Coaching for confidence:
A study of the impact of training GAA coaches to conduct brief interventions for alcohol use.

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Dissertation submitted to National University of Ireland Galway in part fulfilment of the requirements for the degree of M.A. in Health Promotion by Minor Dissertation

School of Health Sciences
Discipline of Health Promotion
National University of Ireland, Galway
2013

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Acknowledgements

With the likelihood of unwittingly offending others unmentioned, I would like to acknowledge the following people out of the many who have helped me complete this thesis.

The ASAP Officers at Provincial, County and Club level throughout the 32 counties and abroad for going out there and doing all the work that I only talk about.

Ciara McHugh Murphy my favourite daughter.

Colin Regan for his great energy, enthusiasm and for being one of the really good guys.

Dara McHugh Murphy my favourite son.

Dr Saoirse Nic Gabhainn, my dissertation supervisor, for being so cool and so warm at just the right times.

James O’Shea and Paul Goff for their generosity of spirit in sharing the SAOR model, for sharing their time and expertise so freely and for being great fun to be around.

Paraic Duffy, Director General of the GAA for his support in completing this thesis. It wouldn’t exist without him.

Sarah McHugh Murphy my favourite daughter.

Vincent O’Loughlin for all his help with referencing. Now we’re quits.
Dedication

This is for Anna. Most of what I do is.
Abstract

Sports participation, particularly team sports, appears to discourage illicit drug use and promote harmful alcohol use. Drinking patterns among team members often revolve around team training sessions and games and are inclined to involve higher levels of binge drinking. This study was designed to answer the research question ‘Can a single health education session increase the likelihood of sports coaches performing brief interventions for problematic alcohol use with their athletes?’

The Gaelic Athletic Association (GAA) provided four groups of coaches with a two-hour training course in how to intervene with players who may be experiencing problematic alcohol use using the SAOR model of brief intervention. Quantitative and qualitative data were gathered using pre-training questionnaires and follow up survey data were collected one week later via email.

Regardless of the level of coaching qualification, coaching experience or prior experience intervening with players about alcohol use coaches reported increased confidence to intervene with players about their alcohol use after completing the intervention. Training coaches to perform brief interventions for problematic alcohol use may be a productive exercise to reduce alcohol related harm and promote health.

Keywords: brief intervention, alcohol, training, sport, coach, GAA
Introduction

For, usually and fitly, the presence of an introduction is held to imply that there is something of consequence and importance to be introduced.

- Arthur Machen

Context for thesis

Speaking to people about our concerns about their alcohol use is not easy. It can be uncomfortable through not knowing what to say and even if one knows what one wants to say, fear of causing offence may prevent it from being said. However the words have been found and can be learned and it appears that people don’t mind being asked about their drinking if it is done in a manner that they find non-threatening (Wallace & Haines, 1984), (Richmond et al. 1986).

One such way of talking to people about their alcohol use is to use a short, structured and supportive conversation more commonly referred to as a Brief Intervention (BI). Among health promoting actions BI’s are widely regarded and internationally recognised a valid, cost effective and helpful way to address alcohol consumption related problems. A Cochrane Collaboration meta-analysis of 29 randomised control trials of a variety of BI models for addressing alcohol use among participants with an average weekly consumption of 306 grams of alcohol found that at one year follow up the BI group were drinking less than the control groups. The average difference was 38 grams per week, with range of 23 to 54 grams (Kaner et al. 2007).

Extensive evidence has been endorsed and promoted by the World Health Organisation (WHO) showing when organisational factors are aligned to provide BI in a structured and consistent manner, alcohol related harm is reduced (WHO, 2010). Within an Irish context the 2009 Interim National Drugs Strategy (NDS) recognised that brief interventions for alcohol could be used in both specialist addiction treatment services and in non-specialist settings including probation
services, GP’s, Garda Síochána and emergency departments (National Drug Strategy, 2009, p.42). In addition the NDS goes on to recommend;

> Many sports and youth organisations have substance misuse policies in place or in development. The Steering Group considers that there is a need to further promote the development of substance misuse policies in these settings, along with the development of a brief interventions approach, where appropriate (ibid, p.99).

**Background to study**

The specific setting in which the central study of this thesis takes place is the Gaelic Athletic Association (GAA). The GAA has since 2006 developed a health promotion project, entitled the Alcohol and Substance Abuse Prevention (ASAP) Programme and this initiative forms the background for the study of brief interventions at hand. In a survey conducted by the ASAP Programme 347 coaches reported on their experiences of alcohol related problems among GAA players. A total of 52% of coaches had dealt directly with the problems of alcohol and other drug use amongst their players and yet only 6% expressed a high confidence in their abilities to successfully handle these situations. Furthermore 84% of participants expressed a willingness to attend training on how to respond to such issues (Murphy & Gottsche, 2010). It was apparent that alcohol related problems were present among GAA players and that coaches had a desire to respond to them in a meaningful way. The GAA subsequently agreed to undertake the further investigation, development and delivery of a brief intervention training programme which led to the germination of this thesis.

The research question ‘Can a single health education session increase the likelihood of sports coaches performing brief interventions for problematic alcohol use with their athletes’ was formed to frame this investigation and the details of the structure and process behind its’ design and execution will be elucidated herein. Attempting to find an answer to this question is both important and relevant. Its importance is derived from the opportunity to discover if such an intervention could be used to reduce the harm associated with alcohol consumption. Should such an inference be made the potential to promote the health and wellbeing of GAA members is not insubstantial. Its relevance is drawn from the higher than average
level of alcohol use among athletes who take part in team sports (Pate et al. 2000) and the GAA is no exception to this (O'Farrell, 2010). This thesis will describe in detail a piece of research where GAA coaches were taught to address their concerns about athletes alcohol use to them both directly and sensitively using a BI format.

The sample and intervention
In order to better understand the people who chose to participate in this study, a pre-training survey was designed to enquire about the activities, qualifications, experience, motivations and needs of GAA coaches in relation to alcohol related issues. This had the added benefit of avoiding asking questions that were only problem focused in nature and led to a gradual revelation of coaches’ opinions on alcohol and their experience of and confidence in addressing alcohol related problems with players. By contrast, the post-training survey delivered one week after the intervention enquired about coaches’ experience of the training course and what they had gained as a result of completing the training before asking them to outline what they else they needed to assist them to respond to players with alcohol related issues.

The intervention was a two-hour education session that introduced coaches to the SAOR model of brief intervention with the intention of providing them with the necessary information and skills to positively affect their confidence to intervene with GAA players who they were concerned may have alcohol consumption related problems. It is worth noting that the SAOR model was chosen as it appeared to have the best cultural fit for GAA purposes. This may have been because the SAOR model was developed in Ireland and its' language and general tone was more familiar than other BI models that originated elsewhere. As part of the follow up survey coaches were asked to report again on their level of confidence to intervene with a player with an alcohol related problem. This measure was central to the research question as the hypothesis being tested was that coaches who completed the training in how to perform a brief intervention for alcohol would be more confident and therefore, more likely to do so.
Thesis structure

The data gathered from the surveys will be presented on which to build a platform to draw conclusions and make recommendations for further actions. Noteworthy changes in favour of the hypothesis occurred across each of the measures throughout the research fields including the crucial measure of coaches’ reported confidence to intervene with players experiencing alcohol related difficulties. Using charts, tables and text the Results chapter will detail a range of other measurements across the variety of topic areas and conjecture connections between them and the experiences of the participants.

The choice to write inclusively about the range of factors common to various BI models was taken over the option of rating their individual efficacy to attempt to find an approach which would reign supreme. As a result the reader will be guided through the topic of brief interventions and ways to frame conversations about alcohol related concerns using elements that are universal to a number of models (Graham & Fleming, 1998), (Miller & Sanchez, 1993). This theme will be developed while alluding to Motivational Interviewing (MI) for some guidelines used when addressing a person about their alcohol related issues. In addition some detail will be entered into to help dispel some of the confusion that has been created by poorly researched papers that have misconstrued the differences between brief interventions and MI.

Throughout this thesis the reader would be well advised to remember that in the execution of a BI, or any other action aimed to cause individuals to give thought to altering their alcohol use, there is ultimately only one agent of change, the individual drinker. The change that takes place in a person to move away from being a harmful drinker may be initiated by outside forces but the choice to remain in that position is ultimately an internal and individual one as all change is fundamentally self change (Prochaska & DiClemente, 1983).
Thesis objectives
The objectives of this thesis are fivefold and help form the structure of the following chapters. The objectives are:

* To outline a range of harms related to alcohol use and compare consumption levels between athlete and non athlete populations.
* To describe the development of the GAA ASAP Programme and the subsequent growth of health promotion initiatives in the Gaelic Athletic Association.
* To detail the origin and efficacy of brief interventions and clarify the differences between brief intervention and motivational interviewing.
* To examine if coaches who completed the training in how to perform a brief intervention for alcohol use would become more confident about doing so.
* To draw conclusions and make recommendations as to how the findings can be developed and implemented in a manner likely to reduce alcohol related harm and promote health.
Chapter One

Alcohol
Alcohol

"To alcohol! The cause of... and solution to... all of life's problems"
-Homer J Simpson

Alcohol and harm
Before delving the issues that are specific to coaches and athletes in a sports setting, it is worth considering the impact that alcohol consumption has upon the wider population. Drinking alcohol is something that most people have done. According to the World Health Organisation (WHO) Global Status Report on Alcohol in 2011 those who have never drunk alcohol are in the minority at 45% (WHO, 2011). From the majority who have drunk alcohol, 2.5 million people die every year as a result. Alcohol results in 4% of all deaths worldwide and almost 9% of all deaths in the 15 to 29 age group. The World Health Organisation has identified alcohol use as one of the leading causes of mortality and ranks it as the worlds 3rd largest risk factor for disease burden and the 2nd in Europe (WHO, 2013). Alcohol use is also directly associated with innumerable other individual, familial, social, industrial and economic costs (Hope, 2008). The association between alcohol and negative outcomes on individual physical, mental, and sexual health is well documented as is the impact on the family, friends and the wider community of the drinker (Mongan, 2007).

Alcohol related harm in Ireland
The harms that have been linked to alcohol use are many and varied yet societal tolerance of such a wide array of harm appears to exist alongside these. This may be due to the many roles that alcohol has within Irish society ranging from those of emotional comforter, celebratory vehicle, religious symbol, relaxant, de-stressor, employment provider, tourism generator and all round social lubricant. It may be that because of the continuing range of uses of this product that it remains broadly acceptable in Irish society. Tobacco was probably that most recent example of a product that was seen to have similar social, economic and personal benefits before recent cultural changes made it less socially acceptable.
Ireland has in recent years, surpassed every other country in Europe with regard to instances of binge drinking (consuming 5 or more standard drinks on one occasion) among young people and both the level and pattern of Irish alcohol consumption have been directly related to significant harms to individual drinkers and the people who they come into contact with (Hope, 2007). In addition to interpersonal harms, alcohol use is associated with other harms as outlined in Table 1 below.

**Table 1. Categories of alcohol related harm.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Harms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical harms</td>
<td>Mouth, larynx, oesophagus, liver, colorectal and female breast cancers, accidents, injuries, chronic ill-health, premature death, alcoholic liver disease, alcohol dependency or alcohol poisoning and cirrhosis of the liver.</td>
</tr>
<tr>
<td>Psychological harms</td>
<td>Suicidal behaviour, psychosis, depression, anxiety and addiction.</td>
</tr>
<tr>
<td>Economic harms</td>
<td>Presenteeism and absenteeism at work, lower productivity, work related accidents, increased illness related costs, health service expenditure and criminal justice system costs.</td>
</tr>
<tr>
<td>Social harms</td>
<td>Noise disturbance, increased demands on health and social services, public order problems and community dysfunction.</td>
</tr>
<tr>
<td>Interpersonal harms</td>
<td>Relationship problems, road traffic accidents, public safety, violence, child neglect, foetal alcohol spectrum disorder, abusive behaviour, drink driving and homicide.</td>
</tr>
</tbody>
</table>

**State responses to alcohol related harm**

Considering the breadth of problems with which alcohol consumption has been correlated it will be of little surprise to the reader to learn that a wide range of political, legislative and operational measures have been employed to reduce these harms. At a national level, a range of policies have been developed from the earliest in 1945 when the Mental Treatment Act (Government Stationery Office,
1945) was instigated through to the current Interim National Drug Strategy 2009 – 2016 (National Drugs Strategy, 2009) and towards the anticipated National Substance Misuse Strategy. These documents provide a framework for legislation to be drafted and enacted to reduce the harms associated with alcohol use. Within the context of this legislation state funding was provided to develop prevention, education and treatment initiatives over a 70 year period to reduce the negative impact of alcohol consumption within Irish society (Butler, 2002). Despite the influence that these initiatives have had upon the drinking landscape, the problems that remain are significant.

**Alcohol and sports participation**

It is well documented that participation in sport has benefits which include an increase in physical fitness and health (Thorlindsson 1990, Riddoch 1998, Sallis 1994, Sallis & Owen 1999). As well as this, adolescents who take part in sports often rate themselves healthier than inactive adolescents. (Balaguer et al. 1997, Vilhjalmsson & Thorlindsson 1998). Balaguer et al. (1997) find that participation in sport advocates a healthy lifestyle and minimises risky behaviours. Participants in sport appear to believe that by participating they are automatically healthier than people who do not participate. It may be that due to this belief that participation in sport also has a strong link with positive health outcomes, functional capacity, positive mood and general wellbeing (Plante & Rodin 1990, Warburton et al. 2006). The importance of this should not be overlooked as it highlights the association between exercise and health and the impact it has on participants perceived health status. In addition to the physical and mental health benefits, sports participation also teaches participants about the value of rules, discipline, responsibility and fair play.

As will be outlined below in detail multiple studies have proclaimed that participation in sport leads to lower rates of substance use but on closer inspection it would appear that tobacco and illicit drug use are reduced while alcohol consumption remains unaltered. Rates of alcohol use tend to be at least the same and usually greater among sports participants compared to non participants. The extent of this finding would appear to have regularly overlooked. Ferron et al. (1999) examined findings from a Swiss national survey on adolescent health
behaviours which included participants sporting activities, use of tobacco, alcohol and illicit drugs use alongside a number of other variable including seat belt use, self image, and sexual behaviours. The data was drawn from a postal survey that was distributed among 10,000 adolescents (aged 15-20) and had notably high return rates of 95%. From the data they drew findings that showed a lower use of tobacco and illicit drugs among those who took part in sports compared to those who did not. With the exception of wine, sports participants drank more types of alcohol than non-participants. With regards to wine consumption both sports participants and non-participants drank equal amounts. This may be accounted for by cultural reasons that are specific to Switzerland as wine would be regularly consumed with meals.

In a nationally representative sample of 14,221 US high school students (Pate et al. 2000) measured the prevalence of sports participation and how it related to tobacco alcohol and illegal drug consumption. They also measured sexual activity, violence, weight loss practices, and other dietary behaviour. One of the key findings showed lower tobacco and illegal drug use in males that took part in sports across three ethnic groups compared with their non-participating counterparts. However, alcohol use was higher among athletes in all three ethnic groups. This is a noteworthy finding considering the breadth of the study and that there was considerable variety amongst other health behaviours.

Wichstrom and Wichstrom (2005) analysed the substance use behaviours of 3251 Norwegian high school students aged 13 to 19 years in a longitudinal study beginning in 1992 and finishing in 1999. Not only did they find higher rates of alcohol use among athletes during adolescence but they noted that young people who took part in sports were more likely to have higher rates of alcohol intoxication throughout adolescence and into their early adult years. One of the strongest findings from the study was the differences that were outlined between the types of sport, with participants of team sports showing significantly higher rates of alcohol use than athletes who took part in individual sports.
A similar finding was reported by O’Farrell et al. (2010) from the study of 960 Gaelic Athletic Association (GAA) players aged 16 and upwards. Players had significantly higher rates of binge drinking and alcohol related harms than their age and social class counterparts. Interestingly, the days on which the binge drinking and resulting harms took place correlated with player’s training sessions and games. Upon further analysis it became evident that following training or matches team members would routinely go drinking together, often to excess and this in turn led to the alcohol related harms. Once again smoking was found to be lower amongst GAA players than non-participants in the wider population and in this instance participants were not asked about their illicit drug use. Independent of the research that was being undertaken by O’Farrell et al. the GAA initiated the Alcohol and Substance Abuse Prevention Programme in response to members concerns about substance use. It has since developed a comprehensive response to preventing drug related problems throughout its network of sports clubs.

With regard to elite athletes the picture remains the same. Hildebrand, Johnson and Bogle (2001) found that adolescents who participated in elite sport engaged in a larger amount of alcohol and drug use than adolescents who participated in recreational sport. The commitment of elite athletes is such that they may not consume alcohol over periods of time to fit in with their training regimen but when they do drink they may justify their higher consumption levels as ‘catching up’.

Dams-O’Connor, Martin and Martens (2007) found that athletes believed that non-athletes consumed more alcohol per week than they did and these assumptions justified ‘catching up’ behaviours. Thus, even if athletes were consuming the same as non-athletes, they are more likely to believe they are not and are at greater risk of binge-drinking (Toben & Wechsler, 2001).

Ford (2007) identifies the focus that team sports place on (i) team bonding and (ii) the intensity of competition as two factors that “make it a fertile ground for the growth of alcohol and drug use”. Smith et al. (2010) describe how players spoke of the tribal culture that sport has and the social bonding that team sports provide. This social bonding was reinforced by regularly drinking alcohol with team mates. The participants of the study believed alcohol was a ‘legitimate vehicle towards
social cohesion and thought it to be relatively harmless’. Alcohol use was found to be a normal part of the experience of being part of a team. While participants viewed alcohol as a vital aspect of team bonding they also acknowledged two other uses within a team setting, its importance when celebrating a victory and its use to jointly commiserate a loss.

It would appear that for many teams, the use of alcohol has become central in how team sports create cohesion, maintain bonds and respond to success and failure on the playing field. Despite differences in the type of sporting activity, remarkably similar findings are replicated in multiple studies including Lorente et al. (2003), Nattiv & Puffer (1991), Martin (1998), Martens, Dams-O’Connor, & Beck (2006), Martens et al. (2001), Leichliter et al. (1998), Kunz (1997), Kirckcaldy et al. (2002), Hildebrand et al. (2001) and Grossbard et al. (2009).

From this review it would emerge almost universal that while participation in sport has many health benefits and is positively correlated with lower rates of tobacco and illicit drug use that it is linked with higher rates of alcohol use. It may be that the relationship between sport and alcohol is symbiotic and often damaging.
Chapter Two

The Gaelic Athletic Association
The Gaelic Athletic Association

The miracle of the GAA is that it works so well despite itself. Paranoia, self-doubt, trenchant conservatism, fear of outside sports and veneration of the past are all key parts of the GAA psyche. In order to love the GAA, you have to swallow these faults whole.
- Keith Duggan. The Irish Times (2002)

Introduction

The Gaelic Athletic Association (GAA) is Ireland's largest sporting and cultural organisation. The GAA includes a network in excess of 2300 clubs throughout Ireland and spread across the world ranging from the very small with less than 20 members to the very large with over 1500 members (www.gaa.ie/about-the-gaa). The GAA is primarily a volunteer led community organisation that promotes the Gaelic games of hurling, football, handball and rounders and it centres many of its activities around the advancement of Irish culture through its promotion of the Irish language, music, dance and song (www.gaa.ie/about-the-gaa/cultur-agus-gaeilge/scor). It is widely regarded as being part of the Irish consciousness and has played an influential role in Irish society from before the beginning of the Irish Republic.

The GAA has a democratic structure where members elect officers to serving positions on a variety of tiers up to and including the position of President. Overarching the sporting and cultural activities is the ethos that the GAA is primarily a community based organisation (www.gaa.ie/about-the-gaa/mission-and-vision). To this end the GAA have developed many non-competitive initiatives aimed at improving the health and wellbeing of its members including Go Games, Cúl Camps, Respect Initiative, Healthy Club Project, Social Initiative and the ASAP Programme.
The GAA ASAP Programme

In 2004 the GAA Substance Abuse Task Force (GAA, 2004) was convened in partnership with the Department of Health and Children to examine the extent of the alcohol and other drug problems within the Association and report on measures that could be taken to remedy them. In 2005 the Health Service Executive (HSE) and the GAA embarked on a partnership arrangement to develop and implement the initial proposals that were recommended by the Task Force the previous year. The Alcohol and Substance Abuse Prevention (ASAP) Programme was developed as a result of that partnership. During the following five years over 1500 volunteers were appointed as ASAP Officers to implement a range of actions including developing GAA Drug and Alcohol Policies in the club, county and provincial structures throughout the Association. These policies were supported by a range of resources designed for the ASAP Officers to enact prevention, education and response measures to deal with alcohol and other drug related issues that could arise within the GAA context (www.gaa.ie/asap).

The ASAP Programme, in keeping with its name, is a drug prevention initiative. Drug prevention theory focuses on preventing initial use of alcohol and other drugs by reducing or preventing access to such substances, educating people about the dangers of their use and emphasising the harms that can be encountered through such use (Henderson, 1995). To this end, sports participation has been hailed as a prevention mechanism with regards to alcohol and other drugs (Botvin, 2003). This has often been exemplified by sportspeople who develop corresponding beliefs that prevent them from ever becoming involved in using drugs. In such instances sports participation can be more accurately regarded as a primary prevention of drug use as it may help delay or thwart the initiation stages of alcohol or other drug use.

In contrast to, and often in opposition of the abstinence philosophy, is harm reduction theory. Harm reduction posits the view that a certain number of people will always use substances for pleasure or relief in full knowledge that use may be also be harmful. (Erickson, 1997) The pragmatic view is taken of accepting this position and trying to work towards preventing as much resulting harm as possible. The proposition that some form of drug use is normative in every society is a
central tenet of the harm reduction philosophy and this often causes conflict with those who promote the values aligned with abstinence from alcohol and other drugs (Peele, 1985). Criticism from pro-abstinence groups often centres on the issue that harm reduction practices send out a message that drug use is tolerable and therefore acceptable (www.eurad.net). This argument is most evident in the drug treatment field but is also present in the drug prevention arena.

Harm reduction theory recognises that primary prevention (preventing people from using drugs in the first instance), secondary prevention (working to prevent harm with people who use drugs recreationally), and tertiary prevention (working to reduce harm with people who have serious drug problems) are all valid modes of drug prevention work (U.S. Dept of Health and Human Services, 1997). Expanding the traditional perspective of drug prevention (i.e. primary prevention) to an understanding that which incorporates secondary prevention and tertiary prevention is a journey that the GAA have already began and are continuing through the ASAP Programme. It may be a more fruitful approach than that of the proponents of an abstinence-only philosophy as it has the potential to lead to a wider array of responses and possibly, a reduction in alcohol and other drug use among athletes. Other sports organisations would be well advised to consider joining the GAA on this journey to allow greater leeway to engage in more creative drug prevention initiatives than traditional ‘Just Say No’ (Regan Foundation, 1982) approaches.

**Health Promotion in the GAA**

Health promotion is *the process of enabling people to increase control over their health and its determinants, and thereby improve their health*’ (WHO, 2005). This can be achieved by developing local, regional and national public policies and implementing them in a number of settings including workplaces, education settings, hospitals and local communities (WHO http://www.who.int/healthy_settings/types/en/index.html). As Ireland’s largest community organisation with a presence in every parish in the 32 counties, the GAA are ideally placed to implement initiatives at local, regional and national levels. In recent years the GAA have begun to adapt the development and implementation of a number of their activities to fit with the settings approach to health promotion.
The ASAP Programme is one health promotion initiative in the remit of the role of the Community and Health Manager. This role was developed to draw together a number of health promotion projects that were established in the GAA over the last number of years. In addition to the above, two of the more prominent health promotion programmes are the GAA Social Initiative and the Healthy Club Project. The GAA Social Initiative is aimed at older men who may not be involved in their local community by engaging them in activities and events specifically geared towards them (http://www.gaa.ie/clubzone/gaa-social-initiative/). The Healthy Club Project is employing a ‘whole club’ approach to health through promoting mental well-being and resilience development, drug and alcohol awareness, suicide prevention and response, well-being through physical activity, activities for older and non-playing members and healthy eating and diet (http://www.gaa.ie/Clubzone/gaa-healthy-club-project/). The Healthy Club Project has developed as a partnership between the GAA and the HSE as a result of the successful operation of the ASAP Programme. Considering the substantial foundation it has built on health promotion principles it appears to have the ability to develop a wide range of health related initiatives throughout the GAA. As with the Health Club Project, the philosophy and structure of the ASAP Programme is modelled on the five principal actions of the Ottawa Charter for Health Promotion (WHO, 1986) below.

1. **Build healthy public policy** - One of the fundamental tenets of applying the ASAP Programme in a GAA club setting is that every club has to develop a Club Drug and Alcohol policy. The policy sets the guidelines for all subsequent actions and efforts to be undertaken in the three areas of prevention, education and response to alcohol and other drug problems.

2. **Strengthen community actions** - The GAA club can be in many areas the centre of the local community that brings people of all age groups together. The ASAP Programme proposals to develop policies or alcohol and other drug prevention initiatives address more than what the needs of the club and focus on what is required for the local community (GAA, 2010. p11). Every club is required to develop a policies concomitant with the drug related issues of its local community.
3. **Reorient health services** - The role of the Club ASAP Officer includes linking in with local alcohol, drug and health promotion agencies to avail of their services to help develop policies, coordinate prevention activities, arrange education courses, and where necessary make referrals to treatment services. As a result of this, new opportunities to deliver health services in GAA settings have been developed nationally.

4. **Create supportive environments** - The changes that took place as a result of implementing Club Drug and Alcohol policies have directly led to creating supportive environments for GAA members. Such changes include implementing pitch-side smoking bans, not serving alcohol at club functions, not celebrating after matches in bars and providing healthy snacks and drinks for players after matches and training sessions (GAA, 2010. p123). These actions have helped “make the healthier choice the easier choice” (WHO, 1986).

5. **Develop personal skills** - A number of education courses were developed to address various needs arising in GAA clubs. ASAP Officers were taught how to develop policies and prevention practices to establish the Programme. Parents were offered alcohol and other drug education programmes that included components on the effects, signs and symptoms of drug use and ways to communicate with their children about drug related issues. In addition to working with adults, age appropriate courses for young people were delivered in conjunction with alcohol and other drug educators from community, voluntary and statutory agencies. These courses were designed to be in keeping with best practice and had components in decision making, confidence building, self esteem development and other life skills (Butler et al. 2007). The SAOR initiative to train GAA coaches to perform brief interventions with players about their alcohol use was the most recent move by the GAA to help members develop personal skills to increase control over their health and the health of those around them.
Alcohol in the GAA

The relationship between GAA and alcohol has been longstanding, complex and often controversial. Alongside the health promoting nature of many GAA activities and its development of the ASAP Programme as a first-of-its-kind among sporting organisations lay the contentious issue of sponsorship of one of its premier competitions by an alcohol company. The 18 year arrangement with Diageo Ireland for Guinness to be the title sponsor of the Senior Hurling Championship began in 1995, was altered so that Guinness became one of three hurling sponsors in 2008 and was ended in 2013. High profile media campaigns such as Not Men but Giants, The Stuff of Legend and The Power to Lift us All were credited playing a significant role in re-establishing the popularity of hurling which had been in decline. A new arrangement where Guinness were named as a proud partner of Croke Park Stadium and GAA has since been instituted but the details of this agreement have yet to be released.

Throughout this period the GAA also attracted significant negative attention for without and within its own ranks as a result of initiating and continuing a financial sponsorship arrangement with an alcohol company. The criticism from outside the GAA came from many media sources and alcohol prevention, education and treatment organisations (Baker, 2011). The most notable criticism from within came from former GAA President Dr Michael Loftus who publicly opposed the sponsorship arrangement from it’s outset and absented himself from the Senior Hurling Championship games for 15 years as a form of protest (Loftus, 2012).

Attention was further drawn to the relationship between GAA and alcohol in 2010 on the publication of research conducted by Trinity College Dublin and the HSE which found in a nationally representative study that alcohol consumption amongst GAA players was higher than non-GAA males of a similar age, and that over half of the GAA players surveyed engaged in regular binge drinking (O’Farrell, 2010). The response of the GAA was pragmatic as it moved to end the hurling sponsorship arrangement with Guinness and expand and further develop the ASAP Programme along with its other health promotion initiatives.
Chapter Three

Brief Interventions
**Brief Interventions**

Certain brief sentences are peerless in their ability to give one the feeling that nothing remains to be said.

- Jean Rostand

**Introduction**

The purpose of this literature review is to familiarise the reader with not only the history and major works germane to Brief Intervention (BI) but also to expound on some of the controversies surrounding BI’s to better situate them in the canon of alcohol treatments. The research to date has focused on the development, efficacy and implementation of BI’s for alcohol use within the specialist and healthcare fields. The context for this literature review is the study of the impact of a two-hour training course in the SAOR model of BI on the reported confidence of non-specialist Gaelic Athletic Association (GAA) coaches to intervene with athletes about their alcohol use. Aspects of the impact of the SAOR model on GAA coaches were previously studied by McConnon in an unpublished thesis as a requirement for an undergraduate degree\(^1\).

Throughout the BI literature a variety of loosely congruent terms are used to describe varying levels of engagement with people whose alcohol use have attracted the concern of another. These terms include *Screening and Brief Intervention* (SBI), *Electronic Screening and Brief Intervention* (e-SBI), *Very Brief Interventions* (VBI), *Extended Brief Interventions* (EBI), *Brief Advice* (BA), and *Identification and Brief Advice* (IBA). While there are some differences between each of the above, these are outweighed by commonalities. For the purposes of clarity and economy the overarching term Brief Intervention will be employed throughout this thesis and will apply to BI’s conducted through human interaction as opposed to online, web-based, email etc unless specified.

In addition, some further clarification of what does and does not constitute a brief intervention will also be offered. The review will cover the following topic areas;

1. Common elements in brief interventions
2. History and efficacy of brief interventions
3. Controversy surrounding brief interventions
4. How brief interventions relate to Motivational Interviewing
5. Training people to conduct brief interventions
6. Recent developments in brief interventions

1. Common elements in brief Interventions

There is no universally agreed definition for what constitutes a brief intervention however the following definition appears to gather much of the character of the majority of explanations;

…a short, evidence-based, structured conversation about a health issue with a person that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan behaviour change (NHS Scotland, 2010).

BI’s are not unique to the alcohol treatment field and are used to address a wide range of issues including anxiety, tobacco use, physical exercise, diet and alcohol use (Evans, 2011) and have had varying levels of success in contributing to improving the health status of people with these conditions. Despite the absence of a universal definition for what constitutes a BI, there are a number of common elements that are reported throughout the literature as components of a brief intervention.

**Opportunism** – In contrast to traditional psychotherapeutic interventions that tend to be more formal and appointment-based, BI’s can be conducted by non-specialists in a variety of settings as the opportunity arises.

**Screening** – The person is selected to receive a BI whether through the use of a formal screening tool, direct observation or some other form of information gathering.

**Individuality** – Brief interventions tend to be completed on a one-to-one basis as opposed to in a group setting.
**Focused** – Specific issues, usually behavioural and goal-oriented in nature, are addressed in a BI with the aim of altering their frequency, duration or intensity.

**Short-term** – As the name implies, brief interventions are time limited in contrast to longer term psychological treatments. The duration of individual interventions can typically last between 3 and 20 minutes and range from 1 to 4 sessions.

**Person centred** – The approach taken is one that evokes motivation to change as opposed to instilling it from without. Inherent in this approach is the necessity for the practitioner to regard the person who is considering altering his or her behaviour as being the primary agent of change with the intrinsic ability and choice to do so.

**Information provision** – The provision of resources, direction, encouragement and other forms of support intended to guide the person towards less risk and greater health are usually necessary to complete a successful BI.

Smith, Hodgson, Bridgeman and Shepherd in 2003 argued that while brief interventions appear flexible and do not have unique identities that they are concrete nonetheless;

> Hence, BI should not be regarded as a homogeneous entity, but as a family of interventions varying in duration, content, targets of intervention, and providers responsible for their delivery.

It would appear that the even though the content, context and conduct of a BI is amenable to change by amalgamating some or all of the above it can still retain an essence that identify it as a brief intervention.

### 2. History and efficacy of brief interventions

Research into treatment methods for alcohol problems has highlighted how some individuals appeared to overcome alcohol dependency with greater ease and with shorter durations of treatment than others. The first indication that shorter term treatment or ‘brief intervention’ may be a successful approach for initiating drinkers into alcohol treatment was conducted by Chafetz in 1962 when he showed dramatic increases in drinkers who completed a referral process to a specialist alcohol treatment service. Having previously experienced only 5% of referral to treatment completion this rate was increased to 65% following a brief intervention
completed in a single session by an alcohol counsellor. The brief intervention was structured so that particular attention was paid to displaying an empathic style that communicated respect, understanding and caring to the drinker regarding their use of alcohol.

In an almost identical follow-up study in 1968, Chafetz achieved pre-training and post-training rates of 6% and 78% respectively. Such increases in referral to treatment rates were notable not only because of the high number of individuals that were encouraged to seek further help for their alcohol related problems but also for the relative simplicity of the intervention that led to the increase. It became apparent following the Chafetz study that an empathic approach was a crucial element in getting people to consider making changes to alcohol consumption. While this may be regarded as intrinsic to most treatment approaches in modern times, such was not the case four decades ago (Association of Intervention Specialists, 2013) when highly confrontational approaches were considered the best method.

A study by Elvy, Wells and Baird in 1988 screened for the self-reported drinking patterns of general hospital patients and identified 263 problem drinkers who were subsequently approached by a psychologist and told that their drinking was leading to difficulties for which they needed help. A control group received no such information or referral. Patients who accepted the referral to an alcohol counsellor were offered immediate appointments and at 12 month follow-up these cases showed significant reductions on measures relating to alcohol problems. In addition the same group displayed measures of increased happiness, reduced work-related problems and higher indices of sobriety. The most noteworthy point from this research may be that a significant element of the outcome was derived directly from its design. The researchers selected their sample from patient’s self-reported levels of alcohol consumption. The researchers, when selecting the 263 patients to approach, were giving them direct feedback of their current and potential health problems based upon the individuals self reported alcohol use. The theme of employing brief interventions following a screening process has continued to be a factor in most of the models developed since (Centre for Substance Abuse Treatment, 1999).
Anderson and Scott in 1992 randomly allocated 164 men from eight general medical practices each of who were drinking more than 350g of alcohol each week into control and intervention groups. The intervention group received a single 10 minute consultation with a GP that consisted of an alcohol assessment, feedback, advice to reduce their drinking and a self-help information booklet. After one year of follow-up the intervention group showed a 65g reduction of alcohol consumed per week over the control group. In addition to their selection to be part of the research being based upon their own self-reported consumption, this study is also notable because the intervention group received a self-help information booklet. The provision of this booklet is not only a manual to guide the mode of treatment but it also speaks to the central mechanism of treatment and agent of change, the drinker. By placing the individual as the driver of change, interventions such as these recognise that it is individual drinkers who have the ultimate choice and power to change their drinking behaviours.

It would appear that brief treatment for people with some alcohol problems is often as effective as longer-term treatment. An investigation of this hypothesis was completed by Edwards et al. in 1977 when 100 British men were recruited from an outpatient alcohol treatment service to receive three hours of assessment. A random selection of half of these men received a single counselling session consisting of “sympathetic and constructive” advice with the aim of helping them attain abstinence from alcohol. The other half of the group received a comprehensive treatment package which included medication support for withdrawal symptoms, individual psychiatrist support, social worker support for their wives/partners, dipsotropic medication and in some cases residential treatment. During repeated follow-up interviews over a ten-year period the brief intervention group failed to differ in any significant way from the intensive treatment group with regard to problems relating to their alcohol consumption.

The world’s largest evaluation of a brief intervention initiative for alcohol use was completed by a team of investigators from the World Health Organisation (Babor and Grant, 1992). A sample of 32,000 patients in general healthcare settings from 10 different countries were screened for alcohol use and this generated 1490 people who are deemed to be at risk from their drinking. These patients were
offered a 20 minute health interview and were subsequently randomised to receive i) no advice, ii) five minutes of advice to reduce their drinking, iii) five minutes of advice to reduce their drinking, 15 minutes of alcohol counselling and a self-help workbook aimed at helping them make changes to their drinking behaviour. When compared to the control group (i) who received no advice, the groups who received the additional five and 20 minutes of consultations reduced their alcohol consumption by an average of one third.

Notwithstanding the growing body of literature supporting the efficacy of brief interventions, they are not a panacea for alcohol problems. A widely quoted study which showed brief interventions to have no significant effects on alcohol consumption with heavy drinkers (Heather, 1995) may have been of greater use than originally thought as it has increased understanding as to why BI’s do not work for some people. In fact this study may have contributed more to the field of knowledge than had it only replicated previous findings. As a result of this study it has become clear that brief intervention is more likely to be effective where the persons drinking patterns fall into the low to moderate risk categories and individuals with longer term and more severe alcohol dependence were shown to benefit less from brief interventions (Miller and Sanchez, 1993).

3. Controversy surrounding brief Interventions

The efficacy of brief interventions as a method of treating alcohol problems has been demonstrated for the past 50 years in the literature pertaining to alcohol treatment and health promotion (Miller, Benefield, Tonigan, 1993). Despite its scientific validity, obvious economy in time and financial savings, BI’s were not widely accepted and indeed were frequently criticised by agents of the established alcohol treatment industry for many years (Peele, 1991). The opposition that was encountered by individuals who were proposing brief intervention techniques as a method of alcohol treatment was occasionally frosty and sometimes overtly hostile (Shaw, Cartwright, Spratley & Harwin, 1978). This contentiousness remains the case to this day due to the ideological underpinnings of some forms of alcohol treatment that insist alcohol dependence or ‘alcoholism’ is a disease that can be held in abeyance but never cured (http://www.mayoclinic.com/health/alcoholism/D S00340).
Another possible reason behind the resistance to brief interventions centres on the financial aspects of alcohol treatment. The monetary costs associated with participating in traditional longer term alcohol treatment programmes can be very high depending on the treatment provider in question. This is especially so with regard to residential based treatment. The advent of a new short term, successful therapy for alcohol problems that did not require residential treatment challenged the validity of providing longer term, expensive programmes.

Throughout the 1970’s and 1980’s the promotion of the efficacy of brief intervention techniques for identifying and responding to alcohol problems was not helped, and was often attacked because of its association with the “controlled drinking” model (Sobell & Sobell 1973) of alcohol treatment. The Sobells’ controversial research and writing on the controlled drinking model challenged much of the prevailing wisdom and ideology which in turn drew significant fire in a battle that still rages in the literature amongst some alcohol researchers and practitioners to this day (Carpenter, 2012). As a result of the endorsement given by some of the advocates of controlled drinking philosophies, brief intervention was often rejected by the mainstream alcohol treatment industry (Peele, 1992).

4. How brief Interventions relate to motivational interviewing.
Throughout the literature on brief interventions references are made frequently to Motivational Interviewing (MI) and on occasion without appropriate regard as to how they converge and the ways in which they differ (Evans, 2011). So widespread was the misattribution and confusion of MI and BI that Miller and Rollnick (2009) wrote a paper titled ‘Ten Things that Motivational Interviewing is Not’. It is important to note that while the skills of MI can be used throughout a brief intervention for alcohol they are only one element of a counselling approach that goes beyond the sphere of brief interventions. In addition to this, an adapted version of MI, Motivational Enhancement Therapy (MET) was one of three therapies compared in the landmark study, Project MATCH in 2005 (Allen et al. 1997). MET could be described as a blend of motivational interviewing and brief intervention that was designed to fit the criteria of the study’s design. It would appear from reading of the literature that this blending of approaches has not yet been widely articulated or understood and has left a space for confusion to flourish.
In their most recent book, *Motivational interviewing: Helping people change*, authors Miller and Rollnick (2012) offer three definitions of increasing complexity that outline what motivational interviewing is (ibid, p44). The three definitions of motivational interviewing are;

Layperson’s definition – Motivational interviewing is a collaborative conversational style for strengthening a person’s own motivation and commitment to change.

Practitioner’s definition – Motivational interviewing is a person centred counselling style for addressing the common problem of ambivalence about change.

Technical definition – Motivational interviewing is a collaborative, goal oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.

Put most simply, motivational interviewing is a way of talking with people about change. Motivational interviewing consists of a clear set of skills (open questioning, affirming, reflecting, summarising (ibid, p34) and a less clear but equally important ‘spirit’ element. The ‘spirit’ of motivational interviewing is best described as a certain *mind-set* and *heart-set* that a person needs to communicate by approaching the other with a sense of partnership, acceptance, compassion and evocation (ibid, p22).

The incorporation of the skill and spirit ingredients of motivational interviewing into a conversation with a person about changes they may need to make often leads to an interaction that has a ‘guiding’ quality to it (Rollnick, 2008). The analogy of a person conducting a brief intervention as a ‘guide’ is helpful in this instance. A guide, such as a tourist guide one might employ while on holiday is not a person who directs you to the places that only he wants to go, neither is he a person who follows you to the places that you want to go. Instead he is a person who listens to your thoughts and ideas about what you would like to experience that draws on his
knowledge and skills to escort you safely to your destination. For the purposes of this thesis an example of this would require a coach who wishes to conduct a successful brief intervention with an athlete to be able to sensitively guide a conversation along the path where at times he will need to lead and at other times follow his athlete towards the goal of change.

The basic skills of motivational interviewing needed to successfully complete a brief intervention can be memorised using the mnemonic O.A.R.S. (Miller & Rollnick, 2002) the letters stand for;

- Open questions
- Affirming
- Reflective Listening
- Summarising

**Open questions** - These are questions that typically elicit a longer, as opposed to a short answer. An example of an open question would include “What do you think some of the advantages of cutting down on your drinking would be?” While it is possible that the response to such a question could be “I don't know,” it is equally possible that the answer would include a more lengthy description of positive changes that could occur should the person’s alcohol intake be reduced.

**Affirming** - The benefits of affirming a person when they express their efforts, values, struggles and hopes accrue from not only sharing a greater understanding of their viewpoint but also from the opportunity it provides to help develop rapport. An illustration of one person offering an affirmation to another might look something like, “I can see you’ve been worried about the amount you have been drinking and that you’re thinking about cutting down for the sake of your children. I think that you are doing a good thing and I would like to help you if I can.”

**Reflective listening** – The ability to listen reflectively is a skill that many people have naturally and can be learned by most. It is absolutely essential to motivational interviewing. When done well, reflective listening consists of paying close attention to how a person is expressing him or herself and appropriately paraphrasing and restating those expressions to help achieve a shared understanding.
Summarising – This is the skill that can be regarded as the one that helps most people to get a grasp of a conversation about change. A practitioner uses a summary to gather up the main points that have been mentioned in the discussion and to re-present them to the person as an overview of the conversation. The summary then communicates the extent of understanding, attention and insight that the listener has gained and this can lead to an opportunity to clarify any ambivalence about change that may be present.

The use of the skills of MI have become synonymous with a variety of brief intervention models and are generally regarded as fundamental to creating conditions that are amenable to developing a shared understanding and a potential pathway for change. However it is worth repeating that motivational interviewing is an approach in its own right and has significantly wider applications than the behavioural focus of most brief interventions.

6. Training people to conduct brief interventions
The literature available on the process and outcome of training people how to conduct brief interventions for alcohol use is limited and the majority of it focuses on healthcare staff and not on non-specialists. In the following report on three studies that trained hospital based staff how to conduct BI’s for alcohol using patients significant changes occurred on in staff behaviour and attitudes.

MacLeod, Hungerford, Dunn and Hartzler in 2008 researched an 8 hour training course with a group of 15 first year surgical interns to conduct BI’s with patients who were admitted to hospital with alcohol related traumas. The interns were tested on their skills five weeks before and five weeks after and the training was completed by using actors who imitated typical patients that the interns would routinely come into contact with. The interns were compared with a control group of 23 first year medical interns who did not receive training in BI. The interns were audio taped and coded using a checklist for ten different BI skills. The intervention group differed only slightly from the control group in two of the ten skills at the pre-training stage but performed significantly better at the post-training stage than the untrained group in five of the ten BI skills.
In a similar study in 2004 D’Onofrio, Pantalon, Degutis and Fiellin conducted research with 57 medical doctors in a teaching hospital who had completed a two-hour training course in conducting BI’s for alcohol with patients who attended the emergency department. The 57 participants were trained at one of seven training sessions and their skills practices were audio taped throughout to check for model compliance. 56 participants passed a competency test and went on to deliver 250 BI’s with real life patients as part of a separate study in which they were audio taped and rated for BI compliance.

A novel study on how training nursing staff in BI’s affects negative attitudes towards alcohol using patients was conducted by Lui, Salikin and Winslow in 2013 in a hospital setting. The nurses were trained in the ASSIST model of BI (Humeniuk et al. 2010) and given further reading for self study as part of a randomised control trial where a control group received only the reading material. Upon follow up after 9 months the intervention group showed statistically significant reductions in their negative attitudes towards alcohol using patients and positive changes in their therapeutic attitudes that included a shift away from the disease model of addiction and believing patients had greater capacity to change their alcohol use.

Reasons for training hospital staff to perform BI’s with patients with alcohol problems may be motivated by financial and temporal economy, desire to improve patient care, resource conservation and improved inter and intra-agency working practices. Regardless of the motivation behind such attempts the results appear to warrant further research.

6. Recent developments in brief interventions
Among the range of initiatives that have been implemented to respond to alcohol related harms recently, are brief intervention frameworks (HSE, 2012). These frameworks incorporate not only a brief intervention models but also provide a range of supports for developing tailored policies, training courses and solutions to integrate brief interventions into the fabric of how an organisation can identify and respond to potential alcohol related problems in clinical settings.
Wilson, Heather and Kaner (2011) in a review paper have outlined some subtle but important aspects of the delivery of BI’s to differing age groups and people with various ranges of severity of dependency emphasising that brief interventions are not a ‘one size fits all’ approach to alcohol problems. Additionally they note the uneven spread of BI training and have called for a more systematic approach to staff training and support with regard to brief interventions.

The growth in popularity of brief interventions for alcohol use is reflected in an array of fields including substance-abuse prevention theory, public health medicine, addiction treatment programmes and health promotion initiatives (Dunn, 2001). Such is the evidence to suggest the effectiveness of brief interventions to help people to overcome alcohol problems that the WHO have selected this approach to be its’ foremost public health initiative for responding to alcohol related problems (WHO, 2011).
Chapter Four

Methods
Methods

Man must evolve for all human conflict a method which rejects revenge, aggression and retaliation. The foundation of such a method is love.

- Martin Luther King Jr.

Introduction
The hypothesis behind this study is that coaches who undergo a training course in how to complete a brief intervention for alcohol use are more likely to intervene with athletes who appear to have alcohol related problems. The objective of this study is to test this hypothesis. If the hypothesis is supported, this study will have outlined a method that encourages coaches to intervene with athletes with regard to problematic alcohol use.

The sample of coaches were from four separate locations in Ireland and the first round of data collection, the four interventions and the second round of data collection took place over a five week period in January and February 2013. A quantitative research design was employed as the study sought predominantly quantitative data and requested a small amount of optional qualitative data. Between the first questionnaire (Appendix A) and second questionnaire (Appendix B) being circulated an intervention took place.

The intervention was a two-hour training course on why and how to intervene with players who may have problems relating to their alcohol use. The intervention included elements of didactic tuition, discussion, audiovisual presentation, role-play and feedback opportunities. The brief intervention approach used in the research is the SAOR model. The SAOR model is designed to engage a person supportively, assess the extent of their alcohol related concerns and if necessary, refer him or her on for further help.
This chapter is divided into two sections. The first section will describe the sample and the intervention because the sample self-selection process necessitated engagement with the intervention and therefore, participation in the study. This section will include details on its development, how it was piloted and how it was delivered in four locations. The second section will describe the methodology employed in the design of the study and include information on how the questionnaires were developed and outline the practical and ethical steps taken how to manage the data that was submitted by participants.

**Methodological approach**

A number of possible research designs that could be used were generated. The idea to design two questionnaires to gather data from participants before and after an intervention was chosen as the most suitable for the study. The intervention took place in all four provinces in the order of Connacht, Munster, Leinster and Ulster in the counties of Galway, Cork, Dublin and Monaghan respectively. Each of the four intervention counties were chosen at random.

Participants in all four intervention sites had not taken part in either of the pilot training courses and had no knowledge of the SAOR model prior to being invited to take part in the study. All randomisations were achieved by entering lists of county names from each province into a random name generator downloaded from [http://www.harmonyhollow.net/hat.shtml](http://www.harmonyhollow.net/hat.shtml).

The maximum number of participants for each training course was set at 16 to allow for the tuition, small group exercises, role play activities and discussion to take place within a two-hour timeframe. Places were allocated to participants on a first come, first served basis. A cut off time for registration was set for 12:00 on the day of the course. Every person who applied to take part in a SAOR model training course was contacted by phone or email with confirmation of their acceptance and given directions to the training venue. The relevant ASAP County Officer made the local arrangements for the delivery of the two-hour training course including venues, refreshments and timing of the courses.
Sample
An approach was made to the GAA with the idea of researching the effects of training coaches in brief intervention skills and approval in principle was granted by the GAA. A targeted sample of GAA coaches were chosen from the sampling frame of lists of GAA coaches throughout the country. The invitations that were sent out by email were structured so that participants self-selected to take part in the intervention.

Each GAA club has at least one Coaching Officer with a larger number of coaches working under his or her direction. Almost all coaches work in the GAA on a voluntary basis. Each Club Coaching Officer will work under the guidance of the County Coaching Officer who in turn receives direction from one of the four Provincial Coaching Officers (PCOs). The Alcohol and Substance Abuse Prevention (ASAP) Programme operates a similar structure with Club ASAP Officers, County ASAP Officers and Provincial Officers who report to the ASAP Programme National Committee. The research proposal was presented by the ASAP Programme Chairperson to the ASAP Programme National Committee. The ASAP Programme National Committee, in addition to the Chairperson, consists of 32 ASAP Programme County Officers, 4 ASAP Programme Provincial Officers and to Colin Regan, GAA Community and Health Manager.

In order to successfully invite a sample to take part in this study the ASAP Programme National Committee empowered the four ASAP Programme Provincial Officers to act as link persons between the ASAP Programme and their respective PCOs. The ASAP Programme Provincial Officers contacted the PCOs and supplied them with an outline of the structure of the study and sought their support. The PCOs agreed to support the study and circulated an email invitation to County Coaching Officers for coaches to take part in the brief intervention training course (Appendix C). As is the norm for training courses offered to volunteers in GAA, the participants were asked to register their interest in attending the course by giving their details to their ASAP County Officer. The system allowed participants to self select with regard to their attendance. Self selection is standard practice for GAA training courses for volunteers.
The intervention
A range of ideas of how to train GAA coaches in brief interventions were generated with the aim of developing a two-hour training course. A two-hour timeframe for the training course was chosen as GAA coaches are predominantly volunteers and often have significant and competing demands on their time. As dealing with alcohol related issues may cause some discomfort to GAA coaches it was deemed unlikely that coaches would attend multiple training sessions. The course was designed so that it could be delivered in a single evening and this suited the sample as a variety of GAA meetings regularly take place between the hours of 8:00PM and 10:00PM.

Three brief intervention models were compared for suitability for the purpose of training GAA coaches. The models that were considered included FRAMES model (Bein, Miller & Tonigan, 1993), the 5 A’s model (Fiore MC, Bailey WC, Cohen SJ, et al. 2000) and the SAOR model (O’Shea & Goff, 2009). The FRAMES model is an acronym based on its component skills and involves giving Feedback, emphasising personal Responsibility for change, giving Advice, offering a Menu of alternatives, being Empathic and supporting Self efficacy. The 5 A’s model recommends the use of the steps Ask, Advise, Assess, Assist and Arrange to guide a conversation when asking people about their health behaviours and, if they are found to be at risk, advising them to modify their behaviour, assessing their interest in doing so, assisting in their efforts to change, and arranging appropriate follow-up if necessary.

The SAOR model is an acronym of the sequential steps taken in addressing concerns alcohol related to a persons alcohol use. The steps include Support, Ask and assess, Offer assistance and Refer. While the 5A’s model focuses mainly on the skills involved in delivering the brief intervention, the FRAMES and SAOR models emphasise that the skills and the manner in which they are employed are of equal importance. Both the FRAMES and the 5A’s model are designed for use with a variety of health behaviours while the SAOR model is designed as a brief intervention for substance use.
Each model was assessed for ease of use by non-specialists and for possible adaptation so that it could be taught in a two-hour timeframe. The SAOR model of brief intervention was selected as it had fewer steps and appeared easiest to teach in a two-hour timeframe and for the reason that it focused on both the skills and the manner in which they were used. The SAOR model was developed in Ireland and its’ language and general tone seemed more familiar than other BI models that originated elsewhere. As a result it appeared to be a good cultural fit. Additionally, because the word ‘saor’ is the Irish language word for ‘free’ and one of the aims of the GAA is to promote Irish language and culture, it was hoped that this would aid the entry of brief interventions for alcohol problems into the GAA.

Permission was sought from James O’Shea and Paul Goff to use a version of the SAOR model and was granted. Both O’Shea and Goff were familiar with the ASAP Programme through their involvement in their respective GAA clubs and they generously offered their time and expertise towards the task of adapting the usual SAOR training programme into a two-hour training course for GAA coaches. The authors of the SAOR model were consulted on six separate occasions to help revise the model for use with GAA coaches and a simplified version of the model was generated. Four additional revisions to the structure and content of the training course were made before it was piloted.

**Piloting the intervention**

The provinces of Munster and Ulster were chosen at random to take part in the pilot and Kerry was randomly selected from the Munster counties and Cavan was randomly selected from the Ulster counties to pilot the pre-training questionnaire, the two-hour training course and the post-training questionnaire. The first pilot training course took place in a hotel meeting room and the second pilot training course took place in a GAA club meeting room. Both venues are regularly used by GAA coaches for meetings and training events.

The first pilot began in the Hotel Kilmore in Cavan on September 4th and had 20 participants. The course was delivered by Colin Regan and Brendan Murphy. An unsuccessful attempt was made to adhere to the time schedule. The training started and finished on time and took two hours to complete. It became apparent
to the trainers that the participants needed more time for discussion than what had been anticipated on the training agenda. Participants’ data was gathered using paper based pre-training questionnaires on the night and electronic post-training questionnaires one week later.

The second pilot began in Austin Stacks GAA Club in Kerry on October 17\textsuperscript{th}. 16 people took part in the training course. The training was delivered by Colin Regan and Brendan Murphy. James O’Shea and Paul Goff were in attendance to offer their support and make note of any modifications that may be necessary to help communicate the adapted SAOR model more effectively. The training course started 15 minutes later than planned. The trainers followed the outline of the training course as planned and with the exception of the role-play it ran to time.

Paper based pre-training questionnaires were used to collect data from the participants at the beginning of the course and electronic post-training questionnaires were used to gather participant’s data one week following the course. All of the media produced for the training course were used as planned. The training course finished 15 minutes later than planned. The total training time was 2 hours and 15 minutes. Emails containing a hyperlink to the online questionnaire were sent to all participants one week after they completed the intervention. One further generic email was sent to participants four days later thanking them if they had already completed the post-training questionnaire and requesting that they fill it in if they had not already done so.

The Cavan and Kerry pilot training courses revealed to the trainers the importance of allowing the participants to discuss their previous experiences of dealing with players who had alcohol-related problems and of comparing those experiences with the role-play scenario. Over the following weeks the training schedule was amended to allow for this. The time allowed for discussion and role-play was increased and the time allotted for didactic tuition was reduced. The information gleaned from the participants who took part in the pilot phase of the study was used to make further changes to the timetable for the four planned interventions and to the content of the evaluation questionnaires. One of the questions asked in the pre-training questionnaire was deemed to be confusing.
and of no real value to the overall study and was not included in the final version of the questionnaire. Over the following weeks a series of ideas were exchanged between the trainers and the SAOR authors that resulted in the structure of the feedback mechanism for the role-plays being changed so that the participants were more likely to have both a positive and useful experience of attempting a brief intervention.

**Structure of the SAOR training course**

The training course was designed to mimic the structure and process of a brief intervention using the SAOR model. The trainers used the various parts of the training as an opportunity to demonstrate aspects of the SAOR model throughout the two-hour course. This was done to add a sense of congruence between what the participants were being told by the trainers and what they were experiencing during the training. Table 2 and the following examples below show how the trainers communicated the structure and content of the SAOR model to the participants through their behaviour.

**Support** - The facilitators were openly welcoming to the participants at the beginning of each session and remained deliberately supportive to them throughout by giving positive feedback to them for attending the session, all their work with players both on and off the pitch and for their willingness to take steps to address the difficult issue of alcohol related problems.

**Ask and assess** - By naming the issue of alcohol related problems in the GAA and inviting the participants to discuss how this had affected the teams they coached the facilitators asked and assessed the group about their difficulties that were caused by alcohol. This in turn helped participants realise the extent of the problem and identified the potential opportunities they had to create a change.

**Offer assistance** - The facilitators showed the group how to use the SAOR model, supplied them with resources, planned how they might intervene and got them to practice the SAOR skills in a role play. Each of these steps were occasions of offering assistance to the coaches by helping them to shoulder the responsibilities of intervening with players who had alcohol related problems.
Refer - The group were led to realise that they may on occasion need assistance from a healthcare professional and were given directions of how to refer a player to those services. They were also reassured that they could refer to the personnel of the ASAP Programme at anytime for further help and were given contact details of health promotion, alcohol and others drugs agencies.

Table 2. Structure of the process and content of the SAOR training course

<table>
<thead>
<tr>
<th>Support</th>
<th>Individually welcomed and given positive feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Willingness to address difficult issues acknowledged</td>
</tr>
<tr>
<td></td>
<td>Thanked for their work on and off the pitch</td>
</tr>
<tr>
<td>Ask &amp; assess</td>
<td>Named the alcohol issue as a problem</td>
</tr>
<tr>
<td></td>
<td>Discussed the extent of the problem</td>
</tr>
<tr>
<td></td>
<td>Assessed the possibility &amp; potential for change</td>
</tr>
<tr>
<td>Offer assistance</td>
<td>Demonstrated the SAOR model</td>
</tr>
<tr>
<td></td>
<td>Gave handouts to guide an intervention</td>
</tr>
<tr>
<td></td>
<td>Practiced the SAOR skills through role play</td>
</tr>
<tr>
<td>Refer</td>
<td>Described how to make a referral</td>
</tr>
<tr>
<td></td>
<td>Offered ongoing support from ASAP Programme</td>
</tr>
<tr>
<td></td>
<td>Linked in with other agencies</td>
</tr>
</tbody>
</table>

Procedure

Each training course was delivered by two trainers. One trainer attended all four intervention sites to deliver the training. The trainers at each of the four intervention sites used the same structure and content so as to reduce variation between courses. All four of the training courses were facilitated by two people with experience in training GAA personnel to respond to alcohol and other drug related issues and the training took place in meeting rooms that were routinely used by GAA club members.

Participants were welcomed individually as they came into the room, given a folder containing the handouts that would be used and were invited to have tea or coffee while waiting for the course to formally begin. The training began with the facilitators introducing themselves and thanking the participants for coming.
Participants were asked to introduce themselves and state the club they were from to the group. The boundaries of confidentiality and anonymity were outlined to the participants and they were requested to fully engage with the training and reminded that they were free to withdraw from the course at any time. The content of the two-hour course was outlined and participants were told that by the end of the session they would have been given information on how to use the SAOR model, shown a demonstration of the SAOR model and had a chance to practice the skills of the SAOR model. The purpose of getting the participants to introduce themselves and hear what the proposed content of course was to help them become more comfortable.

Each person was reminded that they had been informed that they would be asked to complete a questionnaire at the beginning of the course and another one in one week’s time. The participants were informed that the course was part of a study being conducted in conjunction with National University of Ireland Galway and the GAA and that their participation in it was voluntary and if they chose to take part in it that their participation would be would be appreciated. Participants were informed that what they chose to write would be kept confidential and that they could not be identified from the questionnaires. All of the participants agreed to complete a pre-training questionnaire and a blank questionnaire and pen was given to each person.

At two of the intervention sites participants had tables on which to complete the pre-training questionnaires and in the other two sites the participants filled them out while resting them on the folders they had been given. Upon completion the participants placed the questionnaires in a collection box where they remained until after the course ended. The completed questionnaires were then transferred to a box file where they were kept until inputted manually into a database.

In the next section of the training participants were told about research that indicated a higher than average level of alcohol related problems among GAA players and asked about any alcohol related problems they encountered while coaching teams. Following this discussion, information was presented to them on the negative effects that alcohol consumption has on athletic performance.
The participants were given a corresponding handout (Appendix D) and encouraged to use it to engage with individual players or as an education tool for use when addressing a teams upon returning to their club. The group were then introduced to the SAOR model and with the use of two further handouts were shown how each step could be used by a coach (Appendix E) when speaking with a player (Appendix F) about an alcohol related issue. The four stages of a SAOR brief intervention were explained and the participants were guided by the facilitators to know how and when they could intervene with a player. Occasions on when a referral to a healthcare professional may be necessary were outlined and directions on how to complete a referral were given. Throughout the training course questions were invited and discussion of the coaches’ experiences with alcohol using players was encouraged.

A piece of video footage (Club Matters, 2010) containing a vignette of a coach performing a brief intervention with a player was shown to the participants and comments on how the coach performed were welcomed in order to help the group interact and suggest possible adaptations. A discussion was facilitated to allow the participants to describe what skills they had observed the coach in the vignette using and they were guided towards explaining how they could use similar skills if they were in a comparable situation. This allowed for coaches who had experience in intervening with players about alcohol related issues to describe how they had acted and compare it to the SAOR model.

In order to practice the skills used in the SAOR model each participant was paired with another and given oral and written instructions (Appendices E and F) to assume the role of either coach or player. Each pairing was requested to enact a scenario where a coach approaches a player who has been drinking alcohol excessively and attempt a brief intervention using the SAOR model. The role play scenario lasted 10 minutes and following completion of the role play each person was given an opportunity to describe their experience. Following the conclusion of the role-play, descriptions were sought first from the person who was in the role of the coach. Positive feedback was given by the facilitators in every instance where the person in the role of the coach intervened in keeping with the SAOR model.
The person in the role of the player was debriefed next and asked to highlight if the coach had said or done during the role play that they found particularly helpful.

The facilitators recapped the content of the session and outlined to the participants that they had in a two-hour period learned why and how to use the SAOR model, seen a demonstration of the SAOR model and practiced a brief intervention using the SAOR model. All participants were given the contact phone numbers and email addresses of both trainers should they need to discuss anything in confidence or require further information. They were also referred to the ASAP Programme website www.gaa.ie/asap should they need further information, or need to access the contact details of any drug, alcohol or health promotion service in their geographical area. The session was concluded by the facilitators thanking the participants for their attendance and participation and a reminder that a post-training questionnaire would be forwarded to them in one week's time.

The participants were sent an email containing a hyperlink to the online version of the post-training questionnaire one week after they completed the intervention. In addition one further generic email was sent to participants four days later thanking them if they had already completed the post-training questionnaire and requesting that they complete the questionnaire in if they had not already done so.

Variations in the delivery of the four interventions were kept to a minimum. The differences that did occur were slight and had to do with group size and room layout. In two rooms the participants sat around a table whereas the other two interventions took place in rooms where there were only chairs. The presence of the table restricted the freedom of movement for participants during the role plays. The numbers of participants varied between intervention sites and these will be outlined in the Results chapter.

**Measures**

The creation of almost all of the measures for the SAOR model training course and the administration of the course was done by using the GAA Mail system. The GAA Mail system is an application created by Google for the GAA and has all the functionality of a Gmail account with some extra applications. The GAA
Mail system is the primary communication system used by all GAA club, county, provincial and national administration networks. The Drive function utilises a Microsoft Office type suite of programmes that was used to create the invitations, handouts, questionnaires and databases used in the administration of the SAOR model training course and the collection of data for this study.

The only resource used that was not specifically created for the SAOR training course was a piece of existing video footage from the ASAP Programme DVD (Club Matters, 2007). The other training materials consisted of eight slides (Appendix G), a handout on alcohol and sports performance (Appendix D) and two handouts for the role plays (Appendices E and F).

**Questionnaire development**

As the study was designed to assess any change to coaches reported confidence to intervene with athletes who appear to have alcohol related problems following a training course, a pre-training and post-training questionnaire method was chosen as the most appropriate model to assess this change. Both questionnaires were designed using the Forms function on the Drive application of a GAA Mail account. This method was chosen as it is frequently used by the GAA to garner information from Association members and therefore is familiar to members of the sample. A paper version of the pre-training questionnaire (Appendix A) was designed for participants to complete at the beginning of the training course. An electronic version of the post-training questionnaire (Appendix B) was designed to be sent to participants one week after completing the course.

A total of 67 possible questions that could be asked of coaches about alcohol related issues among athletes were developed based on the researchers’ previous experience of working as an addiction counsellor with people with alcohol problems. Questions that were not obviously related to a study of brief interventions were discarded. The remaining items were used to form the first drafts of the questionnaires were grouped into the four categories. The categories grouped data about of (i) the participants (ii) the course, (iii) the impact of the courses and (iv) the relationship between the course and its impact. The
categories were helpful in further eliminating unnecessary questions and re-ordering the remaining items. Both the pre-training and post-training questionnaires consisted of a mix of tick box, agree/disagree, Likert-style and open-ended questions. All possible answers to each question were generated to help define the questions. The pre-training questionnaire asked participants to reveal information about their location, duration and category of the players they coached and about their coaching-related qualifications.

The questionnaires also asked about the coaches’ motivation, experience, opinions, ambitions and confidence in dealing with players’ alcohol related issues. The post-training questionnaire asked coaches for information on their experience, relevance and the benefits accrued from the SAOR training course. It also asked about their behaviour and confidence since completing the SAOR training course. In addition it asked for suggestions to improve the course and for what else they needed and what the GAA needed to do next to develop this initiative. Both questionnaires asked participants for their date of birth and the province that they were in. The answers to these two questions were used to link a participants pre-training questionnaire with his or her corresponding post-training questionnaire.

The ASAP Programme committee members were given the first version of the pre and post-training questionnaires for comment. Some changes were made to the questionnaires following their suggestions and a panel of four people were selected from the committee to trial the questionnaires and provide feedback to the Chairperson. Following suggestions made by this panel further revisions were made to the questionnaires.

**Data Management**

The pilot and intervention data from the pre-training questionnaires were examined for errors and manually inputted into databases the day after they were received using the Spreadsheet function on the Drive application of a GAA Mail account. The pilot data were kept separate from the intervention data. A separate database was created using the Forms function on the Drive application of a GAA Mail account to remotely receive the data from participants post-training questionnaires.
Each answer was checked to see if it appeared to make sense and to see if there were any obvious errors. One example of such an error includes a participant who wrote the wrong province, possibly mistaking where he or she was from with where the training actually took place. Another error was where a participant wrote 1877 as the year of his or her birth instead of writing 1977. The first error was easily corrected as it was evident where the training had taken place. The second error was less evident and a note was taken of the data as being possibly erroneous and that it should be cross checked with the post-training questionnaires which also asked for the participants’ date of birth. Upon receipt of the post-training questionnaires it was possible through a process of elimination to identify the correct date of birth. As the data from the pre-training questionnaires was manually inputted and the data from the post-training questionnaires was remotely inputted onto the database the format of the data was visually checked for errors. It became apparent that two fields required minor adjustments to the display of decimal points in order to present the data correctly.

The data in the GAA Mail Spreadsheet were visually re-checked in a column-by-column to see if they appeared congruent with answers from other participants and with expected answers. A new file was created in version 20 of the Statistical Package for Social Sciences (SPSS) software to receive the data and set the parameters for data ranges. A codebook for describing each variable and range of data was created in Microsoft Word. The numeric data from the GAA Mail Spreadsheet was copied one column at a time and pasted into the Data View of the SPSS file. The parameters and ranges for the data were defined in the Variable View of the SPSS file in conjunction with the codebook. The data in the SPSS file were compared with the corresponding columns in the GAA Mail Spreadsheet to check if there had been any changes that occurred when transferring it between programmes. The numeric data submitted by each participant in the SPSS file were visually checked to see if they were in keeping with answers from other participants.

The data that were generated in response to 12 of the questions on the post-training questionnaire were numeric. The remaining two questions asked participants for suggestions on future developments. The answers to these two questions generated string data. String data was not copied from the Spreadsheet file in the GAA Mail
account into the SPSS file. The string data was subjected to a thematic review and the themes were grouped and will be discussed further in the Results and Discussion chapters.

The data were further prepared for analysis in SPSS by stratifying the participants into a workable sample. A total of 50 participants completed the pre-training questionnaire and intervention. From this group 46 people returned the post-training questionnaires. This group were stratified to remove the data from 10 participants who had not coached GAA players. The remaining data from 36 participants taken across the four intervention sites were merged into the sample analysed by the SPSS software.

**Data Analysis**

A data analysis plan was developed on the basis of the study objectives and the data collected. Each step of the plan determined the analysis undertaken. The data were imported into version 20 of the Statistical Package for Social Sciences (SPSS) software for processing. The data from all four intervention groups were merged and were analysed using a range of statistical tests. Descriptive analyses included frequencies and cross tabulations to produce percentages within the sample to see if changes had occurred within sub-groups of the sample and across time and inferential analyses included paired Samples t-tests with a significance level of $p<0.005$ was chosen to test the hypotheses. The variables were grouped for analysis into four categories (i) the participants (ii) the course, (iii) the impact of the courses and (iv) the relationship between the course and its impact. These categories were also used to structure the manner in which the results were reported.

**Ethics**

The preparation for this study included a number of arrangements to address ethical issues including permission, consent and protection. The research proposal and questionnaires were submitted to Colin Regan, GAA Community & Health Manager for comment and upon his endorsement, for circulation to the GAA Management Committee, Coiste Bainistí for approval. Coiste Bainisti consented to the study being conducted with GAA coaches in each of the four provinces in Ireland in keeping with the research design.
Bogdan & Biklen (1992) claim that ethics in research are dominated by two main concerns, that of informed consent and the protection of subjects from harm. This study was designed to take account of both of these concerns. With regard to the first concern, it is important that consent for research is informed, that participants are informed about the research and freely volunteer to participate (Jones & Tannock, 2000). Consent was given by all the participants in the sample when they applied to attend the course.

Participants were informed in writing during the application process that the SAOR training course was subject to being researched and that they would be asked to complete a pre and post training questionnaire. Participants were reminded of this upon arrival and their verbal consent was sought and given. Masson (2005) explains that the researcher should always explain fully the purpose, process and intended outcomes of research and seek consent on that basis with Lindsay (2007) outlining that participants should have the right to withdraw from the study at any point in time. Participants were reminded that the SAOR training course was voluntary as was their participation in the research and were informed that they were under no obligation to participate and that withdrawal would not lead to any negative repercussions.

The second concern regarding protecting participants from harm was addressed by using ethical guidelines to become more aware of hidden problems and questions (Alderson & Morrow, 2011). Due to the sensitive nature of the issues in this study the research was carried out with a high standard of ethical conduct. The experience of discussing alcohol related issues has the potential to be disturbing for participants. In an attempt to prevent this, the participants were not asked about their own alcohol consumption or asked to discuss alcohol related issues from their own family. The focus of the questionnaires and the intervention was on alcohol related issues in a GAA context. In addition they were supplied with contact details for a range of drug, alcohol and other support services should they need assistance following the training course.
Participants were informed that the data they submitted in questionnaire was confidential and that the questionnaires were not traceable. When participants completed the online questionnaire and clicked on the ‘submit’ button their data were collated automatically in a database by the Spreadsheet function on the Drive application of a GAA Mail account. The data was accessible only to the owner of the GAA Mail account and was protected by two passwords. The participants’ names and contact details were not gathered with the questionnaire data. All data that could potentially identify participants were stored in a separate password protected file.
Chapter Five

Results
Results

Insanity is doing the same thing, over and over again, but expecting different results.  
- Narcotics Anonymous

Introduction

GAA players appear to be a high risk group for developing alcohol related problems and GAA coaches may be in a unique position to identify players at risk and intervene to prevent problem development. This chapter details the results of a study to test the hypothesis that coaches who completed training in how to perform a brief intervention for alcohol would be more confident and therefore, more likely to do so.

A total of 50 participants returned the paper-based pre-training questionnaires and completed the intervention in four different sites. The numbers of participants in each site were 15 in Galway, 13 in Cork, 4 in Dublin and 18 in Monaghan. None of the participants chose to opt out of any part of the training courses. Four of the participants had no prior experience of GAA coaching and were their data was excluded from the analysis. Of the 46 participants who had experience coaching GAA players 10 people did not return the post-training questionnaires and their pre-training data was excluded from the analysis. The remaining 36 coaches who completed and returned the online-based post-training questionnaires make up the sample. This is not representative of all GAA coaches but a description of this sample of GAA coaches.

The questions answered by the participants on both questionnaires were loosely grouped into the four categories of (i) the participants (ii) the course, (iii) the impact of the course and (iv) the relationship between the course and its impact. These categories form the structure for this chapter. For ease of use all the percentages have been rounded to the nearest whole number which on occasion may total just above or below 100%.
i) The participants
The data described in this section was taken from the early part of the pre-training questionnaire where participants submitted descriptive information about themselves and their coaching activities. The coaches ranged in age from 23 to 66 years, with a mean age of 42 years. The distribution of age was evenly spread with four coaches aged 35, four aged 45, two aged 37 and two aged 41. All of the coaches currently or previously trained more than one age group of GAA players. The most common group coached was Under 14 age group with 16 of the 36 coaches with experience with this age group. There was a high level of coaching qualifications within the sample. 35 of the 36 coaches had at least one coaching qualification. As outlined in Table 3, participants were asked to indicate their highest level of coaching qualification from a list of five ascending options. Half of the sample was split between the lowest two levels, 14% were at the midpoint and 33% were spread between the two highest levels of qualification.

<table>
<thead>
<tr>
<th>Coaching qualification</th>
<th>Number and percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Foundation</td>
<td>9 (25%)</td>
</tr>
<tr>
<td>Level One</td>
<td>9 (25%)</td>
</tr>
<tr>
<td>Level Two</td>
<td>5 (14%)</td>
</tr>
<tr>
<td>Level Three</td>
<td>9 (25%)</td>
</tr>
<tr>
<td>Coaching Tutor</td>
<td>3 (8%)</td>
</tr>
</tbody>
</table>

When asked about their reason for attending the training course 83% of coaches said that they were ‘interested and would like to find out more’. In a measure that may represent the self selection in regard to attendance, none of the sample selected ‘I’m not interested but I was told I had to go’. One third of the sample selected that they currently had players that they ‘need to speak to about their alcohol use’ and one third of the sample also indicated that they have in the past ‘had players with alcohol related problems’
The overall group were very experienced in coaching. While two group members had less than one year of coaching experience 24 people (67%) had more than five years experience coaching. The data in Table 4 describes the types of alcohol related problems that 83% of coaches observed while coaching GAA players. Within that group the most common problem observed was ‘players under-performing’ and was closely followed by ‘players missing training’.

Table 4. Players’ alcohol related problems observed by coaches

<table>
<thead>
<tr>
<th>Problems with players</th>
<th>Connacht</th>
<th>Leinster</th>
<th>Munster</th>
<th>Ulster</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never had alcohol related problems with players</td>
<td>27%</td>
<td>0%</td>
<td>0%</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>Players have missed training due to alcohol use</td>
<td>45%</td>
<td>75%</td>
<td>100%</td>
<td>64%</td>
<td>67%</td>
</tr>
<tr>
<td>Players missed matches due to alcohol use</td>
<td>45%</td>
<td>50%</td>
<td>86%</td>
<td>57%</td>
<td>58%</td>
</tr>
<tr>
<td>Players arriving to under the influence of alcohol</td>
<td>27%</td>
<td>25%</td>
<td>0%</td>
<td>21%</td>
<td>19%</td>
</tr>
<tr>
<td>Players under-performing due to alcohol use</td>
<td>64%</td>
<td>75%</td>
<td>71%</td>
<td>57%</td>
<td>64%</td>
</tr>
<tr>
<td>Players being disruptive due to alcohol use</td>
<td>9%</td>
<td>0%</td>
<td>29%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Players injured due to alcohol due to alcohol use</td>
<td>9%</td>
<td>25%</td>
<td>43%</td>
<td>29%</td>
<td>25%</td>
</tr>
<tr>
<td>Players being aggressive due to alcohol</td>
<td>9%</td>
<td>0%</td>
<td>14%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Players being ill due to alcohol</td>
<td>9%</td>
<td>25%</td>
<td>43%</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>Other alcohol related problems with players</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>14%</td>
<td>6%</td>
</tr>
</tbody>
</table>
In response to the question ‘How serious a problem do you consider the use of alcohol to be in Ireland today’ with four possible answers ranging from ‘not a problem’ to ‘very serious problem’, 97% of the sample rated it as a ‘serious problem’ or a ‘very serious problem’.

Figure 1 outlines coaches level of confidence that they ‘had the skills to speak with a player who has an alcohol related problem’ before they completed the SAOR training course. A total 26 (72%) of the coaches reported that they had little or no confidence, nine reported they were confident and one coach reported being very confident.

**Figure 1. Coaches’ confidence to intervene with players about their alcohol use before completing the SAOR training course**

The frequency that coaches had spoken to GAA players about problems related to the players use of alcohol was almost evenly distributed between 14 who had spoken to players less than five times and 12 coaches who had spoken to players more than five times. There were a further eight coaches who had never raised the issue with a player.

Participants were asked to choose from five options that described what they wanted to get from the SAOR course. All of the requests were captured in three categories with 83% of coaches looking for skills to speak to players about their use of alcohol.
Figure 2. What coaches hoped to get from the SAOR training course

![Bar chart showing coaches' hopes for the SAOR training course]

ii) The course

The data submitted by the participants in the post-training questionnaire forms the basis for the information displayed below about the SAOR training course. It outlines the participants’ subjective experience of the course and focuses on their level of enjoyment of the course and the relevance it has to their role as a GAA coach.

Table 5 outlines some of the experiences of coaches attending the SAOR course. Over 94% of participants indicated that they “agreed” or “strongly agreed” the training course was appropriate, understandable, clearly presented and helpful to them.

<table>
<thead>
<tr>
<th>Table 5. Coaches’ subjective experience of attending the course.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strongly Disagree</strong></td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>I was right person to attend the training</td>
</tr>
<tr>
<td>I found it was easy to understand</td>
</tr>
<tr>
<td>It was clearly presented</td>
</tr>
<tr>
<td>It will help me in my role</td>
</tr>
</tbody>
</table>
The ratings for both enjoyment and relevance of the course to the participants in Figure 3 was high with no participants indicating that they enjoyed “none” or “a little of it”. A total of 92% of coaches stated they enjoyed “a lot” or “all of it”. The figures among participants for the relevance of the course are similar with 86% indicating it was relevant to their role.

**Figure 3. Coaches sense of enjoyment and relevance of SAOR training course**
iii) The impact of the course

The impact of the course was measured by comparing the pre-training and post-training data and noting the changes that had occurred over time. With the exception of one hope from the Dublin group, the participants data about what they hoped to get from attending the course and what they believed they got as a result of attending the course indicated findings that universally met or exceeded their hopes. This is outlined below in Table 6.

### Table 6. Coaches hopes and outcomes from attending the SAOR training.

<table>
<thead>
<tr>
<th>Hope and outcome</th>
<th>Galway</th>
<th>Dublin</th>
<th>Cork</th>
<th>Monaghan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoping to get some more information about alcohol</td>
<td>27%</td>
<td>25%</td>
<td>43%</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>I got some more information about alcohol</td>
<td>27%</td>
<td>25%</td>
<td>57%</td>
<td>21%</td>
<td>31%</td>
</tr>
<tr>
<td>Hoping to get information that I can give to players</td>
<td>73%</td>
<td>75%</td>
<td>71%</td>
<td>50%</td>
<td>64%</td>
</tr>
<tr>
<td>I got information that I can give to players</td>
<td>82%</td>
<td>25%</td>
<td>71%</td>
<td>71%</td>
<td>69%</td>
</tr>
<tr>
<td>Hoping to get skills that I can use to speak to players</td>
<td>82%</td>
<td>100%</td>
<td>100%</td>
<td>71%</td>
<td>83%</td>
</tr>
<tr>
<td>I got skills that I can use to speak to players</td>
<td>82%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
<td>92%</td>
</tr>
<tr>
<td>Hoping to get something else from the course</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>I got something else from the course</td>
<td>9%</td>
<td>0%</td>
<td>0%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Not hoping to get anything from the course</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>I got nothing from the course</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Coaches' confidence to intervene with players

A paired sample t-test was chosen to test the hypotheses that coaches who completed training in how to perform a brief intervention for alcohol would be more confident and therefore, more likely to do. The 36 coaches reported confidence to intervene with players about their alcohol use before the training course was compared with their level of reported confidence at least one week after the training course. The paired sample t-test showed that there was a significant difference $t=10.648$ @ 35df; $P<0.00$ ($\bar{X}_1$ 2.11(.85); $\bar{X}_2$ 3.67(.79)) in coaches reported confidence before and after the training.

The data that shows an increase in reported confidence is reflected in Figure 4 where the change in levels of confidence is apparent from the movement along the confidence scale from the lower end on the left to the higher end on the right. These data are also illustrated in percentage form in Table 7 below. At the lower end of the scale where eight coaches initially reported being “Not at all confident” before the training course was reduced to zero following the training course. At the higher end of the scale the number of coaches who reported being “Very confident” increased from 1 to 5 following the intervention. A general trend towards an increase in reported confidence is reflected throughout the study.
Figure 4. Coaches reported confidence to intervene with players about their alcohol related problems before and after completing the SAOR training course.
Table 7. Coaches reported confidence to intervene with players about their alcohol related problems before and after completing the SAOR training course.

<table>
<thead>
<tr>
<th>Confidence before training</th>
<th>Not at all Confident</th>
<th>A little Confident</th>
<th>Quite Confident</th>
<th>Confident</th>
<th>Very Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>22%</td>
<td>50%</td>
<td>25%</td>
<td>0%</td>
<td>3%</td>
<td></td>
</tr>
</tbody>
</table>

Confidence after training

<table>
<thead>
<tr>
<th>Not at all Confident</th>
<th>A little Confident</th>
<th>Quite Confident</th>
<th>Confident</th>
<th>Very Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>6%</td>
<td>36%</td>
<td>44%</td>
<td>14%</td>
</tr>
</tbody>
</table>

A comparison of groups of coaches with less than and more than 5 years coaching experience yielded results that showed higher levels of reported confidence throughout both groups after completing the training course. Figure 5 represents coaches with more than both groups with low levels of confidence to intervene before the training course and the straight lines outline the increase in confidence among both groups following the intervention.

Figure 5. Reported confidence of coaches with more than 5 years coaching experience to intervene with players about their alcohol use.
Figure 6. Reported confidence of coaches with less than 5 years coaching experience to intervene with players about their alcohol use.

![Confidence of Coaches with Less Than 5 Years Experience](image)

Similar findings are evident in Figures 7 and 8 where coaches with lower and higher levels of coaching qualifications showed an increase in reported confidence to intervene with players about their alcohol use.

Figure 7. Reported confidence of coaches with lower levels of coaching qualifications to intervene with players about their alcohol use.

![Confidence of Coaches with Lower Qualification](image)

Coaches with lower qualification before training
Coaches with lower qualification after training

Coaches with less than 5 years experience before training
Coaches with less than 5 years experience after Training
Figure 8. Reported confidence of coaches with higher levels of coaching qualifications to intervene with players about their alcohol use.

The data displayed in Figures 9 and 10 outlines the reported confidence of coaches who had previously intervened with players about their alcohol use more than five times and coaches who had intervened less than five times respectively. There was no reduction in reported confidence in either group.

Figure 9. Reported confidence of coaches who had previously intervened with players about their alcohol use less than 5 times
Figure 10. Reported confidence of coaches who had previously intervened with players about their alcohol use more than 5 times.

(iv) The relationship between the course and its impact

The data represented in this section was gathered from the participants’ answers to the open ended questions on the questionnaires asking for their opinions. The participants were asked to indicate if they had completed any actions from a list of 9 options related to the SAOR training that described their behaviour since finishing the course. The choices were:

1. Spoken to other people in your club about it
2. Recommended that others complete it
3. Recommend that others do NOT complete it
4. Planned to speak to a player/member about their alcohol use
5. Planned to conduct a brief intervention using the SAOR model with a player
6. Spoke to a player/member about their alcohol use
7. Performed a Brief Intervention using the SAOR model
8. None of these
9. Done something else since the course

The two most popular answers were ‘Spoken to other people in your club about it’ and ‘Recommended that others complete it’ with each of them receiving 24 (67%) responses. The next most significant answer came from six (17%) participants who had ‘planned to speak to a player about their alcohol use’ but had not yet done so.
This was followed by two (5%) who ‘planned to conduct a BI using the SAOR model’, and two who indicated that they had already intervened with a player since completing the course. The range of responses are outlined in Figure 11 below.

**Figure 11. Coaches actions since completing the SAOR training course.**

![Coaches actions since completing SAOR training](chart)

The participants were asked to ‘agree’ or ‘disagree’ with six proposed changes that could be made to the SAOR training course in order to elicit further information about how the content and structure of the course impacted on their experience. The thrust of the participants’ suggestions as outlined in Table 8 were to keep it brief, provide more resources and increase the amount of participation.

**Table 8. Participants’ suggestions for improving the training course**

<table>
<thead>
<tr>
<th>Suggestion</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make it longer</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>Have more handouts</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>Show more videos</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>Have more role-plays</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>Have more discussions</td>
<td>29</td>
<td>7</td>
</tr>
<tr>
<td>Have more presentations</td>
<td>17</td>
<td>19</td>
</tr>
</tbody>
</table>
The responses to the open question ‘Are there other things you would change about the training?’ led to a range of responses from 11 participants are grouped into four categories in Table 9.

**Table 9. Summary of coaches’ suggestions to change the SAOR training**

<table>
<thead>
<tr>
<th></th>
<th>Suggestion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have more small-group discussions</td>
</tr>
<tr>
<td>2</td>
<td>Have more role plays</td>
</tr>
<tr>
<td>3</td>
<td>Have more information on alcohol and other drugs</td>
</tr>
<tr>
<td>4</td>
<td>Have more of this type of training</td>
</tr>
</tbody>
</table>

In response to the open ended question ‘What do you think the GAA needs to do next to help players with alcohol-related problems?’ 20 participants made suggestions and 10 participants responded to the open ended question ‘What else do you need to deal with players who have alcohol-related problems?’ Answers to each of the questions have been grouped into three categories in Table 10 below.

**Table 10. Summary of coaches needs to help players with alcohol-related problems.**

<table>
<thead>
<tr>
<th>What do you think the GAA needs to do next to help players with alcohol-related problems?</th>
<th>What else do you need to deal with players who have alcohol-related problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Formalise links with alcohol and other drug services.</td>
<td>1 More links with alcohol and other drug services.</td>
</tr>
<tr>
<td>2 Greater promotion of the ASAP Programme.</td>
<td>2 More pocket sized handouts, leaflets and posters.</td>
</tr>
<tr>
<td>3 Provide more education and support for players and coaches.</td>
<td>3 More of these types of education courses.</td>
</tr>
</tbody>
</table>

**Summary**

The data in this chapter can be summarised under the four categories of (i) the participants (ii) the course, (iii) the impact of the course and (iv) the relationship between the course and its impact.
(i) The participants - The coaches had an age range over 43 years, were experienced in training a variety of GAA teams and largely well qualified to do so. All of them chose to attend and one third currently had players that they needed to speak to about their alcohol use. Throughout their coaching career in excess of 80% had observed alcohol problems while coaching GAA players and 97% rated alcohol as a ‘serious problem’ or a ‘very serious problem’ in Ireland today.

(ii) The course - Almost all (94%) of the participants “agreed” or “strongly agreed” that they found the training course was appropriate, understandable, clearly presented and helpful to them in their role as coaches. Additionally 92% of coaches enjoyed “a lot” or “all of it” while 86% of them indicated it was relevant to their role.

(iii) The impact of the course - The course met or exceeded their all their hopes for information and skills to use with players who have alcohol related problems. The data received from the coaches indicates that regardless of the level of their coaching qualifications, years of coaching experiences or prior experience intervening with players about their alcohol use, the intervention did not cause a reduction in their reported confidence to intervene. A paired sample t-test showed that there was a significant difference in confidence to intervene with players about their alcohol use among coaches who submitted pre and post-training questionnaires.

(iv) The relationship between the course and its impact - The coaches identified that the if ongoing SAOR courses and more resources could be allied to ongoing professional support and education, coaches would be better able to continue to address alcohol related problems with players.
Chapter Six

Discussion, conclusions and recommendations
Discussion

If you don't find some way to discuss what's going on inside you, it can come out in other ways that are self-destructive.

- Viggo Mortensen

The general thrust of the findings of the study are in support of the hypotheses ‘Can a single health education session increase the likelihood of sports coaches performing brief interventions for problematic alcohol use with their athletes’. These findings will be discussed in this chapter in the same categorical order in which they were reported; (i) the participants, (ii) the course, (iii) the impact of the course and (iv) the relationship between the course and its impact before recounting of some of the strengths and limitations of the research and the intervention in a more generalist manner.

(i) The participants

Of the original 50 participants who attended the course, 46 returned the post-training questionnaires. Response rates of this level (92%) are rare and it was unfortunate that ten of the participants who had no experience of coaching. As a result the data they submitted were excluded from the study. Had stricter entry criteria been advertised and applied it may have led to a higher number of eligible participants. Due to an administrative error with the Dublin intervention only 4 coaches took part in the training course. This led to an approximate reduction of 8 to 12 coaches from taking part in the study. A larger number of coaches in the sample would have led to more interesting results.

Following the randomisations that were applied to the sample, the ranges of age, reasons for attending, qualifications and coaching experience among the participants were widely spread as was their reasons for attending and what they hoped to gain as a result of completing the SAOR course. It is possible that the high level of fulfilment of their hopes was achieved as a result of the narrow focus
of the course and the specificity of their hopes. The finding that none of the coaches reported a reduction in confidence to intervene with player about their alcohol use is likely to also have positively affected their sense of hopes being fulfilled.

As the training courses and the efficacy studies on BI’s for alcohol use reported in the literature were conducted with healthcare professionals this may be the first time that such an initiative had been conducted in sports setting. Should this be the case it is in keeping with the proposal put forward by Smith, Hodgson and Bridgeman (2003) who recognised that BI’s could be delivered by a range of providers all of whom did not necessarily need to be health or social care professionals. Consequently the participants in this study are likely represent a novel and unique group in the canon of brief intervention trainees.

Considering the intensity and duration of the controversy (Shaw, Cartwright, Spratley & Harwin, 1978) about brief intervention that has persisted within the alcohol treatment arena the participants in this study showed very low levels of resistance to the philosophy, practice and results of the SAOR model of brief intervention during and after the training course. One reasons for this may be that coaches are not invested in a particular alcohol treatment philosophy and therefore have little to lose by incorporating it into their range of coaching skills. In addition to a ‘nothing to lose’ approach coaches may have adopted a ‘something to win’ approach. A coach who successfully intervenes with a player in difficulty and helps to reduce his or her alcohol related problems is likely to create a benefit for the entire team and move closer to their goals of helping the individuals and team reach their full potential.

The findings for this group of coaches while not representative of all GAA coaches are in keeping with the wide array of literature confirming the validity of brief intervention as a method for addressing concerns about a persons alcohol use and with the relative ease and which brief intervention can be applied within a short time frame (Kaner et al. 2007). In this instance the recognition that brief intervention can be used by non-specialists to address alcohol related concerns is a significant addition to the literature.
ii) The Course
The data outlining the high level (94%) of agreement that the training course was appropriate, understandable, clearly presented and helpful to was probably a reflection of the way that the course content was structured so that it attended specifically to coaches needs. The coaches’ subjective experience of enjoyment and relevance of the course were also rated highly and this may have been related to the style of presentation of the trainers who attempted to deliver the training in a manner that was congruent with the supportive ethos of the SAOR model. The coaches’ experience of the course as both highly enjoyable and relevant to their role may also be related to the concept of ‘empathy’. Throughout the literature from the early studies by Chafetz (1962) to the most recent work of Miller and Rollnick (2012) empathy has been regarded as a central tenet of conducting a brief intervention. Coaches need to have an implicit understanding of the concept and practice of empathy to connect with their players to realise when it is appropriate to challenge or support them to draw on the players’ motivation to perform at their best. As the language of brief interventions includes concepts of empathy, motivation, connection, challenge and support perhaps it is not as alien to coaching as it may have originally seemed and as a result could easily be both enjoyable and relevant to GAA coaches.

The SAOR training course was adapted for GAA with the aid of its authors, James O’Shea and Paul Goff. The usual SAOR training is 12 hours in duration delivered over a two day format to healthcare professionals. This is in accordance with many of the training courses in a variety of brief intervention models. The training course for initiates in the FRAMES model and the 5 A’s model are often delivered over a similar time period. The SAOR training for GAA coaches was shortened to two hours in keeping with the research design to see if a ‘single health education session increase the likelihood of sports coaches performing brief interventions for problematic alcohol use with their athletes?’ The training course was engineered to reflect a SAOR brief intervention in both process and content and included instruction on the common elements among all BI’s of opportunism, screening, individuality, focused, short-term, person-centred and information provision. While the topic being focused on in this study is alcohol the evidence of the applicability of BI’s with issues including anxiety, tobacco use, physical exercise and diet
abounds (Evans, 2011). These issues are core to the performance of players and have direct relevance to players’ on-pitch and off-pitch lifestyle and consequently are important to GAA coaches. Coaches may be able to adapt the SAOR information to address these issues in order to positively influence the health and wellbeing of their players.

(iii) The impact of the course

The change in coaches reported confidence during the time period between their completion of the pre-training and post-training questionnaire was notable as there was no reduction in confidence among participants and all but one reported an increase in their confidence to intervene. The possibility of bias must be considered here as there are a number of ways that it could have influenced the participants and the researcher (Shuttleworth, 2009). The pre-training and post-training questionnaires completed by coaches may include an element of bias because they were reporting on their own confidence levels and as a subjective measure and cannot be measured objectively. There is also potential for bias on behalf of the coaches as they were aware that one of the trainers who delivered the training at each intervention site was conducting the study and was the chairperson of the ASAP Programme. This increases the risk of bias as the participants may consciously or unconsciously want to provide positive results for the researcher. Due to the multiple levels of involvement of the researcher this also leaves this study open to further criticisms of bias.

In the week following the intervention two of the coaches reported that they conducted a brief intervention about alcohol use. This study was designed to measure changes in coaches reported confidence to intervene with players the amount and not coaches actions as a result of completing the SAOR course. While it is possible that the two coaches in question would have intervened with players about their alcohol use regardless of attending the SAOR course and it is also possible that this was something that they did as a result of completing the training course. Further investigation is required to discover the full impact of the SAOR course on coaches’ subsequent actions and to highlight any other changes that may have occurred in their coaching practice as a result of their participation in the intervention.
(iv) The relationship between the course and its impact

The completion of the training course coincided with an increase in coaches' reported confidence but as yet there is no proof that the former had a mechanistic effect on the latter. The participant's sense of enjoyment and relevance of the course to their coaching work was a likely factor in their high levels of willingness to speak about it and recommend it to others. This may have been aided by the novelty of the training course and the discussion of such issues in a GAA setting. The responses submitted by the participants that recommended repeating and expanding this type of training and developing further coach-specific resources and support networks intimate that coaches have a range of needs that are as yet unmet in the GAA. Were initiatives to be designed to address these needs and further research be completed it is likely that greater understanding of the subtleties of how the course impacted on coaches' confidence to intervene with players about their alcohol use could be gained.

The request by coaches to expand the range of training, build supportive networks and develop further resources to use with players are in accordance with the Dunn's (2001) observation of the growth of BI's in a number of new fields including health promotion. The coaches' request appears to be mirroring the recommendations of the HSE Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use (2012). The HSE Framework document outlines the need to ensure that high quality training packages in BI's be delivered to staff and that structures be developed to see that staff are supported and resourced adequately to implement BI's in a consistent manner with appropriate service users. A further instance of this 'mirroring' between the GAA and the HSE can be seen in the HSE's selection of SAOR as the model of choice for building its brief intervention framework. As the GAA have committed to developing health promotion initiatives across a range of topics, the introduction of a tailored version of the SAOR model of brief intervention in a coaching setting appears to be both compatible and welcome.
Strengths and limitations

Some of the factors that added to the strengths of this study were that it was conceived and delivered internally within the GAA. As it was designed exclusively for the GAA to accentuate the work of the ASAP Programme and as a result it appeared to be a good fit for the participants. This may also have been a limitation due the lack of objectivity that was present and a review of the process by an outside source could lead to some interesting observations and revisions.

The use of the GAA mail system to design the measures, administered the sample selection and conduct the data gathering process was familiar to coaches and fit well within GAA communication structures and assisted with the transition coaches underwent in completing training in an issue that GAA had not offered them heretofore. Should further research be attempted with a similar sample the GAA Mail system would likely be an invaluable tool to assist in that process. While the effect time between the completion of the intervention and the post-training questionnaire of one week saw two coaches’ complete brief interventions with players it was too short a time period to see the potential full range of the effect of the intervention. Allowing for a longer time between the intervention post-training questionnaires may have shown greater gains.

The intervention was designed to measure if a single session training course could increase coaches reported confidence to intervene with players around their alcohol use and this led to a positive finding. In keeping with the research design there were no follow up training sessions planned. Had the research being designed to include follow-up booster sessions at a later stage it could have allowed for the development of coaches learning in the area of brief interventions and the collection of further data to outline if any further changes took place.

The same two trainers delivered both of the training courses in the pilot study while the same trainers did not lead all four intervention training sessions. This procedure was overlooked in the intervention study and as a result only one trainer attended all four intervention sites. Had the same two trainers attended all four of the intervention sites and delivered to training in each site it is likely that a more
congruent approach could have been taken to the delivery of the training and a more robust administration of the study would have been present.

The entry criteria could have been more clearly defined. In number of individuals who took part in the training course were not coaches. As a result their data was excluded from the analysis. Had the entry criteria being more clearly specified that the training was for people with coaching experience, a larger number of coaches could have taken part in the study.

Conclusion
This study has found that a sample of GAA coaches reported an increase in confidence to intervene with GAA players following completion of a two-hour training course in the SAOR model of brief intervention for alcohol use. Considering the breadth of evidence that has shown the efficacy of brief interventions as a method of treating alcohol problems in healthcare settings it is possible that training non-specialist coaches to intervene with athletes may be a useful initiative to reduce alcohol related harm and promote health.

Recommendations
The participant’s recommendations to advance their involvement and proficiency in responding to alcohol related issues will be reported in the categories of relevance to i) policy, ii) practice and iii) research.

(i) Relevance to policy
The suggestion that the Gaelic Athletic Association continue to develop and deliver this type of training to coaches has a direct impact on GAA policy. The development in recent years of a number of health promotion initiatives such as the ASAP Programme, the Social Initiative and the Healthy Club project is evidence of the continuing commitment to the ethos of community espoused by GAA. Continuing to develop initiatives in support of the SAOR training course would be further confirmation of that principle and be in keeping with the National Drugs Strategy (2009).
Developing additional links with health promotion services for alcohol and other drugs could lead to the opportunity to engineer further education initiatives and treatment pathways for GAA members. The benefits of developing such support networks would include not only greater access in time of need but also increase the possibility of novel ideas for service re-orientation and development.

(ii) Practice
The development of the SAOR training course and similar initiatives would require a further operational of the existing ASAP Programme structure. The requirement to train more trainers is a necessity if the SAOR training course was to be developed for wider audiences and this would require a ‘training for trainers’ type course to be developed and administered in order to examine if these recommendations can be translated into wider practice.

(iii) Research
The suggestions to develop further resources such as pocket sized cards containing information on SAOR could be initiated with a small scale research project that would trial a variety of information and formats. This is also true for developing other information resources recommended by participants. In order to develop further education and training initiatives a larger scale piece of research may be needed to assess what the purpose, content and delivery mode of such courses would be. Both of these initiatives could be instigated with an initial survey of GAA coaches using the GAA mail system to determine the parameters of each project.

Summary
The objectives of this thesis were fivefold and intended to describe a range of topics that were relevant to the research question ‘Can a single health education session increase the likelihood of sports coaches performing brief interventions for problematic alcohol use with their athletes?’ The chapter on alcohol outlined the widespread harm that is related to alcohol use and presented evidence that defined the concept of drug prevention and how it is linked with sport. It went on to elaborate on the difference between how sport can have a preventative effect on illicit drug use while at the same time promote alcohol use. The development of
the GAA ASAP Programme and the some of the initiatives it led to were reviewed using the principles of the Ottawa Charter to inherent its health promotion structure.

The mechanism of action at the centre of the research question in this study is the SAOR model of brief intervention. The history and efficacy of brief interventions were presented alongside the accompanying controversy in the alcohol treatment field. The initial opposition to BI appeared to be more ideological than evidence based but continues to this day despite the regular and substantial evidence that shows the validity of BI’s as a method of mediating alcohol related concerns. By way of clarifying the theory, practice and effectiveness of brief interventions, motivational interviewing was described so as to offer a counteractive view on the stance in some of the literature that MI and BI are analogous. While it is important to recognise that there are occasional similarities it is more appropriate to discuss the differences and to recognise how the extent of the contribution that motivational interviewing has offered to the field of psychotherapy outweigh that of brief interventions.

The examination of the research question relating to coaches reported confidence to conduct brief interventions led to the detail of the Methods and the Results chapters being exposed. The question was answered in the affirmative and a number of observations were made that if acted upon, could have the effect of increasing health promotion activities throughout the GAA. The conclusions that were drawn and the recommendations that were made on the potential to promote health through further use of SAOR and other brief intervention frameworks have yet to be tested, but appear plausible in light of their congruence with existing literature.
References
References


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Appendix
Appendix A

SAOR Model Skills Practice

Coach

Imagine you are a coaching a team in your local club.

One of the best players you coach has not been performing as well as usual over the last two months. You have heard from another coach that this player has been drinking heavily over the season.

The player arrives at training and appears under the weather.

Using the SAOR model as a guide, have a short conversation with the player.

| S | SUPPORT | Ensure an open and friendly style of communication  
Assure the person know that you understand their current situation/ difficulties  
Build up the persons confidence to make a change |
|---|---|---|
| A | ASK THE RIGHT QUESTIONS | Ask about alcohol use  
Elicit the members concerns about drinking.  
Check for obvious problems associated with drinking  
Check out what else is going on  
Check out if they are ready to make a change |
| O | OFFER ASSISTANCE | Give advice and feedback about the effects of drinking.  
Leave responsibility for change with the member  
Discuss a variety of options for change  
Agree goals for change |
| R | REFER | Discuss the range of help/support services that are available  
Advise member to seek further help if necessary  
Check in on progress after a period of time |
Appendix B

SAOR Model Skills Practice

Player

Imagine you are a very competent player in your local club and competitive by nature.

You have been having a difficult time personally over the last few months and noticed that you have been drinking more than normal.

This has affected your training and games to some degree.

Your coach, who you like and respect, approaches you to speak about this.

You are initially a bit resistant to this but you see that your coach is genuinely concerned for your wellbeing.
Appendix C

Alcohol and Sports Performance – www.gaa.ie/asap

The social side of Gaelic Games is very important and celebrating with team members after a match is a tradition in some clubs. However, if your celebrations involve drinking alcohol and especially if you drink to the point where you get drunk, this can seriously affect your fitness. If you take your sport seriously, and like to do the best you can for yourself and your team, it’s worth knowing the facts and what you can do to reduce your risk of poor performance.

**Greater risk of muscle cramps:** During exercise, your muscles burn sugar thereby producing lactic acid. Too much lactic acid leads to muscle fatigue and cramps. If you drink in the 24 hour period before a match the alcohol contributes to a bigger build up of lactic acid and dramatically increases your risk of cramping.

**Greater risk for injuries and complications:** Alcohol increases the bleeding and swelling around soft tissue injuries (sprains, bruises, and cuts- the most common sports injuries) requiring a longer recovery period. Alcohol also masks pain, which may lead you to delay in getting treatment—rapid treatment can make all the difference in a speedy recovery. If you’ve been injured, avoid alcohol, as it will complicate your recovery.

**Greater body heat loss:** Alcohol is a vasodilator (it causes the blood vessels near the surface of the skin to expand) and thereby promotes heat loss and a lowered body temperature.

**Reduced endurance:** The blood sugar your body needs for energy is produced by the liver when it releases glucose into the blood stream. Drinking alcohol in the 48 hour period before a match reduces your body’s ability to produce this sugar, so you have less energy and less endurance capacity.

**Slower reactions:** Alcohol is a sedative and it can affect your performance during a game for up to 72 hours after you have finished drinking. Some players think they have less tension and increased relaxation as a result of alcohol. The actual result, however, is poorer hand-eye coordination and slower responses.

**Dehydration:** Alcohol promotes water loss. It reduces the production of the anti-diuretic hormone, causing you to urinate more. This, in turn leads to dehydration.

**Vitamin and Mineral Depletion:** Water loss caused by alcohol consumption involves the additional loss of important minerals such as magnesium, potassium, calcium, and zinc. These are vital to the maintenance of fluid balance and nerve and muscle action and coordination.

**Reduced aerobic performance:** Alcohol reduces the body’s ability to convert food to energy and also reduces carbohydrate/blood sugar levels. These effects, together with lactic acid build-up and dehydration, combine to reduce aerobic performance.

**Muscle injury:** The usual treatment for injury (rest, ice, compression, elevation) can be negated due to the painkilling effect of alcohol. If you can’t feel the pain of your injury you are less likely to take care of it and slow your recovery time or even cause further damage.

So, no matter how much training and conditioning you’ve put in, drinking up to 72 hours before a match or training will take the edge off your fitness. Drinking after playing slows recovery time too.

If you want to be the very best you can be at your sport you’ll have more of a chance of achieving that by not drinking alcohol. However if you do want to drink, then it's better to drink a little and not too often.
Appendix C

SAOR Training Course

The SAOR training course has been specially designed to train GAA coaches how to have short structured conversation with players about their alcohol use. The decision to roll out training for GAA coaches in this area arose from a national survey carried out by the ASAP programme in 2010 to which 347 coaches responded.

A total of 52% of coaches stated they have had to deal directly with problems of alcohol and other drug use amongst their players while only 6% expressed a high confidence in their abilities to successfully handle these situations. When 84% of respondents stated they would be willing to attend specific training for coaches in how to deal with problems caused by alcohol and other drugs, the ASAP programme set about facilitating this.

The SAOR Brief Intervention model was devised by two addiction treatment professionals Jim O’Shea and Paul Goff, both of whom are GAA members and ASAP Officers for their own clubs. The course was called SAOR, the Irish word for ‘free’ as it is an acronym for the four steps in the intervention:

S – Support  
A – Ask and Assess  
O – Offer Assistance  
R – Refer

It is important to note that very few, if any interventions in a GAA setting will ever reach the Refer stage – simply engaging in an encouraging conversation on the topic has been shown to be effective in getting players who are engaging with alcohol in a harmful way to change their behaviour.

GAA coaches have been identified as being in a unique position to identify players that may be struggling with issues related to alcohol or other substances e.g. they
may be missing training sessions, struggling with form and fitness, drinking to excess after games or at club functions, or struggling to adhere to periods of abstinence imposed on a squad. In addition, the respect and trust that exists between coaches and their players also places them in a strong position to bridge this potentially sensitive topic through using the SAOR approach.

The ASAP Programme’s National Coordinator Colin Regan and National Committee chairman, Brendan Murphy will deliver the training to 20 GAA coaches from across the county with the help and support of …….., Provincial ASAP Officer. At the training, coaches will be educated on how the use the SAOR model and how best to respond to certain alcohol or other drug-related issues in squad setting and they will be given a number of resources to take away with them. They will also be sent two short questionnaires by email in the days before and after they attend the course.

In an ideal world a GAA coach will never have to use these skills but we know coaches are already dealing with such issues. However we know from piloting this training elsewhere that coaches are finding it both reassuring and helpful and are glad to have learned some new skills. It is expected that the SAOR model will also help coaches deliver a new element of player welfare to their squad, get an appreciation of issues relating to substance misuse in Ireland today, and potentially reduce rates of player attrition in their clubs.

As this is the first time the SAOR training have been rolled out to club coaches by any sporting organisation in Ireland we can expect some very positive media coverage both locally and nationally for our engagement in this pilot.

_________________________

ASAP Provincial Officer
Appendix D

GAA SAOR Model - Pre-Training Questionnaire

To help you in your role in your club you have been invited to attend this training in how to speak to GAA players about alcohol related problems. During the SAOR Brief Intervention training you will be shown various ways that you can have short, helpful conversations with players who may be experiencing problems due to alcohol use.

We would be very grateful if you would fill out this short questionnaire before you attend the SAOR training course. It should only take 2 to 3 minutes of your time. Your answers to this survey will be treated as confidential information, be used to improve the training and will form part of a research project that is being conducted through NUI Galway.

1. Which of the SAOR training courses are you going to attend?
   - □ Connacht
   - □ Leinster
   - □ Munster
   - □ Ulster

2. What age group do you coach? (Please tick all that apply)
   - □ Under 14 (and younger)
   - □ Under 16
   - □ Minor
   - □ Under 21
   - □ Senior
   - □ None of these

3. How long have you been coaching GAA players?
   - □ Less than 1 year
   - □ 1 - 3 years
   - □ 3 - 5 years
   - □ More than 5 years
   - □ Other: ____________________________________________________
4. Which of the following coaching qualifications have you completed?
   (Please tick all that apply)
   □ Foundation
   □ Level One
   □ Level Two
   □ Level Three
   □ None of these
   □ Other: ________________________________________________

5. What is your date of birth? _______/_______/_______

6. What role(s) do you hold in your club?
   (Please tick all that apply)
   □ Chairperson
   □ Secretary
   □ Treasurer
   □ Registrar
   □ Coaching & Games Officer
   □ P.R.O.
   □ Irish Language & Culture Officer
   □ Vice Chairperson
   □ Vice Secretary
   □ Vice Treasurer
   □ Insurance Officer
   □ ASAP Officer
   □ Players Representative
   □ Development Officer
   □ Children’s Officer
   □ None of these
   □ Other: ________________________________________________
7. What is the main reason that you are going to attend this training course? (Please tick all that apply)

☐ I'm interested and want to go to find out more
☐ I have players that I need to speak to about their alcohol use
☐ In the past I have had players with alcohol related problems
☐ I'm not interested but I was told I have to go
☐ Other: ________________________________

8. How serious a problem do you consider the use of alcohol to be in Ireland today?

☐ Not a problem
☐ Small problem
☐ Serious problem
☐ Very serious problem

9. What alcohol related problems have you encountered when coaching players? (Please tick all that apply)

☐ Players missing training
☐ Players missing matches
☐ Players arriving under the influence
☐ Players under-performing
☐ Players being disruptive
☐ Players injured due to alcohol
☐ Players being aggressive due to alcohol
☐ Players being ill due to alcohol
☐ I have not encountered any alcohol related problems
☐ Other: ________________________________
10. How confident are you that you have the skills to speak with a player who has an alcohol related problem?

☐ Not at all confident
☐ A little Confident
☐ Confident
☐ Quite confident
☐ Very confident

11. How many times have you had to speak to players' about problems caused by their alcohol use?

☐ Never
☐ Once
☐ Twice
☐ Three times
☐ Four Times
☐ Five times
☐ More than five times

12. What are you hoping to get from completing the SAOR Brief Intervention training course? (Please tick all that apply)

☐ Some information about alcohol
☐ Some information that I can give to players
☐ Some skills that I can use to speak to players about their alcohol use
☐ None of these
☐ Other: __________________________________________________
Appendix E

GAA SAOR Model - Post training questionnaire

Thank you for completing the SAOR Brief Intervention training and agreeing to take part in this survey. We would like to know some of your thoughts about the training and would be grateful if you would answer the questions below. It should only take 4 to 5 minutes of your time.

1. Which of the SAOR Brief Intervention training courses did you complete?
   - [ ] Connacht
   - [ ] Leinster
   - [ ] Munster
   - [ ] Ulster

2. The SAOR training took about 2 hours to complete. Was this.
   - [ ] Too long
   - [ ] Too short
   - [ ] About right

3. Did you enjoy any of the SAOR Brief Intervention training?
   - [ ] None of it
   - [ ] A little of it
   - [ ] Some of it
   - [ ] A lot of it
   - [ ] All of it

4. How relevant was the SAOR Brief Intervention training to your role in your club?
   - [ ] None of it was relevant
   - [ ] A little of it was relevant
   - [ ] Some of it was relevant
   - [ ] A lot of it was relevant
   - [ ] All of it was relevant
5. Please tick the statements below that you agree with...

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was the right person to attend the training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was the right person to attend the training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It was easy to understand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It was clearly presented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It contained information that can help in my role</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. How could the SAOR Brief Intervention training course be improved?  
(please tick all that apply)

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make it longer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have more handouts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Show more videos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have more role plays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have more discussions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have more presentations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Are there other things you would change about the training?  
________________________________________________________________
________________________________________________________________
________________________________________________________________

8. What did you get from completing the SAOR Brief Intervention training course?  
(please tick all that apply)

☐ Nothing

☐ Some information about alcohol

☐ Some information that I can give to players

☐ Some skills that I can use to speak to players about their alcohol use

☐ Other: ____________________________________________________________
9. Since completing the SAOR Brief Intervention training have you.
(please tick all that apply)

☐ Recommended that others complete it
☐ Recommend that others do not complete it
☐ Performed a Brief Intervention using the SAOR model
☐ Spoken to other people in your club about it
☐ Planned to speak to a player/member about their alcohol use
☐ None of these

10. How confident are you that you now have the skills to intervene with a
player who has a problem with alcohol?

☐ Not at all confident
☐ A little confident
☐ Confident
☐ Quite confident
☐ Very confident

11. What do you think the GAA needs to do next to help players with alcohol
related problems?

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

12. What else do you need to deal with players who have alcohol related
problems?

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
Alcohol use amongst GAA players

960 players - 90% current drinkers - 8% smokers

– 31% regularly exceeded the recommended 21 standard drinks per week; 54% binged once a week
– Over 87% of the 864 drinkers reported at least one harm due to their drinking
– All alcohol misuse outcomes were higher than the national average for males of a similar age

What to watch out for!
Observe for evidence of alcohol related problems including:

- Regular heavy use during or outside club activities
- Regular drunkenness at club events or activities
- Alcohol withdrawal symptoms
- Needing more alcohol just to get the same effect
- Noticeably strong desire or compulsion to drink
- Difficulties controlling use during or outside club activities
- Regular attempts to stop/cut down
- Large amount of time spent on drinking & related activities
- Noticeable deterioration in game performance
- Neglect of club related activities

Alcohol & playing performance

- Greater risk of muscle cramps
- Greater risk for injuries and complications
- Greater body heat loss
- Reduced endurance
- Slower reactions
- Dehydration
- Vitamin and mineral depletion
- Reduced aerobic performance
- Can exacerbate muscle injury
SAOR Model

- Irish word for free
- New Model for Screening & Brief Intervention with Alcohol & Substance related problems developed in Ireland in 2006
- Initially developed at Waterford Regional Hospital while training hospital staff
- Contains all the key elements of evidence based practice in Screening and Brief Intervention
- Adapted for national guiding framework by HSE

Talking About Alcohol

**SAOR** Model

- Supports the person
- Asks & Assesses
- Offers Assistance
- Refers on (if necessary)
What the SAOR does!

<table>
<thead>
<tr>
<th>Supports</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>– Builds up trust</td>
</tr>
<tr>
<td></td>
<td>– Helps person to open up &amp; talk</td>
</tr>
<tr>
<td>Asks &amp; Assesses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Gets a description of the drinking</td>
</tr>
<tr>
<td></td>
<td>– Gauges readiness to change</td>
</tr>
<tr>
<td>Offers Assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Gives information on menu of choices</td>
</tr>
<tr>
<td></td>
<td>– Agrees next step</td>
</tr>
<tr>
<td>Refers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Gets help for person</td>
</tr>
<tr>
<td></td>
<td>– Links them with the right supports</td>
</tr>
</tbody>
</table>

Thanks

For more information contact…
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Brendan.Murphy@gaa.ie
087 2350970
or
www.gaa.ie/asap