few others that might have really helped to see how that might have looked like in different situations with different examples or heard maybe a few more of the others. (P7, female, homeless service).

There were mixed perceptions regarding the length of the training for participants from the police service, with some finding that the half-day training was rushed as there was a lot of information to get through, whereas others preferred the half-day training. Contrary to police officers/staff, homeless service staff desired the full-day training (for those who attended the half-day training), to allow more time to practice ABI, engage in further group work, and to discuss more case studies. Homeless service staff prefer in-person training.

> So, some of our team got it in person, and it feel like they maybe enjoyed it a bit more than we did online, which obviously is no-one's fault. I feel like, maybe for online it was a little bit long, but they're like face to face it would have been OK. (P15, female, homeless service).

Discussion

This feasibility study aimed to tailor and deliver the Blue Light approach (Alcohol Change UK, 2014) and additional alcohol identification and ABI training, for staff who work in the police service and homeless services, using co-production techniques. We conducted a process evaluation of the feasibility and acceptability of the training using quantitative data on sign-ups and attendance and qualitative data from interviews. Regarding demand, there were high attendance rates for the in-person training sessions (above 80 % for the full-day and half-day training across both organizations), but lower attendance at the online training sessions, with only 55 % of police officers/staff and 73 % of staff from homeless services attending. From the qualitative analysis, the study identified four themes, each with two or three sub-themes, demonstrating (i) the importance of training for working practice, (ii) implementation of interventions, (iii) relationships within and between organizations, and (iv) recommendations for changes to the training.

We encountered difficulties within the organizational process when signing up police officers/staff to attend the training due to the demand-driven nature of their work meaning they have to respond to emergencies. Confounding demands which impact attendance and the enactment of interventions suggest the need for negotiating capacity and reframing organizational structures, to ensure interventions become embedded in everyday practice (May et al., 2016). Among police officers/staff, there were differences between recognising that the training was important and worthwhile compared to beliefs that the interventions should be part of their working practice, consistent with previous research regarding issues in ABI implementation (Thom et al., 2016), whereas staff from homeless services recognised the importance and believed that the interventions should be incorporated within all services. Understanding the importance of interventions can contrast with perceptions that organizations can or should actively participate in implementing the interventions, i.e., 'cognitive participation' (May, 2006). The lack of cognitive participation can inhibit collective action and the routine incorporation of interventions into everyday practice, though this can be enhanced if individuals involved can see the immediate and longer-term benefits (Murray et al., 2010). There is a need for wider organizational change within the police service in communicating the importance of implementing the intervention techniques and in taking a preventative approach to alcohol harms.

This study found some evidence to indicate that participants are implementing the intervention techniques into working practice, demonstrating cognitive participation (NPT) (May, 2006). It was apparent that police community support officers were more likely than

police officers in other roles (e.g., response and resolution) to use ABI, stating that the training has increased their confidence in being able to engage with people with AUDs. This finding is imperative given that the prevalence of AUDs is significantly high (over 70 %) in police custody settings (Newbury-Birch et al., 2016) and 50 % of police officers/staff workload is alcohol-related (Institute of Alcohol Studies (IAS), 2015). In addition, we heard suggestions to incorporate the AUDIT-C into their existing vulnerable persons referral form to ensure alcohol identification is embedded into working practices. The Blue Light approach was difficult for police to implement due to challenges within their roles, e.g., fewer opportunities for regular and sustained engagement, highlighting structural barriers to cognitive participation (May et al., 2016). In contrast, this approach aligned with existing working practices of homeless organizations, but provided new insights, enhanced knowledge, and increased confidence. Interventions that are minimally disruptive of existing practices are more likely to become embedded (Murray et al., 2010). Changes in attitudes and stigma were clear outcomes, as the training appeared to result in changes in terminology used and generated a greater understanding of barriers to engagement faced by people with AUDs. This outcome is critical as stigma can be a barrier to treatment seeking (Hammarlund et al., 2018). We found evidence of relational restructuring, a key outcome of NPT (May et al., 2016), through changes in working relationships within each organization, across organizations, as well as with other organizations not involved in the training, similar to assertive outreach, which has been shown to be effective in reducing alcohol-related hospital admissions (Hughes et al., 2013).

It was apparent that the full-day training may be more suitable for homeless services, focussing on the Blue Light approach, whereas half-day training may be more appropriate for the police service, concentrating on alcohol identification and ABI. Across the interviews, participants were positive about the training being rolled out on a larger scale to their organization and other organizations. For the police service, if expanded, the training must be delivered to those in suitable roles (e.g., neighbourhood/local policing, response, and resolution units). The senior representative from the police service suggested that the training could be incorporated into new recruits' initial training programme, to ensure all employees take a preventative approach to intervene early to avoid harmful consequences, which is a priority of the Policing Vision 2025 (NPCC, 2016). Staff from homeless services suggested expanding the training to wider organizations, such as drug and alcohol services, mental health services, and GPs. The evaluation of this feasibility study suggests that expanding the training programme will be beneficial, with early evidence from other community-based approaches demonstrating that these interventions can be sustained to reduce alcohol-related harms (Ure et al., 2020).

The development, delivery, and evaluation of this feasibility study had limitations. Within the development stage, there was limited time for prototyping (Hawkins et al., 2017), and we were not able to share the tailored training materials with key stakeholders or people with lived experience to then make further changes. However, the training materials were reviewed by the research team. Additionally, the intervention delivered the training to fewer people than intended, highlighting structural challenges in recruiting police officers/staff, due to the demand-driven nature of their work, meaning they must prioritise responding to emergencies. We planned to hold all training sessions in-person, but rail strikes meant that some training sessions had to be held online, and these sessions had lower attendance rates, particularly within the police service where the facilities are not as suitable for online work (i.e., limited access to private computer spaces). There were challenges recruiting police officers/staff to take part in the interviews (9 interviewees out of 68 training attendees) compared with staff from homeless services (14 interviewees out of 43 training attendees), even after targeted recruitment, and more police officers/staff attending the training session. The evidence may be narrowed through social desirability bias, with participants providing responses they perceive will be desirable (Bergen & Labonté, 2020), and it is plausible that those who did not find the training useful were less likely to provide feedback.

Conclusions

The findings of this feasibility study are promising, with evidence to suggest that the training has provided worthwhile knowledge and intervention techniques that can be embedded into practices to support people with AUDs who are not engaged in treatment, to subsequently reduce alcohol-related harms. Nevertheless, structural barriers emerged, primarily within the police service, with clear disparities between recognising the value of the training and what is achievable in practice, given the competing demands. There is uncertainty regarding the sustainability of the implementation of interventions post-training, and longer-term follow-ups and additional outcome measures are required to provide more robust evidence to support firm conclusions of the impact of the training. These findings will inform further tailoring of the Blue Light approach and a formal evaluation of the implementation of interventions, to determine the impact on alcohol-related hospital admissions and/or crimes, and engagement with specialist alcohol services.

CRediT authorship contribution statement

Patricia Irizar: Conceptualization, Methodology, Formal analysis, Investigation, Resources, Visualization, Writing – original draft, Writing – review & editing. **Emily Vicary:** Methodology, Formal analysis, Investigation, Writing – review & editing, Funding acquisition. **Zoe Glossop:** Investigation, Resources, Data curation, Writing – review & editing, Project administration. **Gillian Waller:** Formal analysis, Writing – review & editing. **Carly Lightowlers:** Conceptualization, Methodology, Investigation, Writing – review & editing, Funding acquisition. **Zara Quigg:** Conceptualization, Methodology, Investigation, Writing – review & editing, Funding acquisition. **Louise Roper:** Conceptualization, Methodology, Investigation, Writing – review & editing, Funding acquisition. **Ian Gilmore:** Conceptualization, Methodology, Investigation, Writing – review & editing, Funding acquisition. **Simon Coulton:** Conceptualization, Methodology, Investigation, Writing – review & editing, Funding acquisition. **Dorothy Newbury-Birch:** Conceptualization, Methodology, Investigation, Writing – review & editing, Funding acquisition. **Laura Goodwin:** Conceptualization, Methodology, Investigation, Resources, Data curation, Writing – review & editing, Visualization, Supervision, Project administration, Funding acquisition.

Declaration of competing interest

None.

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Appendix A. Supplementary data

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References

Addison, M., Mcgovern, R., Angus, C., Becker, F., Brennan, A., Brown, H., … Hickman, M. (2018). Alcohol screening and brief intervention in police custody suites: Pilot cluster randomised controlled trial (AcCePT). *Alcohol and Alcoholism, 53*(5), 548–559. https://doi.org/10.1093/alcalc/agy039

Alcohol Change UK. (2014). Alcohol concern's blue light project: Working with change resistant drinkers. The project manual. https://s3.eu-west-2.amazonaws.com/files.alcoholchange. org.uk/documents/The-Blue-Light-Manual.pdf?mtime=20181118115002&focal=none.

Babor, T. F., Higgins-Biddle, J., Saunders, J., & Monteiro, M. (2001). *The alcohol use disorders identification test (AUDIT): Guidelines for use in primary care*. World Health Organization, Department of Mental Health and Substance Abuse.

Bergen, N., & Labonté, R. (2020). "Everything is perfect, and we have no problems": Detecting and limiting social desirability bias in qualitative research. *Qualitative Health Research, 30*(5), 783–792.

Black, C. (2021). *Review of drugs: Phase two report*. GOV.UK: GOV.UK.

Blackwood, R., Lynskey, M., & Drummond, C. (2021). Prevalence and patterns of hospital use for people with frequent alcohol-related hospital admissions, compared to non-alcohol and non-frequent admissions: A cohort study using routine administrative hospital data. *Addiction, 116*(7), 1700–1708. https://doi.org/10.1111/add.15354

Bowen, D. J., Moinpour, C., Thompson, B., Andersen, M. R., Meischke, H., & Cochrane, B. (2009). Creation of a framework for public health intervention design. In A. P. Association (Ed.), *Handbook of cancer control and behavioural science: A resource for researchers, practitioners, and policymakers*. https://doi.org/10.1037/14499-003

Brown, N., Newbury-Birch, D., McGovern, R., Phinn, E., & Kaner, E. (2010). Alcohol screening and brief intervention in a policing context: A mixed methods feasibility study. *Drug and Alcohol Review, 29*(6), 647–654. https://doi.org/10.1111/j.1465-3362.2010.00223.x

Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., & Bradley, K. A. (1998). The AUDIT alcohol consumption questions (AUDIT-C): An effective brief screening test for problem drinking. *Archives of Internal Medicine, 158*(16), 1789–1795.

Coulton, S., Newbury-Birch, D., Cassidy, P., Dale, V., Deluca, P., Gilvarry, E., … Oyefeso, A. (2012). Screening for alcohol use in criminal justice settings: An exploratory study. *Alcohol and Alcoholism, 47*(4), 423–427. https://doi.org/10.1093/alcalc/ags048

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: Descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet, 384*(9953), 1529–1540. https://doi.org/10.1016/S0140-6736(14)61132-6

Fountain, J., Howes, S., Marsden, J., Taylor, C., & Strang, J. (2003). Drug and alcohol use and the link with homelessness: Results from a survey of homeless people in London. *Addiction Research & Theory, 11*(4), 245–256. https://doi.org/10.1080/1606635031000135631

Hammarlund, R., Crapanzano, K., Luce, L., Mulligan, L., & Ward, K. (2018). Review of the effects of self-stigma and perceived social stigma on the treatment-seeking decisions of individuals with drug-and alcohol-use disorders. *Substance Abuse & Rehabilitation, 9*, 115. https://doi.org/10.2147/SAR.S183256

Hawkins, J., Madden, K., Fletcher, A., Midgley, L., Grant, A., Cox, G., … Bonell, C. (2017). Development of a framework for the co-production and prototyping of public health interventions. *BMC Public Health, 17*(1), 1–11. https://doi.org/10.1186/s12889-017-4695-8

Heather, N., Lavoie, D., & Morris, J. (2013). Clarifying alcohol brief interventions: 2013 update. https://ranzetta.typepad.com/files/clarifying-alcohol-brief-interventions-2013-update.pdf.

Hughes, N. R., Houghton, N., Nadeem, H., Bell, J., Mcdonald, S., Glynn, N., … Walters, M. (2013). Salford alcohol assertive outreach team: A new model for reducing alcohol-related admissions. *Frontline Gastroenterology, 4*(2), 130–134. https://doi.org/10.1136/flgastro-2012-100260

Institute of Alcohol Studies (IAS). (2015). Alcohol's impact on emergency services. https://www.ias. org.uk/uploads/Alcohols_impact_on_emergency_services_full_report.pdf.

May, C. (2006). A rational model for assessing and evaluating complex interventions in health care. *BMC Health Services Research, 6*(1), 1–11. https://doi.org/10.1186/1472-6963-6-86

May, C., & Finch, T. (2009). Implementing, embedding, and integrating practices: An outline of normalization process theory. *Sociology, 43*(3), 535–554. https://doi.org/10.1177/0038038509103208

May, C. R., Albers, B., Desveaux, L., Finch, T. L., Gilbert, A., Hillis, A., … Mair, F. S. (2022). Translational framework for implementation evaluation and research: Protocol for a qualitative systematic review of studies informed by Normaliza- tion process theory (NPT). *NIHR open research, 2*, 41. https://doi.org/10.3310/nihropenres.13269.1

May, C. R., Johnson, M., & Finch, T. (2016). Implementation, context and complexity. *Implementation Science, 11*(1), 1–12. https://doi.org/10.1186/s13012-016-0506-3

Murray, E., Treweek, S., Pope, C., MacFarlane, A., Ballini, L., Dowrick, C., … O'Donnell, C. (2010). Normalisation process theory: A framework for developing, evaluating and implementing complex interventions. *BMC Medicine, 8*(1), 1–11. https://doi.org/10.1186/1741-7015-8-63

Newbury-Birch, D., McGovern, R., Birch, J., O'Neill, G., Kaner, H., Sondhi, A., & Lynch, K. (2016). A rapid systematic review of what we know about alcohol use disorders and brief inter- ventions in the criminal justice system. *International Journal of Prisoner Health*. https://doi.org/10.1108/IJPH-08-2015-0024

NPCC. (2016). Policing Vision 2025. https://www.npcc.police.uk/documents/Policing%20Vision.pdf.

Public Health England. (2020). Alcohol-attributable fractions for England: an update. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/958648/RELATI_1-1.pdf.

Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers*.

Roberts, E., Morse, R., Epstein, S., Hotopf, M., Leon, D., & Drummond, C. (2019). The prevalence of wholly attributable alcohol conditions in the United Kingdom hospital system: A systematic review, meta-analysis and meta-regression. *Addiction, 114*(10), 1726–1737. https://doi.org/10.1111/add. 14642

Thom, B., Herring, R., & Bayley, M. (2016). The role of training in IBA implementation beyond primary health care settings in the UK. *Drugs: Education, Prevention & Policy, 23*(5), 374–381. https://doi.org/10.1080/09687637.2016.1195792

Ure, C., Burns, L., Hargreaves, S. C., Coffey, M., Audrey, S., Kenth, K., … Cook, P. A. (2020). Mobilising communities to address alcohol harm: An Alcohol Health Champion approach. *Perspectives in Public Health, 140*(2), 88–90. https://doi.org/10.1177/1757913919899700

Williams, R., Aithal, G., Alexander, G. J., Allison, M., Armstrong, I., Aspinall, R., … Burton, R. (2020). Unacceptable failures: The final report of the lancet commission into liver disease in the UK. *The Lancet, 395*(10219), 226–239. https://doi.org/10.1016/S0140-6736(19)32908-3