



# Delivering Alcohol IBA

Broadening the base from health to non-health contexts: Review of the literature and scoping

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The authors are solely responsible for the content of the report.

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## Summary

There is a drive to encourage the delivery of alcohol IBA (Identification and Brief Advice) in a range of contexts beyond primary care and hospitals where the evidence for IBA is strongest. The main aims of the review and scoping are: to identify the key issues which arise in trying to roll out alcohol IBA approaches beyond primary care and hospital settings; and to identify possible facilitators and barriers to its uptake in diverse contexts.

There is a growing body of literature on the delivery of IBA in pharmacies, the criminal justice sector and educational settings. Although there is some evidence for the effectiveness of IBA in those settings the findings are complex and less clear than the evidence for its use in primary care. In the case of the delivery of IBA in educational organisations, the evidence comes primarily from the USA. A scoping exercise (UK only) identified a considerable number of projects delivering alcohol IBA in a wide range of settings – for instance, to young people drinking in open spaces, in services for homeless people, in leisure and activity centres, as well as in private sector businesses and social work contexts. However, few of these projects have been evaluated in any way; there are few narrative accounts of the implementation process and it is unclear how sustainable the projects are or to what extent skills and experiences are transferred to other contexts when projects cease.

There is considerable consistency across the literature regarding some of the challenges faced when trying to implement alcohol IBA. Notably, feelings of role inadequacy, concerns around role legitimacy and feeling that there is insufficient support to work with people with alcohol problems – issues identified many years ago as barriers to the delivery of IBA in primary care – are still relevant and highly important. As well as individual and professional factors, organisational support and commitment to integrating policies and interventions to address alcohol issues into strategies and work programmes often prove difficult.

Key points emerging from the review and scoping are:

- There is good evidence of the effectiveness of IBA in primary care, and to a certain extent in hospital emergency departments. Many of the skills needed are transferrable to other delivery contexts.
- There is a strong desire to broaden the reach of IBA beyond health settings, although the evidence base for effectiveness is not currently established.

- Barriers to implementation of alcohol IBA include lack of strategic and organisational commitment, professional lack of role adequacy and role legitimacy, lack of knowledge and skills, workload pressure, lack of time and resources, and perceived lack of support.
- In probation, pharmacies, and in schools and universities, delivery of alcohol IBA is feasible and there is some evidence of effectiveness. However, staff may need to be convinced of the value of IBA and need to be supported to optimise implementation of IBA into their usual practice.
- The workplace is a promising context for IBA delivery with potential benefits for both employees and employers. Integrating IBA into a wider workplace health and wellbeing strategy and ensuring confidentiality may encourage its acceptance. However, employers are likely to need incentives and to be convinced of the business case for supporting staff to take on IBA.
- Financial incentives may increase delivery but it is unclear how much the incentive needs to be to have an effect.
- Training staff, on its own, does not guarantee delivery of IBA.
- Computer based and especially online IBA models have potential to reach individuals who may not access health or support services. This method has been shown to be acceptable to student populations but requires much wider evaluation of the quality of provision, its uptake and effectiveness.
- In promoting further roll out of alcohol IBA in community settings, longer-term planning may be useful to ensure that organisational and professional commitment is sufficient to meet the challenges, that there is an appropriate target group for the delivery of IBA, and that training and support for implementation is tailored to the specific needs and cultures of organisations, professionals and client groups.
- Following allocation of resources, including training opportunities, to alcohol IBA and alcohol awareness promotion, there is a need to consider the potential role of monitoring and outcome evaluation in fostering implementation and demonstrating activity.

# Delivering Alcohol IBA: Broadening the base from health to non-health contexts

## Introduction

### IBA: the concept and its application

IBA stands for Identification and Brief Advice. Other related terms are SBI (Screening and Brief Intervention), OBI (Opportunistic Brief Intervention) and ABI (Alcohol Brief Interventions). 'Identification' generally uses a validated screening tool (such as AUDIT - Alcohol Use Disorder Identification Test; Babor et al., 2001). 'Brief intervention' describes a family of approaches (Heather, 1995) and 'brief advice' is a kind of brief intervention which can be defined as:

*'a short, evidence-based, structured conversation with a patient/ service user that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their behaviour'*

(NHS Health Scotland 2011).

Identification is typically followed by the offer of structured brief advice to increasing and higher risk drinkers with the aim of encouraging them to reduce their alcohol consumption. Drinkers identified as probably dependent are offered a referral to specialist services.

Brief advice has been advocated by health organisations such as NICE (National Institute of Clinical Excellence) to promote and encourage a range of lifestyle health behaviours, for example physical activity and smoking cessation (NICE 2013; 2006). Simple Brief Intervention approaches, delivered by a non-alcohol specialist, lasting no longer than 5 or so minutes are usually referred to as IBA (Identification and Brief Advice); longer approaches, usually using brief motivational counselling of between 20-30 minutes are commonly known as EBI (Extended Brief Interventions), sometimes also called 'brief lifestyle counselling'. The length of the intervention and the skills needed to deliver it has implications for who should deliver IBA and EBI and in what setting.

A recent briefing paper by the Alcohol Academy (Heather et al., 2013) raised a number of issues regarding the definition and application of IBA. For example, the authors questioned whether simple feedback (giving feedback on the person's risk level and a leaflet) could be considered brief intervention. The authors argued that, despite no direct evidence as yet to support their effectiveness, such approaches considered as 'minimal intervention' or 'IBA lite' may be acceptable and worthwhile in situations where other

approaches are not feasible, i.e. when the time available for the practitioner is limited. The briefing paper also raised the question whether the use of shorter screening tools, such as the AUDIT-C (Bush et al., 1998), FAST (Hodgson et al., 2002), PAT (Patton et al., 2004, Smith et al., 1996) or SASQ (Williams and Vinson, 2001) could be accepted and lead to Brief Advice without the use of the more comprehensive full AUDIT score, as shorter tools do not allow for differentiation between at-risk or likely dependent drinkers. The authors argued that the choice of tool was a matter of balancing what was feasible at a particular point in time with the aspiration for optimal outcomes. Providing information on local services and where to get help could be essential if such a brief approach was taken. With regards to the length and quality of training for non-specialists, Alcohol Academy (2013) suggested that training in providing simple brief advice could be delivered within a short time-frame of a few hours, whereas for brief motivational interviewing more advanced skills and training approaches were needed. While IBA training is available face-to-face and online, it was argued that non-alcohol specialist practitioners were likely to benefit more from training where they could practice delivery skills in face-to-face sessions.

These issues: the form of brief advice, who delivers it, in what setting, and the nature and extent of training needed to deliver IBA are particularly relevant when considering the implementation of IBA in contexts beyond traditional health care settings. Research conducted in general practice and hospital contexts has provided useful insights into the problems of implementation and we will consider this briefly before turning to the literature on attempts to use IBA outside these well-researched settings.

As IBA has been found to be effective in medical/clinical/specialist settings, it has been suggested that the expansion of IBA beyond these sites into a range of other settings could be beneficial to reduce alcohol related harm in the wider population. However, whilst there is strong evidence for its use and effectiveness within general practice and hospital settings, its acceptability and effectiveness in a wider range of contexts is less clear, and there are on-going problems implementing IBA even within the traditional health care contexts. Workforce capacity, skills and therapeutic commitment to delivering IBA are considered a fundamental requirement for the successful implementation of the approach. However, organisational factors and workforce issues have received little attention outside the literature on the use of IBA within primary care and hospital emergency departments.

## **Aims and structure of the review**

This review and scoping is part of a larger study examining the role of training in delivering IBA in non-health contexts. It is a narrative review which seeks to

provide an overview of the use of IBA within settings beyond general practice and hospitals. We will draw on lessons learnt from the use of IBA within primary care and hospital settings but the emphasis is on evidence of effectiveness and suitability across other settings. The focus of the review is on identifying barriers and challenges to delivering alcohol IBA in contexts outside the more traditional health settings and on looking at the role training may play in attempting to broaden the base of IBA delivery.

The main aims of this overview and scoping are:

- to summarise briefly the main insights from IBA approaches in health care settings
- to provide an overview of research on IBA in other non-health settings
- to provide some illustrative examples of current UK projects identified outside the literature
- to identify the key issues which arise in trying to roll out IBA approaches beyond traditional health care settings;
- to identify possible facilitators and barriers to its uptake in diverse contexts
- to provide a brief overview of the role of training in IBA delivery.

Following a description of the methods used to compile the literature review and scoping, we provide an overview of the main findings from studies on the implementation of IBA in two main health contexts - general practice and hospital settings. As most of the research has been conducted in these settings and the findings comprehensively reviewed, we will provide only a brief overview. This review then moves on to broader health contexts - pharmacies where there is a growing body of research, and dentistry where the possibility of delivering alcohol IBA has just begun to be explored. The next section looks at settings outside health and includes criminal justice and educational settings – where there is a considerable body of work, before turning to research on IBA in other non-health contexts. We then provide a brief overview and discussion of the role of training for the delivery of alcohol IBA in non-health contexts.

## Methods

The discussion of IBA in general practice and hospital settings relies on published reviews and aims to provide a broad overview. To identify literature on the use of IBA in other contexts, a comprehensive review of the published literature was conducted searching for peer reviewed articles on delivery of IBA and on training for delivery for IBA. The CINAHL, Medline and IBSS databases were searched. Other papers were identified from references

provided by the project advisory group, from colleagues who commented on drafts and from the researchers' own knowledge.

It was hoped to find additional projects described in grey literature and we attempted to identify others by using scoping approaches. These searches focussed on studies carried out in the UK.

The [Alcohol Learning Centre website](#) provided two potential methods of gaining information. Firstly two online forums; one for general questions, one for IBA trainers were accessed and requests for information on IBA in non-health settings requested. This resulted in one response from a trainer who left contact details. The second method was to search the 'Local Initiatives page' using the search facility. This produced several local projects which are described later in this review.

A range of ABI activity has been carried out in Scotland, including in criminal justice, social work, housing, homeless and young people's settings. Some details of these activities have been collected in a scoping exercise last year by NHS Health Scotland and brief details provided on their [web site](#). Only a few of the project results have been published. Of the 38 projects listed, we contacted 23 with a request for further information. We omitted from the scoping projects which offered awareness only, those which were vague about the target group or setting and those run by specialist alcohol/drug services. Replies were received from seven local co-ordinators.

A request for information to the INEBRIA Google group returned two responses. Both sources confirmed that a whole range of non-medical IBA activities were taking place in Scotland, including social work, criminal justice, housing and young people's settings. Unfortunately few of these projects have translated into published studies. Still, two interesting reports could be found, the results of a pilot IBA work in community justice settings (McAuley, 2012) and an evaluation of IBA training in social work (Fitzgerald, 2012).

The [Alcohol IBA blog](#) provided a page of information, links to conferences and links to presentations and papers presented at conferences specifically about IBA in non-medical settings.

A [Drug and Alcohol Findings](#) website search for IBA provided some further background papers but nothing specifically on non-medical settings above what had already been identified in the formal literature search.

A Twitter request for information on alcohol IBA in non-health settings was re-tweeted but also returned no responses.

A 'Google search' for alcohol IBA in non-health settings turned up little above and beyond what had been found via the formal literature search and a search of the alcohol learning centre website and IBA trainers forum.

To identify relevant studies regarding the provision of IBA training in non-health settings, a search was undertaken of the Alcohol Learning Centre website [local initiatives page](#) under 'Identification and brief advice projects'. The search found several local IBA training projects in non-medical settings. Descriptions of the projects are available on the website; only one had an evaluation report. Where contact details were provided an email was sent to project coordinators to request project write-ups or evaluations, should they exist. One contact replied, but no write-up was available.

Nilsen et al (2008: 254) point out that "the BI term has been used flexibly in the alcohol literature to encompass a wide range of activity in addressing alcohol-related risk and misuse ..." and that as a result "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". Equally, a number of terms are used in the literature – BI (brief intervention), IBA (identification and brief advice), ABI (alcohol brief intervention), for example. When discussing specific studies, the term used in the study is employed. Otherwise in this review, we use the term IBA or BI.

## IBA in health care contexts

### Primary care and hospital departments

The majority of research evidence for alcohol IBA has been undertaken in primary care and to a lesser extent, in hospital departments. Heather (1999) provides an account of the early research on minimal interventions in these settings and documents some of the challenges and barriers to its adoption and delivery. Although the focus of this review is on IBA use and implementation in the UK, the literature also draws on research from other countries.

There is now a large body of international research on the effectiveness of alcohol brief advice in primary care settings, including meta-analytic reviews (Poikolainen, 1999; Moyer et al., 2002; Kaner et al., 2007). Generally, the approach has been accepted as cost-effective in primary care contexts. Kaner et al. (2007:2), in a review of reviews, concluded that “Overall, brief interventions lowered alcohol consumption” and that “Longer duration of counselling probably has little additional effect”. The evidence for IBA in hospital settings is still inconclusive. In their overview of the literature, Wilson et al. (2011a) suggest that looking across hospital sites of emergency, inpatient, and trauma care, evidence of effectiveness is mixed and there is little evidence of long-term effects from interventions delivered in this setting.. However, they add that it is difficult to draw overall conclusions because of the distinct characteristics of different hospital departments and the different characteristics of patients across these settings.

The evidence for EBI (extended brief intervention) is less conclusive. EBI has been shown to significantly increase an individual's readiness to change and motivational levels (Kaner et al., 2013). Research frequently failed to find any evidence that longer (more intensive) brief interventions add significant additional benefit over shorter input (Bien et al, 1993; Freemantle et al., 1993; Moyer et al., 2002; Ballesteros et al., 2004; Kaner et al., 2007). However, some researchers argued that the mixed findings for EBI can be attributed to a failure to successfully implement the more intensive EBI in routine practice rather than to EBI itself (Kaner et al., 2013).

There are questions around the effectiveness of the approach for some people. In particular, studies have differed regarding the effectiveness of brief interventions for women. For instance, while Ballesteros et al. (2004) found no gender differences, Kaner et al. (2007) concluded that IBA in primary care was effective in men, with benefit at a year after intervention, but for women, they argued, there was insufficient research data. The degree of dependence is another complicating factor. IBA is intended for risky drinkers – those who drink at increasing or higher risk levels but are not alcohol

dependent and there is some discussion about whether IBA can work for dependent drinkers (Saitz, 2010). However, research has suggested that dependent drinkers might potentially benefit from IBA as an initial element of treatment on the basis of a stepped approach to treatment (Moyer et al., 2002). Wilson et al. (2011a) discuss the differential effects of BI on different population sub-groups and propose that further research is needed to understand what works for whom under what circumstances.

There is also debate around other aspects of IBA effectiveness and delivery. For example, some studies have questioned the effectiveness of IBA over the long-term and argued that booster sessions would be necessary to maintain positive effect. (Kristenson et al., 1983; Wutzke et al., 2002). Examination of who delivers the intervention – practitioner characteristics – is discussed by Wilson et al. (2011a). They note that the results of studies indicate the possible importance of ethnic matching and of counselors' skills level when the brief intervention model draws on motivational interviewing approaches. Apart from individual characteristics, some studies have considered the attitudes of professional groups towards IBA delivery. Continuing reluctance of general practitioners and hospital doctors to deliver IBA encouraged efforts to recruit other health professionals – mainly nurses – to undertake this role. Smith et al. (2003), for example, describe a nurse-led brief intervention delivered to young males attending hospital with alcohol-related facial injuries. The authors report a significantly greater reduction in the percentage of hazardous drinkers in the motivational intervention group than in the control group. Similarly, Coulton et al. (2009) in a randomised controlled trial of IBA delivery in accident and emergency departments report positive outcomes of an intervention delivered by an alcohol health worker. On the other hand, a randomised controlled trial in a Swiss accident and emergency department, found that delivery of a BI by a trained research assistant was ineffective in decreasing alcohol use and health resource utilization (Daepfen et al., 2003).

More recently the Screening and Intervention Programme for Sensible Drinking (SIPS) study, a large IBA research project, was undertaken in the UK to evaluate the effectiveness of different brief intervention strategies to reducing harmful drinking in health and criminal justice contexts. (Kaner et al., 2013; Coulton et al., 2009). The randomised controlled trial in primary care (Kaner et al., 2013) consisted of two interventions and a control group. After initial screening, the control group received a patient leaflet together with feedback of assessment results; the interventions consisted of five minutes of structured brief advice, and 20 minutes of brief lifestyle counselling after structured brief advice. The study reported a decrease in participants' drinking levels but found no evidence for the effectiveness of the two interventions compared with controls. The authors stressed that the findings of this study supported the conclusion from an earlier Cochrane

Collaboration systematic review (Kaner et al., 2007) that longer and more extensive brief interventions would not add significant benefit over shorter interventions. The authors further concluded that, given the extensive published evidence on the effectiveness of screening and brief intervention on reducing hazardous and harmful drinking, the case for wider implementation within primary care was strong.

A new research project is under way in England that is a spin-off from SIPS, known as [SIPS junior](#). It will address children's alcohol-related attendances at hospital emergency departments. It will be a large £2 million study led by the Institute of Psychiatry at Kings College, London. It aims to measure the level of alcohol consumption and alcohol related problems of children attending the departments, as well as developing, implementing and evaluating a screening tool and interventions that are aimed at adolescents in this setting.

In Scotland delivery of ABIs is a significant component of the Scottish Government Alcohol Strategy (2008). As part of the strategy, the NHS Health Boards were set a new health improvement target - HEAT H4 – which specified a target number of ABIs to be delivered across three priority settings, primary care, accident and emergency and antenatal care. Financial support and staff training were provided, and a national evaluation of its implementation was undertaken (Parkes et al., 2011). The aim was to achieve embedding of ABI delivery into the core business of the three settings. The evaluation indicated that Health Boards were able to deliver targets successfully, with the three year target of 149,449 ABIs delivered ahead of schedule. Healthcare staff were positive about the approach and felt that it was an appropriate part of their role. A population-wide approach to delivering IBA was favoured as less stigmatising than targeted approaches. Health Boards were also flexible in adapting the ABI programme to local contexts and needs. The extent of reach and impact of ABIs across the country was mixed with different approaches and infrastructures for delivery being adopted by general practices in response to payment structures. Common features which appeared to support implementation included:

- nationally co-ordinated and locally supported training opportunities
- 'leaders' at national to local levels able to support training opportunities
- 'leaders' at national to local levels able to support and encourage implementation.

## Barriers to uptake of brief interventions in general practice and hospital settings

There is a wealth of evidence from many countries that brief intervention can be effective in reducing clients' drinking levels. There is also evidence to suggest that patients are willing to be asked about their drinking. Research into the acceptability of brief advice highlighted high levels of patient satisfaction with this intervention, and that patients in primary care were willing to receive feedback, written information and advice about their drinking (Kaner, 2013). At the same time, the uptake and delivery of brief intervention within primary care and hospital departments has continued to be problematic despite recent improvements. A number of issues have been identified as barriers to implementation.

One major barrier is the continuing reluctance of general practitioners to identify and, in particular, to advise patients themselves (Shaw and Cartwright, 1978; Heather 1999). According to Spandorfer et al. (1999), who evaluated primary care physicians' screening methods for alcohol use and their management of problem drinkers in the USA, 72% of the physicians preferred not to do counselling with non-dependent drinkers but rather to refer the individual with alcohol-related problems to specialists; only 28% favoured the use of brief counselling treatment interventions. Roche and Friedman (2004) who conducted a review of the effectiveness of delivery of brief intervention within primary care internationally suggested that GPs' failure to screen and detect individuals with alcohol-related problems was associated with time constraints within primary care practice although short but accurate screening tools and computer-based rather than pen-and-paper based screening tools for use in busy primary care settings have been developed to encourage the uptake of brief interventions.

Perceptions of inadequate *role support*, are a consideration in low uptake of IBA but there are other, possibly more entrenched, barriers. Shaw and Cartwright's (1978) examination of attitudinal factors is still relevant in considering professional reluctance to undertake IBA. They highlighted a lack of *role legitimacy* as contributing to poor uptake. Many GPs feel that screening and brief advice is not a legitimate part of their work. This may be accompanied by feelings of *role inadequacy* - fear of losing patients, finding it difficult to raise questions about harmful drinking, holding potentially negative attitudes towards individuals with a drinking problem, feeling that there is nothing they could do to help a person with a drinking problem, and a lack of confidence and skills to address drinking problems. There is some indication that, within primary care, these barriers may have lessened. A study on changes between 1999 and 2009 in GPs' attitudes and practices found that there was a significant trend towards GPs identifying and managing more patients in 2009 than in 1999; most felt that it was a legitimate part of their role. However, the authors concluded that there were still considerable

gaps between actual practice and the potential for preventative work. Practical barriers – such as low levels of training and support and too little time - were seen by GP's to be more important than attitudinal factors as barriers to early intervention approaches (Wilson et al., 2011b).

Support for the view that practical and organisational factors may now outweigh attitudinal factors as challenges to implementing IBA comes from the findings of the evaluation of Scottish ABIs. Main organisational barriers were identified as:

- lack of 'lead in' time to set up organisational structures
- competing priorities
- initial lack of adequately trained staff and difficulties maintaining trained staff levels
- problems with the mechanisms for recording IBA delivery. (Parkes et al, 2011: abstract).

The issues highlighted from studies in primary care settings have wider relevance. Role legitimacy, role adequacy, task-specific self-esteem and motivation and issues of workload, time and support, and organisational context are likely to be of even greater significance for the implementation of IBA in contexts which go beyond the core health settings.

## Pharmacy settings

Pharmacists and pharmacy staff make up the third largest professional health care work force in the UK and globally (FIP Global pharmacy workforce report, 2012). In the UK, their potential to deliver alcohol IBA has been confirmed in a number of reviews and evaluation studies.

Holyfield (2009) reviewed evidence on the role of pharmacies in addressing risky drinking based on seven UK studies and one from New Zealand. The studies focussed on feasibility and acceptability of IBA in pharmacy settings and on the effectiveness of IBA training. Pharmacists are very well located in different communities with good access to the population and the results from Holyfield's review showed that it is feasible and appropriate to deliver IBA; however a number of difficulties were identified:

- Very few pharmacists actually delivered IBA despite receiving training.
- Time management/workload issues were seen as a reason for failure to deliver.
- There was a perception of patient embarrassment.
- There was lack of knowledge and a need for training.

Holyfield concluded, therefore, that there is only limited good quality evidence for the effectiveness of IBA in pharmacy settings. Training was seen as the key to the ability and confidence of pharmacists to intervene appropriately.

Gray et al. (2012) completed an evaluation of pharmacy IBA implementation in the North West of England. Their study looked at how IBA had been adapted for, and implemented in, pharmacy settings and how its potential to reduce alcohol harm could be maximised. Key points from the evaluation showed that there was great variability in the numbers screened between pharmacies; some were prolific, some screened very few. Similarly, there was great variability in the consistency of the advice offered. Workload and competing pressures affected ability to implement IBA. They found that staff felt a private area or consulting room was essential and some of the staff did not like the tone of the AUDIT screening tool. Respondents felt there were ways of including alcohol within less threatening discussions around lifestyle or health generally, rather than as a stand-alone issue. As in some other settings, service champions were recognised as useful and a good support mechanism. The authors noted that in order for commissioners to continue supporting and funding IBA rollout in pharmacies, clear outcome based evidence would be needed.

Acceptability to customers of an intervention delivered in four community pharmacies was the focus of a study by Dhital et al. (2010). Interviews with 102 participants found that most were prepared to answer questions about their drinking and to accept written information. The majority supported the role of pharmacies as sources of information and pharmacies were thought to be an accessible place for receiving information and advice. Lack of privacy and lack of time were concerns voiced by both customers and pharmacists. Other concerns included:

- whether pharmacists had sufficient knowledge or training to conduct alcohol screening and brief intervention
- some apprehension about discussing 'personal' alcohol use
- customer fears about being patronised or labelled as having an alcohol problem
- concern that the service may not be completely anonymous and that records may be kept.

Nevertheless, 52% were identified as risky drinkers.

In a later stage of the work, the same team conducted a feasibility study of outcomes and customer experience of IBA in 26 community pharmacies in south London. They assessed uptake of the IBA service, examined changes in alcohol consumption following the BI and the acceptability of the

intervention to customers, and considered cost-effectiveness. Of the 663 customers offered alcohol BI, 21 % accepted and three-quarters were identified as risky drinkers. Follow-up interviews were conducted with 61 hazardous/low risk drinkers. Hazardous drinkers were found to significantly reduce unit consumption and drinking days, but not AUDIT-C scores. This was because the 7-day drink diary recorded pharmacy customers' alcohol use in the past 7 days whilst the AUDIT-C asked about their drinking over the period post-intervention (i.e. approximately over three months). Therefore this resulted in varying findings from the samples of population using these different tools. The majority of harmful drinkers contacted post-IBA had accessed further alcohol related services. Over 75 % of customers said they would recommend the service to others. Cost did not appear to be a significant consideration. The authors concluded that community pharmacy-based alcohol IBA is a low cost service that may not have immediate beneficial impact on health and social service use, but can be effective in reducing drinking in hazardous drinkers (Khan et al., 2013).

As mentioned earlier, there are a considerable number of feasibility studies and pilot studies of IBA in pharmacies which have not been formally evaluated or reported. A scoping study, carried out by Herring, Bayley et al. (2012) gathered information from local areas in England where IBA had been delivered in pharmacies. The scoping exercise confirmed that pharmacies were seen to be a potentially important setting for IBA delivery as they reach a wide range of the general public. Some examples of pharmacy IBA projects in England were described:

- Two pilots were carried out in Hampshire in 2009 in both community and emergency pharmacies. £4000 was given to each pharmacy for training costs and materials. During the short (three months) pilot 10 community pharmacies delivered IBA where there were 794 consultations and 801 interventions. In the single emergency pharmacy pilot, there were 214 consultations delivered and 249 interventions.
- In Windsor community pharmacists trained to deliver IBA within 'Medicine Use Reviews'<sup>1</sup> (MUR's) and opportunistically. 22 pharmacists were trained but only 6 actually carried out IBA despite financial incentives. The target was for 1250 IBA's to be delivered but the project only delivered 62. Timing was an issue for this project because it was the end of the financial year and pharmacies had already reached their

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<sup>1</sup> [Medicine Use Review \(MUR\)](#) is a free NHS service by pharmacists in the UK. The review involves a confidential conversation with a pharmacist in a private area in a pharmacy to discuss the patient's medicine, making sure that the patient understands why they have been prescribed, how they have to be used and to solve any problems the patient may have with their medicine.

MUR limit for the year. There was also a reluctance to engage around lifestyle issues and to deliver IBA to particular ethnic groups.

- The project identified an opportunity for health care assistants to deliver IBA.

The report went on to say that it was clear that there was a move to 'mainstream' IBA by providing training, but it was very difficult to tell how many have applied their IBA training.

Evaluation of a novel approach in pharmacies (Davies et al., 2013) reported on a project which focussed on the acceptability of using 'scratch cards' in community pharmacies in London. Although pharmacies were offered financial incentives, there was considerable variation across the pharmacies in the number of scratch cards completed. However, in total, 24,000 customers completed screening scratch cards in 240 community pharmacies; this gives an impression of the potential scale of access to the population in this setting. The evaluation showed that the delivery, which used the AUDIT-C screening tool, via scratch cards was acceptable to men, women, all ages and all ethnic groups. Four out of ten customers who completed the scratch card scored 5 or above, indicating a level of risky drinking.

### ***Challenges to delivering alcohol IBA in pharmacies***

It is clear that attempts to implement IBA in pharmacies have revealed very similar issues and problems to those encountered in primary care and hospital settings. Community pharmacists, like primary care practitioners, are well placed to access the general public and, given the right environment, many customers are willing to accept intervention. However, pharmacists face similar problems of role legitimacy, role adequacy and role support as do other health care professionals. Work by Dhital et al. (2013a) has illustrated that training alone is not sufficient to ensure delivery of interventions. Their study found that training could increase pharmacists' knowledge and could prepare pharmacists to deliver IBA. However, knowledge declined after the initial training indicating the need for 'booster' sessions to sustain service delivery. Positive attitudes towards risky drinkers were an important influence even before training. Post training, the study found that those who had recruited customers and completed IBA had raised their motivation to work with risky drinkers, and had significantly improved their role adequacy and work satisfaction scores, thus indicating the value of experience. Studies mentioned above have raised the problem of organisational factors – such as the perception of the 'public' nature of many pharmacies - as presenting problems of acceptability to customers. However, most pharmacies, in England at least, now have a private consultation room. This is a requirement

for the delivery of some services such as MUR and NMS<sup>2</sup>. The pharmacy profession is changing. The focus is now on delivering public health services rather than on the traditional medication supply role. The delivery of alcohol IBA fits within this broader commitment. It is still unclear if pharmacy IBA would be effective in significantly reducing risky alcohol use; but further insights may emerge from the first randomised controlled trial being carried out by Dhital and colleagues (Dhital et al. 2013b).

### Alcohol IBA in dentistry

Writing in 2011, Shepherd et al. contended that general dental practitioners (GDPs) are potentially in an ideal position to identify excessive alcohol consumption and to provide alcohol related advice (ARA), particularly since alcohol is a well-established primary aetiological risk factor in the development of oral cancer. Noting the lack of information on the professional practice of dentists with regard to alcohol screening, the authors investigated whether GDPs in Scotland were providing alcohol related advice. They looked at intention to provide ARA and at knowledge of the definition of excessive drinking and associated harm, on the assumption that these factors influence behaviour. In line with other UK studies (referenced in Shepherd et al., 2011) the survey found that most dentists (83%) had not provided ARA in the 10 working days prior to completing the survey and most did not have positive attitudes towards delivering this service. Measures of beliefs significantly predicted intention to provide ARA and supported theoretical expectations that more positive attitude, higher subjective norm, greater perceived behavioural control and self-efficacy were associated with greater intention to provide alcohol related advice. Knowledge and the dentist's own drinking behaviour were not associated with intention to provide ARA.

Other research findings indicate lack of clarity in the broader literature on the relationship between personal behaviour and beliefs and professional practice. A review of health professionals' alcohol-related professional practices (which included the publication by Shepherd et al., 2011) found that of 6 studies which examined the association between personal alcohol use and professional alcohol-related health promotion practices, three (including the one on dentists) found no association. The other three studies found that higher personal drinking levels did influence professional practice (Bakhshi and While, 2014).

While the authors highlight findings which signal opportunities for recruiting dentists to deliver ARA, as Heather (2011) stresses in his commentary on the

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<sup>2</sup> The New Medicine Service (NMS) was the fourth Advanced Service to be added to the NHS community pharmacy contract; it commenced on 1st October 2011.

study, there are considerable barriers to overcome. Apart from the common issue of lack of time and financial incentive, there is a lack of appropriate materials and lack of adapted intervention methods. In addition, screening for alcohol is not the only call on dentists to broaden their preventive role. They have been called on to consider screening for hypertension, diabetes, HIV, obesity and other conditions. This raises dilemmas which are common to other health professionals outside the mainstream of primary and hospital care. As one commentator noted, there is a need for guidelines which helps the professional to ensure optimum patient care beyond their dental health, whilst not venturing beyond the traditional dentist role (Geddis, 2013).

The case for persuading dentists to become involved in alcohol screening was made again in a paper published in the Faculty Dental Journal in 2012 (Roked et al., 2012) which suggested the use of screening questionnaires as part of dental consultations. However, the authors noted that the feasibility of screening and treatment in this setting needed further investigation.

## IBA in non-health settings

### Introduction

Given the evidence on its effectiveness to reduce risky drinking levels in individuals, the question arises as to whether it is possible to extend IBA into population-wide public health interventions and whether screening and brief intervention could lead to population-level reductions in alcohol-related harm. In considering these questions, Heather (2012) referred to a lack of empirical evidence as to whether widespread IBA can reduce alcohol-related harm as detectable by population or community level measures and argued that public health benefits would only occur if IBA were disseminated widely throughout the population. A key issue identified by Heather was whether such intensive population-wide dissemination of IBA was politically acceptable to health professionals and to the general population. Although there are undoubted benefits for individuals who receive the intervention, Heather cast doubts on whether even widespread dissemination of IBA without the introduction of alcohol control measures would achieve public health benefits.

Despite most of the evidence coming from primary care settings, and despite the caveats regarding its potential to bring public health benefits, there is enthusiasm to roll out alcohol IBA to a wider range of health services and to non-health and community settings. NICE (2010) guidance recommends that screening and brief interventions are provided to 16 & 17 year olds and adults by NHS and *non-health* staff such as those in the criminal justice services, social services, higher education and other public services. The search on the Alcohol Learning Centre identified 12 relevant projects taking place in criminal justice contexts, young people's services (including sexual health, mental health, employment assistance), pharmacies, housing and workplaces. Five of the projects targetted 'multi-professional groups. These projects are likely to be only indicative of the spread of IBA and IBA training into different service contexts.

In Scotland although targets for ABI delivery had a focus on the three main health contexts, implementation of ABIs was also encouraged in wider contexts. The types of services listed on the NHS Scotland site as involved in ABI included: criminal justice; youth/young people (educational contexts, youth counselling, sexual health for young people, youth workers, services for families); occupational health in firms (e.g. engineering and power transmission); community groups; services for homeless people; leisure services (men's health); housing; fire and safety.

Unfortunately few of these projects are fully described or evaluated and few have resulted in published reports. Many of them are ongoing, awaiting results and we do not know how many have survived over what period of time.

The implementation of poorly evidenced interventions is sometimes explained by the 'precautionary principle':

*'The precautionary principle states that, in cases of serious or irreversible threats to the health of humans or ecosystems, acknowledged scientific uncertainty should not be used as a reason to postpone preventive measures'.*

(Source: Martuzzi M. & Tickner J. Eds.(2004). The precautionary principle: protecting public health, the environment and the future of our children: P 7. WHO Regional Office for Europe))

However as we will see from the review, implementing IBA widely is not as simple as might be hoped.

*'...there is clearly an enthusiasm for improving the delivery of IBA and reaching it out to key settings – the challenge is that this enthusiasm is largely confined to those with a direct interest in alcohol problems. The very essence of the IBA challenge is how we transfer our enthusiasm to the many thousands of non-specialists that are also needed on board...'*

(Source Morris, James (2012) Final comment on alcohol IBA blog post [IBA - are all settings equal](#) Alcohol Academy)

This section of the review will include information from: international published academic papers, a range of reports, grey literature, and information gathered in the course of the scoping exercise regarding the UK situation. It will consider barriers and facilitators of IBA implementation, the role of training for IBA in contexts outside the traditional health care services and possible new modes of training delivery. We begin with an overview of the use of IBA in criminal justice settings and educational settings – the areas where there is most published literature. We then look at social work, homelessness services, and workplace contexts, where there has been less research attention. Finally we address the role of training – frequently called for in considering the expansion of alcohol IBA - as one possible mechanism for increasing use of IBA by staff in non-health settings.

## Criminal Justice settings

There is a small but growing body of research into IBA in criminal justice settings. Again, the literature indicates the potential to implement IBA and highlights problems in doing so.

A review of evidence for IBA in criminal justice settings (CJS) conducted on behalf of the London Health Improvement Board concluded that the effectiveness of IBA per se was accepted (Gecko Social Health Outcomes, 2012); all elements of the CJS have a role to play in delivery of IBA (police, courts, prison, probation) as involvement in the CJS presented a 'teachable moment' where IBA would support self-reflection. In London, 75% of all probation teams had organised IBA training, and a small number actually delivered IBA themselves. The review found that the police were interested in IBA but needed a clear business case for its implementation. Courts also appeared to be appropriate places to conduct IBA. However, delivery of IBA was found to vary across different settings and areas. Barriers to IBA's implementation were explored in Gecko's review and these included: a lack of strategic and organisational commitment, drop-off in delivery after training, lack of time, resources and incentives. Facilitators on the other hand were found to be: making the evidence base relevant, contextualising it so staff can see the benefit, developing 'champions' to influence the hearts and minds of colleagues, quality assurance, follow up and support, and bespoke tools and monitoring performance.

Three national scale studies also provide evidence for the potential for IBA implementation in CJS contexts; but equally they document the challenges.

An evaluation from NHS Health Scotland (Skellington et al., 2011; Skellington et al., 2013) examined pilot ABI schemes in probation, looking particularly at feasibility and potential effectiveness within the community criminal justice setting. The pilot covered clients on probation orders and on community service orders. A randomised control design was used, although the control groups were also screened and given an information leaflet. Clients were followed up at 3 and 6 months. Around 70% of clients were willing to be screened which was encouraging; higher numbers in probation than on community sentences accepted screening. Although the numbers in the study were small the authors concluded ABI could be used effectively to identify and intervene with clients who might otherwise not have been spotted. The study was unable to draw any conclusions about the impact of ABI as there was insufficient follow up data due to lack of engagement. However the study was useful in that it reported some negative staff attitudes towards ABI's appropriateness which were likely to affect successful implementation. This was the priority staff granted to alcohol issues – they felt that clients' drinking was less immediately concerning than other problems clients were experiencing. The study concluded that staff attitudes towards

the complex causal relationship between alcohol and crime and the importance of addressing alcohol problems needed further exploration. Because of the negative impact of staff attitudes towards the implementation of ABI and follow up for the study the authors suggested that staff should be involved in the planning and implementation of ABI; training should be targeted and regular refreshers provided for staff; furthermore local manager champions should be recruited to influence and promote ABI delivery. The study also concluded that delivery of ABI earlier in the pathway might have been more appropriate.

A different criminal justice setting was the focus of a summary report (Blakeborough & Richardson; 2012) which brought together findings from phases one and two of the Home Office (England) alcohol arrest referral pilots where IBA was delivered in police custody suites. These schemes were set up to find out if brief interventions could impact on rates of re-offending, measured via re-arrest data. The pilots were conducted across 12 police forces. The findings overall did not suggest alcohol arrest referral schemes reduce re-arrests. However most offenders in the Night Time Economy were not prolific offenders anyway and most had no previous arrests in the 6 month period prior to or after the intervention. Because of this low number of arrests significant changes were difficult to detect. The reduction in alcohol consumption levels noted in the evaluation was treated with caution as it was not clear if this would have happened anyway, without an intervention. Costs of the schemes varied widely depending on how many detainees were seen; higher numbers equalled lower costs. The authors concluded that it was feasible to deliver IBA in custody suites but that good cooperation between intervention staff and custody staff was needed. Using existing Drug Intervention Programme staff increased value for money. Alcohol arrest referral is possibly a successful treatment entry route rather than a prevention intervention.

The SIPS-CJS studies offer the largest rigorous evaluation of the use of IBA in criminal justice settings (Screening and Intervention Program for Sensible Drinking Criminal Justice System trial). (See: Newbury-Birch et al., 2009 for the study protocol).

An exploratory study was undertaken pending the SIPS research by Coulton et al. (2012) examining feasibility and acceptability of brief interventions in criminal justice settings. The study considered three police stations, three probation offices and three prisons. High proportions of CJS clients screened were found to be drinking at risky levels (73% scored 8 or more on AUDIT). Of the three settings, probation was found to be the most suitable for screening, as clients were positive about receiving an intervention and did not feel coerced. Screening in custody suites was difficult because they were busy and chaotic and detainees were often intoxicated. The prison setting was felt to be more appropriate for more intensive programmes for high risk or

dependent drinkers. People with a positive AUDIT score in this study (Coulton et al., 2012) were also found to have higher use of A&E facilities and have worse overall health than negative AUDIT scorers. They also had more arrests, more days in court and more use of social services. They were more likely to be violent offenders than other offenders. For these reasons the authors felt interventions to reduce reoffending and improve health, such as IBA, potentially, could also reduce costs and societal impacts significantly. Following the exploratory work, offenders from 20 probation offices were randomized to receive either:

- patient intervention leaflet only (PIL)
- brief advice (BA)
- brief lifestyle counseling (BLC).

Outcomes were assessed at six and 12 months. The study found no significant effects of intervention group, screening approach or baseline AUDIT score; there was a decrease in AUDIT scores in all intervention groups for participants who had scored positive on the AUDIT at baseline (Newbury-Birch et al., 2012).

The full results from the SIPS-CJS study have not yet been published.

Local studies demonstrate the importance of local contexts in fostering or impeding the implementation of an intervention. One example of how IBA was encouraged in CJS settings was reported from Hampshire (England). An innovative approach to delivering IBA in probation settings was developed in a pilot study in 2009 where ex-offender 'health trainers', working with probation services in two cities, were trained in and delivered IBA (Mitchell, 2009, 2010). The study evaluated processes and development rather than outcomes and found there was support for the health trainers' role in addressing alcohol. The training appeared to result in increased confidence in trainers' own skills and knowledge to address alcohol; health trainers felt they had the right to ask about alcohol, as did the clients. The trainees were confident they would use their new skills after the training. Some barriers were identified in terms of the clients; these were: the clients' reluctance to address alcohol issues and reluctance to admit that they had a problem, the perception that there was no follow up support, a lack of openness and honesty in clients' answers and clients being 'beyond' the reach of IBA because of already drinking heavily. The evaluation report suggested that providing more opportunities for clients to address alcohol when ready, would improve uptake. Supervision and mentoring was established for Health Trainers from the start of the project and was viewed as crucial to ensure skills and confidence to deliver IBA. This was a limited study as there were a small number of Health Trainers in a few areas and the evaluation did not cover the eventual aims of reducing alcohol consumption in risky drinkers; there was also no control group. The project did, however, begin collecting pre and

post intervention AUDIT scores. The Health Trainers model (applied in probation and prisons in Hampshire) was adopted as part of the area strategy (Hampshire Alcohol Strategy 2011-15).

Examples from projects in Scotland (see below) provide further evidence of interest in delivering IBA in this context and illustrate variety in the approaches and models being tried out.

### *Illustrative examples from the scoping*

Comments from project co-ordinators responding to the NHS Scotland scoping enquiry provide some illustrative material which highlights both the potential for the use of IBA and the challenges and issues faced in attempting to deliver IBA in criminal justice contexts. Example 1 shows that a partnership approach can be productive especially where the specialist provider is pro-actively engaged. However, it also indicates the precarious nature of such services which are dependent on unstable funding. Example 2 provides an insight into the challenges faced when IBA is delivered by custody suite officers. From both the professional's and the custodee's point of view, there are tensions arising from the different roles and responsibilities of being a police officer and acting also as a counsellor. However, such tensions between caring and control functions also arise when the IBA is delivered by an outside partner – as in example 1. Clearly, the context, the resources and the timing of intervention can be challenging. Professional dilemmas regarding priorities are also a feature of example 3 and the need for professionals to engage with IBA and feel it adds to their professional practice is well demonstrated. The importance of adapting training to suit the specific profession and the context of their work is emphasised here. The final example gives the perspective of an alcohol liaison nurse working within a prison setting. The comment again stresses the need for resources and training and suggests that all prison staff could be offered IBA training.

## Example 1: Northern Horizons, Turning Point Scotland: Custody Referral Scheme: delivered by custody referral worker (specialist service base)

This work is undertaken by practitioners employed from a community organisation, working in partnership with the staff in the custody suite. The referral workers have been trained to screen and deliver ABIs as part of their role.

*Targets:* Individuals age 16+ in custody for any alcohol/drug related offence/crime

*Offers:* BI to identify appropriate services to meet needs of individual

*Assessment:* Short, evidence-based, structured conversation about consumption

*Engagement:* Voluntary; with trained counsellor from specialist service; offers further appointment at specialist service

*Results:* During the period 2/5/2009 to 2/5/2010, an Arrest Referral scheme was operated between the specialist service and the police. The police would phone the service and request a Practitioner Worker to visit a custody in their cells. During this period, the specialist staff saw 27 custodies. It was felt that this referral rate could be increased by introducing a more proactive Custody Referral Scheme. The new scheme involved a Custody Referral Worker visiting Police Cells every Sunday to offer advice and help with a view to referring the arrestee to the Drug Substance Misuse Service.

Twelve months after the change had happened, the specialist service had received 109 custody referrals. The 2011-2012 report recorded 89 referrals with 86 engaging in further intervention. The report noted, "As has been identified in other reporting periods a large number of individuals referred do not engage with the service. This may, for a percentage of individuals, be due to having received an appropriate brief intervention whilst being held in custody. Those who do engage with the service prove to do well and stay with the service over an extended period". However, the custody referral scheme was ceased on 24<sup>th</sup> February 2013 due to funding issues. When the scheme ceased it became evident that there was no longer a "link in" service for Police Scotland to signpost on to, relative to the custodies that they were seeing. Monies then became available through the local Community Safety Partnership which secured the future of this scheme for a further year. The referral scheme became operational again on 16<sup>th</sup> June 2013.

*Challenges:* The main challenges are:

- Sometimes the custody referral worker cannot get access to the cell block, because police staff are too busy and it is unsafe for the worker to go in.
- The scheme is good, relationships with police are good, but they have minimal staffing levels in their custody suite. This means that if a couple of incidents occur, they cannot allow our workers in to do the ABI.
- With regards sustainability, we are funded from year to year; there needs to be a long term commitment.
- Police themselves could be trained to do this and refer on to appropriate services.

## Example 2: Police Custody Suite: delivered by custody suite officers

Training was offered to staff prior to introduction of the ABI

1 What was the ABI used?

- FAST screening is performed in each case. If the individual screens positive then a few minutes intervention will take place. This will include the offer of a referral on to the Alcohol Service if indicated.

2 What, if any, were the challenges faced in implementing ABI (or IBA): for the professionals/staff/volunteers and for the target groups?

- The main challenge identified originally was in terms of finding an appropriate time for the intervention depending on how the individual presented in the custody suite e.g. if under the influence of alcohol, mood at time of arrival. In general colleagues report an intervention feels most appropriate once the client has been processed into the custody setting.

3 Any recommendations about what is needed to encourage implementation?

- Locally we have a very strong partnership with police colleagues and they were supportive.

4. Sustainability - are the projects continuing? What issues if any have arisen regarding sustainability?

We recently did a short survey with custody suite officers to gauge their competence in performing ABIs and appropriateness of role. Officers felt confident and that the intervention was appropriate. The following were cited as challenges/barriers to delivery:

- Most people we deal with are already involved or have been involved with the agencies in the past and state that they are tired of asking for help and not getting any.
- Same people coming regularly. They don't want to hear the same questions each time.
- The main priority for me in the custody area, is the custodee's immediate welfare, whilst they are under my care. I feel that often we have other responsibilities. Finding an appropriate moment can be difficult.
- Conduct of the custody on arrival, time and staffing constraints.
- It is sometimes difficult to establish trust with a prisoner.
- Subject is sometimes unwilling to speak to police officer; opposed to custody staff.

### Example 3: Criminal Justice Social Work: delivered by a social worker

Training was offered to staff prior to introduction of the ABI.

#### 1. What was the ABI used?

- FAST screening is performed in each case at the stage of completing a Criminal Justice Social Work Report for Court. If the individual screens positive then a few minutes intervention will take place. This will include the offer of a referral on to the Alcohol Service if indicated. Relevant written information in leaflet form is given to the client.

#### 2. What, if any, were the challenges faced in implementing ABI: for the professionals/ staff/volunteers and for the target groups?

- To date the number of screenings and ABIs has been lower than expected based on case audits.
- We tried improving the materials in the packs to ensure that there was an aide memoire and also easy recording paperwork which workers could pass to admin staff for data inputting. The intention was to minimise additional work for staff delivering ABIs.

The barriers expressed include:

- Social Workers have found it difficult to recognise the added value of an ABI. They already ask about alcohol at Court Report stage and therefore this was perceived as basically recording something that was already part of practice. It is still not clear that the staff necessarily see the ABI as something different to what they are already doing when in fact it is giving a structure to the intervention.
- The focus of the interview is to obtain the necessary information to assist the Court in deciding the appropriate disposal for the client's convictions. There is a lot of ground to be covered in a limited time and social workers find that the structure of the ABI can interrupt the flow of the interview.
- It was felt that the original training session could have been presented in a more social work orientated way, the fact that the delivery of ABIs is an NHS target was not necessarily felt to be helpful.
- It has been observed that there is conflation of screening and ABIs.
- A proportion of the client group was already known to have a dependency issue. It may be the training was not clear about this group not being the target for an ABI.
- For the target groups, the information provided for the screening may not be accurate. For example, self reported alcohol use may be minimised to influence the outcome at Court or exaggerated to avoid responsibility for the offending behaviour being discussed. The client may find it difficult to take in information provided through the delivery of an ABI when their focus is on providing information for the content of the Criminal Justice Social Work Report, the identified purpose of the interview.

#### 3. Any recommendations about what is needed to encourage implementation?

- Tailoring of training to fit the setting.
- Ensuring the business case is clearly articulated to support the trainer and manager in the setting.
- Rigorous monitoring of the recorded use of the screening tool in all Court Report interviews from the outset.
- The availability of follow up and refresher training.

4. Sustainability - are the projects continuing? What issues if any have arisen regarding sustainability?

- Moving towards all Criminal Justice Social Work clients receiving an ABI at the first point of contact with the service.
- Other areas of Social work are building ABIs into a new assessment process. This will enable the process to be mainstreamed. It will also introduce a format for routinely asking about alcohol use at assessment.

#### Example 4: Prison Context: delivered by an alcohol liaison nurse

Setting up ABI is difficult at this time. I am the only one providing this service, though to an extent NHS (name of service) do offer an enhanced addiction service and may provide information similar to ABI.

The current process within HMP(X) commences on admission when all entering the prison are screened using FAST; those scoring 3 and above are referred for further assessment. I then conduct an AUDIT screen and provide ABI as part of the recovery approach. Currently this is mostly through discussion lasting up to several minutes.

The most immediate challenge is the need for ABI training. This would provide consistency and enable targetting more prisoners. Alcohol consumption continues to be underreported. If you consider the extent of alcohol problems within prisons, 50% of prisoners sentenced were under the influence of alcohol at the time of their crime; it is not just a healthcare issue. For this reason I have discussed with my colleagues who agree that ABI training should be offered to officers.

Recommendation:

- Improve reporting of alcohol issues through use of alternative methods other than asking the question.
- Training for all staff within prisons
- Awareness that alcohol use is not just a health issue
- \* Setting up an ABI coordinator may be useful.

Problems

- Prisoners may receive several episodes of ABI during their custody

#### Challenges to delivering alcohol IBA in criminal justice settings

The challenges to implementing IBA outside the health sector emerge clearly from published reviews and studies in the CJS; these studies highlight the importance of the location for delivery, the importance of the type of organisation and the clients it sees; and the need for professional and organisational commitment to addressing clients' alcohol use. On the other hand, the literature also indicates the existence of innovative approaches to

delivering IBA and supports findings from elsewhere that appropriate brief intervention in the right location is acceptable and effective. Harper and Hardy (2000), for instance, concluded that probation officers, trained to deliver IBA, could achieve significant positive change in their clients. Officers felt that IBA was valuable and could be easily integrated into their current practice; but they noted disadvantages such as the time needed to apply the technique in an already busy setting. Another report, calls for IBA training for youth justice case workers who work with young offenders (Alcohol Concern 2013: 14).

It is interesting that in CJS contexts, delivery of IBA is carried out by a range of different professionals – police or prison officers, liaison workers from specialist services, social workers involved in court processes. This differs from pharmacies and health care services where, generally, screening and intervention is carried out by professionals working within the organisation. It raises issues regarding the need for partnership working and considerations as to whether it would be better to train professionals to deliver IBA as part of their work, or recognise that some professional groups are less well placed to deliver IBA and need support from specialist workers. The problems highlighted in the literature and in the project examples suggest the need for a more detailed consideration of the roles and relationships of different professionals within the criminal justice system.

## **Educational and youth settings**

### ***School based interventions***

There are few studies on the effectiveness of IBA delivered in school settings. A systematic review by Tait (2003) found only two studies. A later systematic review by Carney et al. (2014) identified six relevant studies (randomized controlled trials) reported in seven articles. The authors concluded that the quality of evidence for brief intervention in school contexts was low and that further high quality studies examining the relative effectiveness of BIs for substance use and other problem behaviours needed to be conducted, particularly in low- and middle-income countries. In the USA, Werch et al. (2010) evaluated a brief prevention innovation targeting substance use through the use of image-based materials. This clinical trial indicated that the intervention, based on the Behaviour-Image Model, was effective in reducing substance use, especially among drug using older adolescents.

## University and college based interventions

There is a significant body of work reporting interventions to identify and address students' drinking. Much of the research has been conducted in the USA although there are some studies from other countries. From this body of research, a range of interventions have been recommended including wider implementation of screening and brief interventions in colleges and university health centres. For example:

- A USA study by Collins and colleagues (2002) targeted students who were drinking excessively. A non-confrontational, brief motivational intervention was used. This was not strictly IBA as we now understand it. The researchers mailed each student an individual report based on their self-reported information, which included personalised, normative feedback. At six weeks follow up drinking frequency and levels had dropped in comparison with a control group, but at six months the results were no longer apparent.
- As part of a wider research study of the relationship between drinking and participation in sport, Heather et al. (2011) conducted a cross-sectional research study surveying 700 full-time undergraduate students from seven universities across England. The study concluded that there was considerable harmful drinking amongst university students. The report suggested that students who were identified as hazardous drinkers could be offered some form of web-based interventions that have been developed for use amongst university students (Bewick et al., 2008) whereas students identified as harmful drinkers could be offered brief single-session motivational interviewing.
- Health care clinics within educational establishments are clearly a potential location for the use of IBA. Commenting on the results from the College Health Intervention Projects (CHIPs, USA and Canada), Fleming et al. (2010) conclude that the findings provide support for the widespread implementation of alcohol screening and brief intervention in primary care clinics on college campuses. However, they stress the need for training and support for primary providers. "Although brief physician advice is not difficult to administer, it does require training and practice in "saying the words," incorporating these issues into seemingly unrelated patient symptoms or reasons for visit, handling student resistance, and maintaining sense of treatment optimism. Primary care clinicians are often skeptical about the efficacy of brief alcohol counseling with students". (Fleming et al., 2010: 30)

Reviews and meta-analyses provide a useful overview of the findings from these studies.

- A review by Seigers and Carey (2010) considered the evidence for the efficacy of brief interventions for alcohol consumption in college and university health centres in the USA, based on studies that had collected pre/post data to analyse change. The findings from 12 studies found that screening and brief interventions in these settings were acceptable to the students, feasible and promoted alcohol risk reduction. The findings of the review supported the continued use of short, single-session interviews with elements of motivational interviewing and feedback.
- These findings concur with that of a meta-analysis conducted by Carey et al. (2007) that involved 62 studies; the analysis summarised data on individual-level interventions to reduce college student drinking. In line with the results of other research, their findings suggested that individual, face-to-face interventions using motivational interviewing and personalised normative feedback were most likely to reduce alcohol related problems. Implications for future research included maintaining the effects achieved and developing more efficacious interventions for at-risk college drinkers.
- On the other hand, a review by Larimer and Cronce (2007, an update of Larimer and Cronce 2002) of individual focused prevention and treatment approaches for college drinking in the USA did not support single interventions; this included information and knowledge approaches alone, and brief values clarification approaches on their own or with other informational content. However, evidence was found for skills-based interventions and motivational interventions that incorporated personalized feedback. Normative re-education interventions received mixed support, although personalized normative feedback was associated with positive outcomes. Much of the research reviewed had significant limitations, such as small sample sizes, attrition, and lack of appropriate control groups. The review concluded that more efforts were needed to establish the best methods for disseminating such interventions on college campuses and to evaluate interventions with high-risk groups of students.

There is a growing literature on the use of web-based IBA with student populations. Chiauzy et al. (2005) note that college students are possibly the most 'wired' population group and particularly suited to on-line screening and intervention. The screening tools and interventions vary from study to study as do the precise aims and outcome measures for each study. A full description of these interventions is beyond the scope of this review. However, web-based brief interventions have been well described in several studies, and systematic reviews have reported some possible benefits. (see Kypri et

al., 2014 and studies referenced below for further references). The results from the studies are variable.

- In one USA study, Saitz et al. (2006) explored the effectiveness of online SBI on 4,008 students. Students were invited to take part in either an alcohol specific screening or screening as part of an overall health assessment, both methods used AUDIT screening tool. Those with a score of eight or more received either a minimal or more extensive online brief intervention. Follow up after a month showed that 33% of women and 15 % of men who had an unhealthy score at baseline, no longer drank excessively. There were no significant differences between the minimal or more intensive intervention groups.
- Positive results were reported by Bewick et al. (2013) from a UK study of Leeds students. The research aimed to evaluate the effectiveness of [Unitcheck](#), a web-based intervention that screens and provides personalised feedback. The study was a randomised control trial with two arms, a control group which received an assessment only, and an intervention group that received automated feedback. The sample size was 1618 of which 70% were female. The results at 19 week follow up showed a significant effect of completing the assessment, and an additional effect assigned to the intervention arm. Unitcheck is somewhat more involving than straightforward IBA as it requires self-monitoring. This self-monitoring was felt by the authors to be one of the active ingredients in the intervention, supporting the suggestions from other research studies which note the value of an anonymous approach compared to face-to-face intervention for some 'hard to reach' groups (e.g. the work of Chiauzy et al., 2005).
- Chiauzy et al. (2005) describe a randomized controlled trial to compare outcomes from use of an interactive web site intervention (*mystudentbody.com*) with an alcohol education website aimed at heavy drinking college students in Massachusetts, USA. The results indicated that the interactive intervention was especially effective for women and for students categorized as binge drinkers.
- Hustad et al. (2010) also report positive outcomes for heavy drinking USA college students exposed to electronic interventions.
- Heavy drinking students were also the focus of a web-based intervention in the Netherlands (Voogt et al., 2013). However, this randomized controlled trial found no significant main effects of the web-based intervention on any of the alcohol measures.
- In another USA study, Moore et al. (2005) found no difference between the effectiveness of an intervention for binge drinkers delivered by internet

compared to an intervention delivering the same materials in print form. However, the authors evaluated the internet approach as feasible on the basis of accessibility, convenience, ease of data entry, lower overall cost, higher response rates on process evaluation, and favorable participant feedback and concluded that use of the internet offered a viable alternative to more traditional health prevention delivery methods (Moore et al., 2005:42).

- Less positive effects are reported by Kypri et al. (2014) in their study of students at seven New Zealand universities. This large, double-blind, parallel-group, individually randomized trial found no significant reductions in the frequency or overall volume of drinking although there was some reduction in the amount of alcohol consumed per occasion. The description of the recruitment and screening procedures indicate problems in engaging students and recruiting them to the study although this was overcome with considerable effort.

Apart from discussion of recruitment difficulties, there are few accounts of the processes and procedures through which web-based interventions for students have been developed. Hallett et al. (2009) tested the acceptability of the method with a large sample of Australian students. Their study indicated a number of preferences regarding the intervention:

- The intervention should be short (5–10 min).
- The intervention should be easy to complete, requiring minimal reading, preferably with multiple choice answering.
- The language should be informal, non-judgmental and personally relevant.
- Messages should be sent through the student email system, rather than to private addresses to enhance trust and circumvent spam filtering.
- A preference to be contacted early in semester.
- Incentives to participate were important.
- Personalised feedback on drinking was desired.

Apart from some technical problems, there appeared to be few challenges regarding implementation of this type of intervention.

### **Youth Projects**

With the exception of the Scottish ABI projects, we did not identify any published studies on the delivery of IBA to young people in youth settings (e.g. youth clubs or leisure facilities) outside school, university and criminal justice settings. As part of the HEAT targets, up to 10% of ABI delivery could come from 'wider' settings (ie, not the three priority health settings). Stead et al. (2014) report a process evaluation of 10 ABI projects in wider settings, nine of

which were interventions aimed at young people outside school and university. ABIs were delivered in centres offering young people one-to-one advice on health and other issues; other delivery contexts including mobile vans visiting communities, sports pitches and street outreach. Delivery was generally flexible and opportunistic and the approach varied widely. For instance, approaches included: screening all young people who registered for a diversionary activity with the possibility of providing a leaflet and/or brief information in the context of agreeing a physical activity plan; use of a customised vehicle with private sections for ABI delivery, staffed by a multi-disciplinary team; approaching young people outside the vehicle and engaging them in discussion; leisure service staff in local authorities incorporating ABIs in established indoor and outdoor sports.

The report concluded that ABIs in youth settings were perceived to be feasible and acceptable; it identified a number of facilitators and barriers for ABI delivery to young people. These included the availability of appropriate, trained and experienced staff and appropriate team composition; staff perceptions of the relevance of ABI to their work and of its 'fit' to their work context; relationships within and between partnerships. Project funding emerged as an important issue with implications for the sustainability of the work. Stead and colleagues comment that:

“Overall, ABIs were less likely to be implemented where staff viewed ABIs as unsuitable for their setting and potentially harmful for their client group, were cynical, felt uncomfortable about raising the issue of alcohol, perceived the training as top-down and driven by targets and other people’s agendas, or lacked confidence and questioned whether it was even legitimate for them to do this work. Similarly, interagency or interpersonal tensions, lack of support at a strategic level, under-resourcing and competing demands had an effect” (Stead et al, 2014: 44)

The report also highlighted considerations around the practice of fitting the ABI approach to suit the setting and target group in relation to ensuring the fidelity of the approach. As the authors note, all the projects made adaptations to the ABI model and while such adaptations were critical to the adoption of ABI by staff, it meant that it was not always clear that ABIs were being delivered as distinct from other conversations about alcohol.

The NHS Scotland website listed several projects with young people, but only one reply to our scoping enquiry was received.

## Example: Youth Project: delivered by youth workers

Training was offered to staff prior to introduction of the ABI. An aide memoire was provided and also an easy recording excel sheet which is then emailed back to ADP on a monthly basis on activity.

### 1. What was the ABI used?

FAST screening tool was used alongside the assessment paperwork for the specific question on Alcohol/Drug use. The project staff complete this for every young person (YP) they assess. Even if they stated that Alcohol/Drug was not an issue, when using the tool this identified behaviours that they were not aware of previously and would not have been assessed as risky drinking behaviours and therefore no ABI carried out in a timely and early and effective intervention. If the individual screens positive then an alcohol intervention will take place. This will include the offer of a referral on to the Alcohol Service if indicated.

### 2. What, if any, were the challenges faced in implementing ABI (or IBA): for the professionals/staff/volunteers and for the target groups?

The Project requested to be involved in the delivery of ABI as they felt it would be a useful tool to have in assessment and to ensure a consistent approach when discussing and assessing alcohol use. The project reported that the use of the FAST and ABI have provided the team with a method to assess and provide effective early interventions to YP and have the conversation with a YP before they realise it is an issue. Just having this tool has significantly changed the way they assess for alcohol use.

### 3. Challenges

No challenges have been noted in implementing ABI in this setting.

### 4. Sustainability - are the projects continuing? What issues if any have arisen regarding sustainability?

The project has embedded the FAST and ABI into every assessment and due to the change in approach towards assessing alcohol use will continue to use this tool for all future assessments.

## Challenges to the delivery of alcohol IBA in educational settings

To some extent, the published studies address issues of recruiting and engaging young people to IBA interventions (Hallett et al., 2009; Werch et al., 2010) and of testing materials and approaches for acceptability and accessibility to the target group (e.g. see Kypri et al., 2014, for comments on feedback from users and differences between Maori and non-Maori students). Studies mentioned above indicate that the use of web-based approaches address a number of issues, such as confidentiality, and reach at least some young people who drink heavily and who are less likely to engage in face-to-face interventions. The evidence from the Scottish projects indicates that delivery of IBA in youth settings outside schools and university is

feasible but that attitudinal, organisational and resource factors need to be addressed in this context as elsewhere.

What is largely missing from studies of the use of IBA in educational settings are accounts of the implementation and delivery process, of the factors which either facilitated or impeded the use of different screening tools and different intervention approaches. There is an extensive literature on implementation processes and barriers in the literature on school-based alcohol and drug education programmes but this has not been discussed in relation to IBA delivery specifically. Most of the studies on IBA in educational contexts concentrated on the description of the IBA approach and whether drinking (and related behaviours) was reduced as a result of IBA. Studies of web-based IBA suggest that there are few delivery problems once the intervention has been developed and tested for acceptability. The approach has been noted as cost effective (Moore et al., 2005; Kypri et al., 2014). However, environmental issues – not generally examined in the studies - may influence results. Chiauzzi et al. (2005), for instance, found that outcome effects differed across college sites which suggests that there may be barriers to implementation related to environmental factors.

### Social work settings

Heather (1999:183-4) documents the case for involvement of social workers in addressing problem drinking and discusses the findings from studies which indicated similar lack of role legitimacy, role adequacy and role support as found among general practitioners. He cites a pilot study by Shawcross et al. (1996) which aimed to evaluate whether a minimal intervention package could be effectively used in a social work setting. The study found that, despite training and joint planning, most social workers were unable to incorporate minimal interventions into normal practice. And that social workers objected to comprehensive screening of all clients on their caseloads. There appears to have been little progress made in embedding alcohol BI in routine social work practice. Only one study was identified which reported on the use of IBA within social worker contexts. (However, see above the example of social workers in the criminal justice system). Fitzgerald et al. (2012) described an evaluation of the impact of IBA training in criminal justice social work and family social work (and in some medical settings) commissioned by East Renfrewshire Community Health and Care Partnership (CHCP), in Scotland. Telephone interviews were conducted with participants of IBA training, their managers and team administrators. The evaluation revealed that the training was overall positively evaluated. The training improved the knowledge of practitioners with regards to alcohol and units of drinks. Some practitioners revealed they felt more confident about their knowledge and skills in discussing drinking; a few felt more confident in their ability to deliver alcohol brief interventions. There were differing views on what

participants felt the impact the training had on their practice. Only few delivered what they thought was brief intervention, others only had a conversation with a client. The most common reasons for not undertaking brief intervention was that staff felt they did not have the right kind of clients. For example, in criminal justice social work, staff felt that one-off brief interventions were insufficient with clients with serious alcohol problems; they also stated that motivational interviewing techniques were already used by staff. In children and families social work, all clients already had a substance misuse worker. Staff within community mental health teams or older people's teams felt that their clients either did not have a problem with alcohol or they needed more in-depth support. In the early interventions teams, staff felt that their young clients did not drink, but it was suggested that perhaps brief interventions should instead be delivered to their mothers. This study also revealed the difficulty of translating training into change in practice. Some staff recognised opportunities for brief interventions, but did not take them. Even though staff could imagine themselves having a role in the delivery of brief interventions, they felt it was difficult to change their ways of working. The evaluation also highlighted problems in delivering training to multidisciplinary groups of participants. The materials for brief intervention were generic and flexible and worked well for the training. However, it was felt that the participants, their managers and teams needed more time and input to learn, and practice, how to deliver brief intervention within their practice area, and how best to embed brief intervention into their standard systems and procedures. One of the key learning aspects from this evaluation was that training needed to encompass how to implement delivery of alcohol brief interventions into routine practice.

### ***Challenges to the delivery of alcohol IBA in social work***

Although it is readily acknowledged that alcohol-related problems are common among social work clients, there appears to be a continuing reluctance within the profession to identify and manage problem drinking. There are insufficient studies to comment on issues regarding alcohol IBA and there is a need for further research to consider the most effective approaches to delivering IBA in social work settings.

### **Homeless settings**

Few research studies have studied the use of screening and brief interventions for homeless people. Some of the published studies on brief intervention with homeless people were conducted in the USA, but these were set within primary care. For example, recent research conducted in California (Gelberg et al., 2012) tested a primary-care-based screening and brief intervention (SBI) approach to reduce risky substance use and

substance-related harm with patients attending safety-net clinics in Skid Row, an east-central area of Los Angeles with a high population of homeless individuals. Upshur et al. (2013) examined the use of systematic screening of women's alcohol consumption in a health care for the homeless primary care programme. Baer et al. (2007) recruited 127 homeless adolescents, aged 13 to 19, from a non-profit faith-based drop-in centre; the young people were involved in binge drinking and illicit drug use but were not in treatment. Within a primary care clinic, they were allocated randomly to receive either Brief Motivational Intervention (BMI) or treatment as usual; with follow-up interviews at 1 and 3 months after baseline. Despite a number of changes to the clinical protocol no significant benefit was achieved as a result of the intervention. The authors suggested as possible reasons that brief interventions may not be useful for homeless adolescents, or that the enhancements had undermined the effectiveness of brief intervention. However, high satisfaction rates and clinical observation indicated that participants understood the feedback and that the multiple meeting with counsellors enabled the development of a rapport. Results may also have been influenced by different recruitment procedures, for example small incentives given may have influenced motivation to participate rather than motivation to change, recruitment from only one drop-in centre instead of a variety of settings and different patterns of substance use may have attracted a specific clientele. The authors highlighted potential limitations for the effectiveness of brief interventions as outreach for homeless youth; but they concluded that further research was needed to understand behaviour change among homeless adolescents.

While indicating the difficulties of accessing and motivating behaviour change in homeless people, these studies did not provide an analysis of the implementation process or issues regarding the acceptability of BMI to staff and clients.

Even less is known about the use of IBA or EBI in community homeless settings. Hence the recent HAGA-St. Mungo's (London) pilot was a pioneering exercise that aimed to shed light on the effectiveness of these interventions in a homeless setting where high risk and dependent drinking is prevalent. Haringey Advisory Group on Alcohol (HAGA), an alcohol service provider, and St. Mungo's Housing Association collaborated to pilot the use of the Identification and Brief Advice (IBA) and Extended Brief Intervention (EBI) in homeless settings (Luger, 2013). Staff were trained to use the AUDIT screening tool and provide brief advice (BA) and EBI. Staff who attended the training found it useful and relevant to their practice. They appreciated the opportunity of discussing the potential benefits and challenges when using these interventions with their client group. After the training, all participants felt confident and able to use these interventions in their practice. The pilot delivery of IBA took place across five selected hostel settings across London. It was targeted at all clients, not only known drinkers and the alcohol screening was embedded in general health promotion activities. In addition to AUDIT

screening, all clients were asked some scaling questions related to their self-efficacy, motivation, physical health, mental health, offending, financial stability and meaningful activity levels. All individuals identified as risky drinkers were followed up six to eight weeks later for rescreening.

The evaluation revealed that screening and brief advice was acceptable to staff and clients. Most staff (75%) found the AUDIT questions useful in getting the clients to talk about their drinking and to get a quick picture of their drinking behaviour, and as a useful eye opener and motivational tool for clients. Some staff (25%), however, doubted whether AUDIT could bring about change in a client's drinking behaviour. Some staff highlighted limitations of the use of AUDIT with homeless people and that some of the questions were geared towards the drinking levels of the general population rather than the homeless. Most staff (62.5 %) liked BA and felt that it was a natural progression after screening to talk to the client about their drinking. They suggested that IBA should be integrated into the initial client booking-in assessment process. Only few EBIs were carried out during the pilot and overall EBI was considered by staff to be less useful as it involved arranging additional follow-up sessions with a chaotic client group. In addition, most staff felt that the follow-up was already covered through the on-going key working sessions. Workers generally felt that screening and advice alone may not enable the clients to make profound changes to their lifestyle as many homeless clients tend to have complex needs. Staff agreed that IBA could achieve change in those clients who were drinking at increasing and higher risk levels and in those who did not have a history of alcohol dependence. They felt that IBA and EBI could also potentially benefit high risk and dependent drinkers by helping them to think about the potential harm caused through excessive alcohol consumption. Most clients (81.8%) felt comfortable in answering the AUDIT questions and agreed that an intervention like this could change someone's drinking behaviour. They welcomed the opportunity of talking to someone about their drinking; they said that it made them think about their drinking or made them want to change their drinking behaviour. Others (22.7%) did not recognise that they had a problem and wanted to continue drinking. Clients identified barriers to making changes to their drinking, such as the behaviour and influence of others within hostels where alcohol could be consumed, and the wide availability of alcohol. Clients said that they needed somebody to talk to and to have something meaningful to do, they needed help to manage withdrawal symptoms and medication, and access to detoxification.

The analysis of the initial and follow-up screening results showed some reductions in the AUDIT scores. However, it could not be proven whether these changes were a result of the interventions received or other factors that may have influenced the results. When cross-correlating the AUDIT scores with other factors, data analysis showed that a high level of self-efficacy (measured by self-report) was the best predictor of reduced alcohol

consumption at follow-up. This supports the use of interventions to achieve behaviour change: where an individual is ambivalent about change but highly motivated, brief interventions can trigger change.

This was a small study (21 staff and 132 clients) but it indicated the need to consider the importance of clients' personal circumstances and the limitations of what can be achieved by the service delivering IBA.

### **Challenges to the delivery of alcohol IBA in homeless settings**

The lack of studies in this field prevents any clear understanding of the challenges and barriers in delivering IBA to homeless people. Some of the difficulties can be gleaned from the studies mentioned above – the nature of the client group, their chaotic lifestyles and environments and the problems of follow up, either for clinical or research purposes. The nature of the delivery location and the type of staff involved in IBA delivery may also be considerations.

### **Workplace settings**

The workplace is another setting in which there is interest in delivery of IBA. Workplaces are considered ideal for alcohol interventions because they provide access to difficult-to-reach populations, e.g. young men and high risk drinkers (Webb et al., 2009; Richmond et al., 2000) and because of the economic costs of alcohol related harms (Anderson, 2010). Despite considerable agreement regarding the importance of the workplace as a suitable context for identifying early problem drinking and providing a response, there is a lack of good descriptive accounts of attempts to implement this and a lack of good evaluations. Studies cited in a systematic review by Webb et al. (2009), did not comment on the implementation process although some organisational constraints were noted. These referred to the difficulty of carrying out research on interventions in the workplace rather than to the interventions themselves; but they do hint at organizational barriers to delivering IBA i.e. difficulties recruiting participants to take part in the IBA study, lack of managerial support and consequently resistance by individual staff and the organisation. Even where there is interest from employers, often there is a failure to actually deliver the intervention in the workplace (See: McPherson et al., 2009 on research into implementing Screening, Brief Intervention and Referral to Treatment (SBIRT) by employers in the USA).

Occupational health is seen as an appropriate context for IBA delivery but, again, there is little research evidence. One Swedish RCT study (Hermansson et al., 2010) investigated the results of SBI in a large transport company; 990

employees, mainly men, who used Occupational Health services for routine lifestyle check-ups were screened. The study found that 20% of those screened were drinking hazardously (increasing risk). Three groups were studied; a brief intervention group, one that received more intensive intervention and a control group. Follow up after 12 months showed reductions in drinking but no differences between the three groups. The authors concluded the interventions were effective and screening itself had acted positively in terms of reducing drinking. Again, the study by Hermansson et al. (2010), did not describe or analyse implementation issues.

Work in the UK also indicated that occupational health staff were open to adopting IBA. In 2011, Bayley et al. conducted a feasibility study into identification and brief advice in workplace settings in North London. The study aimed to explore the practical aspects of delivering IBA in the workplace and the factors which would enhance or hinder effective implementation. They found that IBA training provided knowledge, practical skills and confidence to address alcohol issues in the workplace as well as raising awareness of treatment service availability. Following the IBA training, a small number of staff did give alcohol advice and some gave out printed information. The fear of asking about alcohol as a routine rather than adopting an opportunistic or problem solving approach was one of the key barriers to implementation of IBA. Staff questioned the appropriateness of their roles to deliver the intervention. Amongst occupational health staff, however, there was a consensus that their roles were appropriate and they were well placed to incorporate IBA into their everyday practice.

A positive view of the potential of IBA in the workplace to reduce alcohol related harm and save public sector resources also comes from Watson et al.'s (2009) Scottish study. The authors concluded that periodic health screening, which includes alcohol screening and offers opportunities for brief interventions, is feasible and potentially beneficial. In this study, possible obstacles were identified regarding the implementation of SBI throughout the workforce: importantly, there were concerns about confidentiality and information being passed back to employers and about issues around 'fitting it into the day job' both for Occupational Health Teams and for employees.

There is an issue of whether to provide alcohol specific screening and intervention or to include alcohol within more general lifestyle screening. Richmond et al. (2000) reported on a work-based lifestyle intervention (Work Screen) to reduce excessive drinking. This intervention involved 8 Australian Post Networks randomly allocated to either an experimental or control condition. The experimental condition involved a broad lifestyle campaign, incorporating support from management, raising health awareness amongst employees and brief interventions for high-risk behaviours, including excessive alcohol consumption. Changes in workplace culture and employees' behaviour were assessed 10 months after baseline. Although there was no

significant reduction in excessive drinking across the organisation, a significant reduction in the number of drinks consumed by women in the experimental condition group was observed. The authors concluded that a work-place based lifestyle campaign can assist employees to reduce their alcohol consumption. There was no mentioning of facilitators and barriers implementation and delivery.

As in the study by Watson et al. (2009), concerns about confidentiality and anonymity were an important factor found in an evaluation of a web-based IBA delivered to the employees of a large pharmaceutical company (Luger et al., 2014). For employees who engaged, 38% decreased their alcohol consumption; in particular the tool was effective for those drinking over recommended levels. However, both managers and participating staff reported that concerns about confidentiality presented the main barrier to using the online tool. This may have been a factor of the research even though assurances were given that the evaluation team were external to the company and that the survey (and the intervention) carried no identifying markers. There was also some suggestion in this study that it may be more acceptable to integrate alcohol issues into general health screening.

### ***Challenges to the delivery of alcohol IBA in workplace settings***

Studies conducted in workplaces suggest that embedding alcohol IBA into workplace screening is likely to encounter resistance. With the exception of occupational health staff, both managers and employees are often unsure of the legitimacy of IBA and there is a concern regarding confidentiality even with web-based approaches. Despite arguments demonstrating the importance and value to business of identifying and assisting employees who may be drinking too much, alcohol is rarely seen as a priority issue. Alcohol may benefit from integration into a wider health and wellbeing agenda.

## The role of training in alcohol IBA delivery

As noted above, the literature provides ample evidence that agreement to implement IBA into practice is insufficient on its own and that this is well understood by advocates of IBA in non-health (and health) organisations. One of the most common responses is to provide training or to suggest additional, improved training. With some exceptions, the training provided or suggested is rarely described in any detail and rarely evaluated. Four evaluation reports were identified although, as the table below indicates, a considerable number of local training initiatives are undertaken.

In Scotland, a national ABI training programme, funded by the Scottish Government, was put in place as part of the push to achieve HEAT H4 targets. This involved 'training the trainers' and using a cascade model to expand training within the Health Boards. Among other actions, a national pool of trainers was established; training resources were developed; and delivery approaches included 'blended learning' (a combination of on-line and face-to-face training). Although the evaluation report identified problems with the training programme – for example limitations with the cascade model, retaining the quality of training over the longer term, variable levels of training received, differences in engagement with the training effort – overall, practitioners reported favourably on the training and felt it made an important contribution to practice (Parkes, et al., 2011)

Dhital et al. (2013a), as part of their studies on the potential to implement IBA in community pharmacies (discussed above), reported on the impact of training on the knowledge and attitudes of community pharmacists. Pharmacists were given a one day BI training course during which they practised delivering BI and were visited approximately fortnightly following training. The research looked at pharmacists attitudes, their knowledge about alcohol and their knowledge about BI. Twenty nine pharmacists from 27 sites participated. The study findings indicated that pharmacists with no prior BI experience could be trained to deliver BI. However, changes did not all last – significant increase in knowledge following training decayed significantly over the 5 months of the study. Pharmacists attitudes towards risky drinkers became more positive although some pharmacists improved their attitudes regarding their own role in delivering IBA to a greater extent than others. Pharmacists who were initially more motivated towards their role recruited a higher number of customers and increased their own work satisfaction.

The evaluation report for project no. 1 on the table (Withnall & Henshall, 2008), described how, in Bradford, a £25,000 budget was used to train 920

professionals to deliver IBA to clients with health, social or behavioural problems suspected to be alcohol related. The training was delivered to health and non-health staff. The non-health contingent included: project workers in adult social care; mental health workers; probation officers; care support coordinators and resettlement workers (housing). The evaluation described the benefits gained from the training programme. Over 75% of those who responded felt they had the skills to deliver IBA, however there was no distinction in the evaluation between the health and non-health participants. One suggestion made by respondents was that the training should be tailored specifically to the recipients' knowledge levels and skills and be more interactive. Also requested were resources/materials specifically for young people. 65% of respondents said they did more IBA after training than before and, as in other studies, time and not having relevant information were reasons for non-implementation.

The other evaluation report, written by Improving Health and Wellbeing UK and The Training Tree (2012), considered a programme of IBA training in Cheshire and Merseyside which showed interesting differences in impact between different organisations. IBA training was provided to frontline council staff (Leisure services), the Fire and Rescue Service (FRS) and two police forces. The training covered IBA skills and resources to deliver IBA training to others.

Analysis of the feedback from the training showed competence and confidence had been raised in the council staff and Fire and Rescue Service, but less so amongst police. Police feedback identified they felt it was not within their remit to train others and they were unlikely to do so. Perceptions of the relevance of IBA differed between organisations too. The police considered IBA less relevant, and 16% felt it was less relevant after the training than before. The FRS and council staff generally considered it relevant. This finding was considered highly significant to the success of the IBA pilot. The 'train the trainers' approach had variable effect: In the FRS a structured approach was used and a cascade effect meant that all staff for whom it was felt that IBA was relevant received the training. In the other settings it was not carried out in such a structured way and in the police it was not cascaded at all. Police expressed the view that training should be delivered by training officers.

Similarly there was variable delivery of IBA between the different organisations. The FRS built recording IBA into their electronic data system with prompts for staff to deliver IBA; it also enabled ongoing monitoring. The council used a paper system pending an electronic one. The two police forces were not able to monitor but one had a system that could have been used, if it had strategic support.

What was actually delivered varied too. The council took a strategic approach to identifying increasing and higher risk drinkers and delivering motivational interventions as per the evidence base. The emergency services on the other hand, if delivering anything, provided identification of higher risk and dependent drinkers and referral to specialist services. There is no evidence base for this approach so it would be difficult to say what the impact of this might be. The strategic council approach linked IBA to the Make Every Contact Count health improvement agenda and resources. They also put systems in place to monitor and they communicated the importance of alcohol interventions to relevant staff. The two police forces had not linked the strategic vision to operational practice and staff expressed scepticism or dismissal of IBA's value to their own roles.

The recommendations flowing from the evaluation included:

- quality assurance mechanisms to be put in place for those who received 'train the trainer' courses
- making use of mainstream training structures
- systems for recording the delivery of IBA are needed
- IBA delivery should be included in job descriptions
- provide ongoing support and include IBA as part of a staff wellbeing approach
- target IBA at those it is most effective for, i.e. increasing and higher risk drinkers.

The search of the [Alcohol Learning Centre website](#) local initiatives page revealed considerable training activity (see table below) and confirmed some of the points made already regarding the need to tailor training and that training does not ensure implementation.

## Training initiatives: Alcohol Learning Centre Website

Area	Description	Staff group/ Setting	Notes
Bradford	Safer communities Bradford and Airedale evaluation of IBA training.	Multi-professionals	Evaluation undertaken (Withnall & Henshall, 2008)
Calderdale	Alcohol brief interventions	Multi-professionals	41 agencies trained in IBA. £25 incentive for each brief intervention delivered by non-PCT agencies or GP surgeries. 14 voluntary agencies, 6 housing associations, 6 statutory agencies took up the incentive. 2008/9 1546 screenings delivered, 907 inc/high risk scores & BI delivered. 466 of these delivered by voluntary agencies, 70 by Housing, 223 by CJS.
Cornwall	Brief interventions training	Multi-professional	Agencies trained included employment, housing, probation/YOT, Occupational health, police, youth services. 53 individuals were trained. Significant majority were more confident and knowledgeable after training.
Bath & East Somerset	Drink think – a brief intervention project with Young people	Multiple youth focussed service settings	2009 – ongoing. Project developed as a result of Young People sexual health issues identified related to alcohol use. Project included development of YP IBA tool and implementation. Schools, GUM services, YOT, youth services, CAMHS agencies trained/involved.
Hampshire	Brief intervention training	Multi-professionals including social workers.	Evaluation of training showed less than half had used IBA skills – also transpired many attendees were from substance misuse services anyway.
Leeds	Pharmacy based alcohol interventions	Pharmacies	5 community pharmacies trained, only one found implementing IBA. Feasibility dependent on involvement of all staff, availability of private area, staff availability in face of conflicting demands.
Liverpool	CLARITY workplace based interventions project.	Workplaces	Included training employees and trade union representatives. in use of IBA.
Nottingham city	Last orders phase 1. Housing association delivered IBA training to health staff.	Health staff	What worked best: training tailored to audience, experience trainers, interactive methods, smaller groups, use of in-house and protected learning time training (improves attendance)

Sheffield	IBA training project	Health and non-health staff.	IBA and 'train the trainers' training provided intending to 'cascade' the training within organisations. Learning: it was essential to have support of managers to allow attendance and to enable them to see the benefits to their client groups and potential to help reach targets. Winning 'Hearts and minds' within management was time intensive but essential.
Wigan	Mainstreaming IBA project	Statutory and non-statutory orgs. Housing, ASB teams, CAB, Youth Services, Community Health trainers.	No evaluation but project merged with 'Make Every Contact Count' strategy covering a range of health issues & signalling an integrated public health approach rather than one focussing on purely alcohol.

In addition to conventional face-to-face training accredited online training is now available, for example, the Alcohol IBA e-learning offers [three courses accessible via the Alcohol Learning Centre website](#): IBA in primary care; IBA in community pharmacy; IBA in hospital settings.

The primary care e-learning course was developed first and is accredited by the Royal College of Nursing and endorsed by the Royal College of General Practitioners and Royal College Physicians. A free IBA training app has also been released<sup>3</sup> to support front line health and social care professionals, it is available to download from the [Apple app store](#), Google or as an Amazon app.

As noted above, a mix of online and face-to face-training was developed as part of the Scottish programme (Health Scotland report *Alcohol Brief Interventions Training for Trainers and Training for Practitioners Evaluation Final Report*. Henderson and Littlewood, 2010, cited in Parkes, et al 2011).

Traditional face-to-face approaches of IBA delivery continue to be the most frequently used training model. However, there is an increasing variety of IBA delivery methods in addition to traditional face-to-face delivery. Online and computer based alcohol IBA programmes are already available from a range of organisations (e.g. [Don't Bottle it Up](#); [Down Your Drink](#); the [Alcohol Health Network](#); and [Thrive](#)).

Computer based IBA may have some potential in producing mass coverage of IBA and be more relevant to younger people and those who consume less health and other services (Nilsen, 2010). There is a growing body of evidence

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<sup>3</sup> The IBA training app is a co-production between South East Public Health Collaborative, Jungle Studios and the Alcohol Academy.

for this approach in alcohol and other lifestyle health fields such as smoking, diet, obesity and activity although more research is needed to demonstrate its effectiveness.

Moyer and Finney (2004/5) discussed the potential to use computers to deliver IBA which could overcome some of the identified gaps in skills, time issues, lack of training and costs of providing an intervention, which can act as barriers to delivery. They suggested that computer programmes could screen effectively and provide tailored advice more privately which could encourage a more honest disclosure from clients. The programmes described allow the users to make their own choices and foster self efficacy. The authors considered computer programmes to hold great promise but it remains to be seen if they are as effective as face to face interventions with a 'live authority figure'.

McAuley (2012) conducted a rapid assessment of the effectiveness evidence in the literature in relation to computer-based alcohol interventions. Ten articles were found to fit the study inclusion criteria: four systematic reviews; three meta-analyses; two qualitative reviews; one non-systematic review. McAuley argued that the potential reach of computer-based and online tools is considerable and likely to impact on groups with risky drinking who have low levels of engagement with traditional, community-based alcohol support services or healthcare, including young people and women. Some of the relevant findings are:

- The majority of studies have been completed in the US with relatively few in the UK.
- There is a lack of evidence on the long-term impact of IT-based alcohol interventions; most studies to date report short-term outcomes only.
- The majority of the computer-based alcohol intervention studies have had small sample sizes, high attrition rates, limited consideration of bias, participant self-selection and a lack of 'pure' control groups.

McAuley's research on the effectiveness evidence suggested that computer-based alcohol interventions have potential, but that more research is needed to fully establish whether they are a viable and cost-effective alternative option.

It may be that these newer methods will take over from training. In the meantime, there is a need to examine and evaluate the nature of the training delivered and, in particular, to consider the appropriateness and effectiveness of training delivered to individuals in non-health organisations

where there is poor organisational commitment and lack of appropriate structures to support staff implement what they have learned.

## Conclusion

This review of the literature has shown that there is potential to broaden the delivery of alcohol IBA into settings beyond primary care and hospital. The scoping indicated the scale of efforts to encourage wider uptake of alcohol IBA training in the hope of raising awareness of alcohol-related harms and encouraging professionals to adopt a more pro-active role with clients across a range of health and non-health settings. However, there are challenges to carrying this out which go beyond the difficulties identified from studies undertaken in primary care, hospitals and clinical contexts. Even where health is the main focus of a non-health organisation (e.g. university health services or workplace occupational health teams) individual, professional and organisational factors may impede the uptake of IBA.

At the individual and professional levels, issues of role legitimacy, role adequacy and role support (identified over thirty years ago by Shaw et al., 1978) continue to arise in health care settings and assume even greater relevance in the eyes of people working in non-health organisations. Few professionals required to carry out IBA will have the training or educational background that provides a framework of understanding and knowledge relevant to dealing with alcohol issues among the people they encounter. Even where training in IBA delivery is provided, it may not be sufficient to overcome long-standing beliefs and attitudes towards incorporating alcohol IBA as part of a non-health role such as policeman, social worker, teacher, youth worker, or line manager.

Organisational factors which influence the implementation of IBA have been poorly researched, even within health service studies. But, it is clear from the literature reviewed, that this is a crucial aspect for successful delivery of IBA in non-health settings and for the sustainability of these initiatives. The scoping exercise has shown that there is a lot of activity and many projects are aimed at encouraging widespread use of IBA as a means of reducing problem drinking. But these projects are rarely assessed in any way and even where there is a short term evaluation, we do not know how long such initiatives survive within organisations or whether staff take their training and experience on with them when they leave and apply IBA in their new workplaces. Organisational barriers to (and facilitators for) implementing IBA, include manager support, financial incentives or the lack of them, perceptions of workload and of priorities for the organisation, and beliefs about the extent to which alcohol is relevant to the core business of the organisation.

It is also unclear what counts as IBA (or ABI) both in training and in a good proportion of the local projects. The findings indicated that one objective of these projects was to spread awareness of alcohol issues and tackle negative attitudes towards intervention rather than necessarily prepare people to apply IBA within their work.

While training has been an important and frequently employed element in implementation approaches, there are few publicly available evaluations to inform training development and to assess the appropriate use of training. From the available information, it is clear that training alone is not sufficient to ensure that IBA is built into practice or improves the chances that IBA delivery will survive in the organisation beyond the involvement of the individual trained.

Aside from providing information on the barriers to IBA delivery in non-health contexts, the literature also indicates some of the facilitators. Providers that were most successful in implementing IBA within their organisations had involved all their relevant staff from the beginning in the planning of the alcohol intervention (Johnson et al., 2011). They created motivation and commitment amongst staff by clarifying the importance of this activity and the relevance to their job, and by offering intensive training before, and managerial support during, the implementation of IBA. Training and education of professionals has been shown to result in small but significant improvements in knowledge, attitudes and activity of practitioners (Anderson et al., 2004; Nilsen et al., 2006). Reminders, ongoing training, interactivity and discussions of practice are more effective than passive approaches such as simply providing information. Financial incentives are also a consideration. Nilsen (2010) asserted that organisational factors including financial incentives have the potential to impact on IBA implementation. Whilst small rewards do not have the required effect, performance related incentives have been shown to increase advice given by GPs in smoking cessation studies (Millet et al., 2007). The nature and size of financial incentives needed to encourage IBA delivery may differ for different professional groups. Currently, ODHIN<sup>4</sup>, a Europe wide project involving research institutions from nine European countries, is investigating whether financial incentives improve implementation rates of IBA in primary health care internationally. This project is expected to help optimize the delivery of health care interventions through furthering understanding of how best to translate the results of clinical research into every day practice.

Acceptability and appropriateness of an IBA intervention to the target group is clearly a key aspect of successful IBA implementation. How, where and under which circumstances clients are offered alcohol screening and intervention are important considerations. For example, we noted earlier the

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<sup>4</sup> Further information on the Optimizing delivery of health care interventions (ODHIN) project can be found at <http://www.odhinproject.eu/>

problems of delivering IBA in some criminal justice settings, to people who were drinking at dependent levels; we also discussed the possibility that alcohol screening may be more acceptable when embedded in a general health and lifestyle questionnaire, offered in well-being clinics, provided as part of general assessments (Coulton et al., 2009), or delivered as on-line self assessment and feedback (Luger et al., 2014).

In considering the 'mainstreaming' of alcohol IBA approaches beyond health service contexts, there is, then a raft of evidence on the factors which impact on effectiveness. But as Nilsen (2010) stated:

*Merely proving that something 'works' under ideal conditions is less important than obtaining knowledge for improved understanding of the more complex issues of 'how', 'why' and 'under what conditions' different solutions may work (or fail). (Nilsen, 2010: 958)*

## Key points from the literature review and scoping

- There is good evidence of the effectiveness of IBA in primary care, and to a certain extent in hospital emergency departments. Many of the skills needed are transferrable to other delivery contexts.
- There is a strong desire to broaden the reach of IBA beyond health settings, although the evidence base for effectiveness is not currently established.
- Barriers to implementation of alcohol IBA include lack of strategic and organisational commitment, professional lack of role adequacy and role legitimacy, lack of knowledge and skills, workload pressure, lack of time and resources, and perceived lack of support.
- In probation, pharmacies, and in schools and universities, delivery of alcohol IBA is feasible and there is some evidence of effectiveness. However, staff may need to be convinced of the value of IBA and need to be supported to optimise implementation of IBA into their usual practice.
- The workplace is a promising context for IBA delivery with potential benefits for both employees and employers. Integrating IBA into a wider workplace health and wellbeing strategy and ensuring confidentiality may encourage its acceptance. However, employers are likely to need

incentives and to be convinced of the business case for supporting staff to take on IBA.

- Financial incentives may increase delivery but it is unclear how much the incentive needs to be to have an effect.
- Training staff, on its own, does not guarantee delivery of IBA.
- Computer based and especially online IBA models have potential to reach individuals who may not access health or support services. This method has been shown to be acceptable to student populations but requires much wider evaluation of the quality of provision, its uptake and effectiveness.
- In promoting further roll out of alcohol IBA in community settings, longer-term planning may be useful to ensure that organisational and professional commitment is sufficient to meet the challenges, that there is an appropriate target group for the delivery of IBA, and that training and support for implementation is tailored to the specific needs and cultures of organisations, professionals and client groups.
- Following allocation of resources, including training opportunities, to alcohol IBA and alcohol awareness promotion. There is a need to consider the potential role of monitoring and outcome evaluation in fostering implementation and demonstrating activity.

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