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RESEARCH ARTICLE

Delivering information and brief advice on alcohol (IBA) in social work and social care settings: an exploratory study

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Abstract

Social workers and practitioners working in social care are potentially key players in the prevention of alcohol-related harm and harm reduction for people using services and their carers. This requires attention to workforce development alongside the selection of appropriate tools to support prevention strategies. We report findings from a UK exploratory study into the potential of using Identification and Brief Advice (IBA) as a tool for screening and prevention in social work and social care settings. Thirty-six social workers and social care practitioners attended one of two training workshops on IBA in the South East of England. Pre and post-workshop surveys ($n = 35$ and $n = 20$, respectively) and four post-workshop focus groups ($n = 36$) were conducted with participants to explore the application of IBA taking into account the paradigmatic shift towards prevention and holistic approaches indicated in recent UK legislation and policy. Four themes emerged from the findings: (1) perceptions of the social work/social care role in responding to alcohol problems, (2) ethical concerns, (3) time conflicts and problems of delivering IBA and (4) the role of training. Further studies are needed to evaluate the effectiveness of motivational techniques and tools that social workers can use to promote preventative practise for alcohol-related harm. Different strategies are required to engage and support those working in social care to increase proactive engagement with problematic alcohol use in everyday practise settings.

Introduction

Alcohol-related harm has a significant impact on the day-to-day work of social workers and is associated with adverse outcomes for the diverse range of people they are in contact with (see Anderson, Chisholm, & Fuhr, 2009; Dance, Galvani, & Hutchinson, 2014; Forrester & Harwin, 2006). The UK National Drug and Alcohol Strategy (H. M. Government, 2010) acknowledged the key role of social work and social care (the provision of personal care, protection or social support services to people with needs arising from illness, disability, ageing or poverty) in addressing problematic alcohol use. The Care Act (Department of Health, 2014) has since stressed the importance of care services in reducing and preventing the need for support. This requires a strength-based approach to promoting independence and resilience by identifying people's anticipation of the risks that they face alongside their informal support network.

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Keywords

Identification and brief advice, alcohol-related harm, social work, social care, prevention

History

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Rishel (2014) has noted that professionals have yet to embrace prevention as a core element of social work practise particularly in the area of alcohol-related harm where there are few resources or tools. Effective preventative interventions for alcohol-related harm may include the use of education, continuing support, family intervention and social support from peers or lay workers outside of traditional medical interventions (Darnton, 2008; Forrester, McCambridge, Waissbein, Emlyn-Jones, & Rollnick, 2008a; Miller & Rollnick, 2002). Screening and the giving of brief advice could be a significant tool within these processes as well as having a positive impact on those working in social work and social care by generating more positive attitudes towards recognising and responding to people with alcohol-related problems.

Within social work education and practise, there has been a struggle to achieve the right level of knowledge, skills and confidence to work effectively with problematic substance use (Galvani & Allnock, 2014; Galvani, Hutchinson, & Dance, 2013; Harwin & Forrester, 2002; Loughran & Livingstone, 2014). A range of studies suggest that social workers tend to underestimate the frequency of problems, fail to recognise signs of problematic use and are hesitant in initiating discussion with service users until the impact becomes significant (Anderson et al., 2009; Dance et al., 2014; Manning, Best, Faulkner, & Titherington, 2009; Newbury-

Birch, Kaner, Deluca, & Coulton, 2012). The need for more effective education to support knowledge, role clarification, different practise approaches, attitudes and increased levels of confidence when coming into contact with problematic substance is well documented (Amodeo & Fassler, 2000; Loughran & Livingstone, 2014; Wiecheltha & Okundaye, 2012). In England, specific curriculum guides, role and capability statements have sought to address terminology, key issues and training content (Galvani, 2012, 2015). Identifying pathways and interdependencies between curriculum areas such as offending, domestic violence, mental and physical health, safeguarding and partnership practise are needed to clarify the broader issues and help locate interventions within a wider framework for practise. A scoping of the literature on alcohol, social work and social work education (Alaszewski & Harrison, 1992; Loughran & Livingstone, 2014) identified substantive gaps in curricula and pedagogic developments, leaving social workers woefully ill-prepared for this complex area of practise. Dance et al. (2014) highlighted the lack of clarity about who is responsible for funding, monitoring or directing resources towards these issues.

Tools for intervention and preventative practise

Few empirical studies exist on the effectiveness of specific preventative interventions in social work on problematic alcohol use, including difficulties in identifying appropriate and practical assessment or intervention tools. The inclusion of relevant questioning about alcohol use into routine social work assessments may address these issues by helping social workers to both identify problems and respond confidently with an appropriate level of knowledge and support (Galvani et al., 2013; Forrester et al., 2008a). Limited empirical work has been done on the effectiveness of specific interventions with problem drinking such as those utilising motivational interviewing in social work settings (Forrester et al., 2008a; Miller & Rollnick, 2002; Tober & Somerton, 2002). Related interventions such as Identification and Brief Advice (IBA) have also been advocated in England and Wales as a cost-effective intervention to address alcohol-related harm (Kaner et al., 2013; NICE, 2006). Whilst evidence on this latter tool comes mainly from primary health care settings, subsequent studies have examined the possibilities and challenges in achieving successful delivery or mainstreaming IBA in more diverse contexts (Herring, Thom, Bayley, & Tchilingirian, 2016; Heather, 2016; Nilsen, 2010; Thom, Herring, Luger, & Annand, 2014). Given social workers' proximity to alcohol-related issues, Schmidt et al. (2015) suggest that brief interventions (BI) might be a useful framework within which to coordinate interventions.

IBA: definitions and terminology

It should be noted that the definition of IBA is neither universal nor international. Equally, the terminology used in the literature indicates the variety of formats this early intervention approach can take. For instance, terms such as alcohol brief intervention or simply BI, screening and brief intervention, opportunistic brief intervention indicate that formal screening (identification) is not always part of the intervention and that the terminology reflects varying implementation contexts and

professional approaches (Thom et al., 2014). Schmidt et al.'s (2015) systematic review of the effectiveness of BI for alcohol use in non-medical settings defined these as a secondary preventative activity comprising a range of interventions that differ in length, intensity and delivery frequency. Ranging from short personalised feedback, discussion on associated health risks through to psychological counselling and motivational interviewing, BI constitutes a broad church encompassing a plethora of intervention styles and an umbrella term which may cover a range of assessments resulting in giving brief advice, counselling or health education (Heather, 2016). Intervention is aimed at moderating an individual's alcohol consumption to acceptable levels and at eliminating harmful drinking practises (WHO, 2009). IBA can be carried out by a non-specialist professional. It entails a screening process, using a validated tool such as Alcohol Use Disorders Identification Test (AUDIT) (Saunders, Aaslund, Babur, de la Fuente, & Grant, 1993) and following identification of alcohol issues, the provision of brief evidence-based, structured advice lasting 5–10 min which is designed to motivate the individual to think about and plan a change in their drinking (Heather, Lavoie, & Morris, 2013). Central to these low-level interpersonal interactions lies an empathic relationship to help people evaluate problem behaviours within the context of their own goals and values and to explore and encourage informed thinking about change (Forrester et al., 2008a). IBA would appear, therefore, to be an approach that social workers might find appropriate to combining good relationships with service users and carers with the discussion of otherwise challenging issues (Forrester et al., 2008a).

IBA in social work contexts

The scope for developing further knowledge and evidence on how those working in social work and social care might improve their engagement with identifying and addressing alcohol-related harm informed the design of this case study on social work contexts. A key question was the extent to which IBA could provide social workers with a suitable intervention tool. We recognise that the term IBA is largely used in England and Wales and that, even within England and Wales there is considerable variety not only in the terminology used to describe the intervention but also in its application. However, as this case study was derived from a larger study which examined the potential for the wider delivery of IBA by housing, probation and social work professionals (Thom, Herring, & Bayley, 2016a; Thom, Herring, Bayley, & Hafford-Letchfield, 2016b), we continue to use the term IBA in this paper.

The remainder of this paper discusses outcomes from an exploratory study seeking the views of social workers and social care workers on the feasibility of using IBA for alcohol problems in their day-to-day work.

Study design

The study design incorporated mixed methods with an emphasis on gathering in-depth qualitative data directly from practitioners. Three methods were used: an IBA training workshop, a pre and post-online survey of workshop participants and post-workshop focus groups. Ethical approval was

given by X ethics committee (anonymised during review). Participation was voluntary and all data were collected with informed consent and treated confidentially.

Alcohol identification and brief advice training workshop

Given that social workers and social care practitioners may not be familiar with IBA they were invited to participate in one of two free 3-h workshops delivered by a specialist trainer. The offer of training provided an incentive to participate in the study. Purposive and convenience sampling drew on a wide range of known networks from a locality within the South East of England. In one local authority, the managers actively nominated staff to the workshop; otherwise, participants were self-selected with authorisation from their employers to attend. Both workshops were oversubscribed indicating interest in the training topics. The workshop aimed to raise awareness of IBA as a tool and to assess its acceptability in social work practise. The workshop covered: (a) the use of alcohol in society and its social, physical and epidemiological aspects; (b) classification of the levels of consumption of alcohol and what constitutes use, harmful use and dependency through looking at guidelines and recommended units; (c) the identification of potentially harmful use (using a case study); (d) the principles of giving brief advice and health education about the use of alcohol, including motivational interviewing and sharing educational resources. The workshop was interactive and drew on participants' own knowledge and skills supported by the provision of a range of learning resources adaptable to practise, including a specially designed IBA 'app' and online resources.

Pre and post workshop survey

A brief online pre and post workshop survey gathered demographic data on the workshop participants and key study specific information. The pre-survey included both open and closed questions to capture practitioners' level of knowledge about, and attitudes towards, working with issues associated with alcohol as well as the nature of the work currently being undertaken in this area. The post-survey included open and closed questions about their experiences of the workshop and the potential application to their practise settings and the enablers and barriers to using IBA. Overall, 36 practitioners attended the workshops of which 35 completed the pre-workshop online survey. Twenty completed the post-workshop online survey emailed to them 3 weeks after the workshop.

Focus groups

Each workshop was followed immediately by focus groups lasting 1 h. The participants attending the first workshop were divided into three groups ($N=8$, 10 and 6) and those attending the second workshop formed one group ($n=12$). The composition of the four groups differed and consisted of: those working with adults (adult social worker focus group): children's social worker focus group: two mixed adult/children social worker focus groups. A broad topic guide

was used for the focus group discussions covering issues such as the relevance of IBA content and delivery to the different service/working settings of the participants; how alcohol-related problems are identified and managed in practise; whether IBA could be delivered appropriately and effectively in the social work and social care setting; discussion of organisational factors and structural issues in the participants organisations that might support or impact the delivery of IBA. The discussions were digitally recorded and the data transcribed.

1 Data analysis

The quantitative data from the survey were abstracted, collated and used to generate descriptive statistics; the qualitative data from the open comments were downloaded and analysed thematically alongside the focus group data. Manual inductive coding of the qualitative data was initially undertaken separately by two members of the team and following discussion and agreement, these codes were grouped and synthesised into broad themes (Braun & Clarke, 2006).

Sample characteristics

Table 1 below illustrates the profile of the sample in relation to the participants' role, service settings, the length of experience and qualifications (from the pre-training survey). Approximately half of participants were working in social care and approximately the same number had a relatively long experience in the sector (11 years or more). It is also noteworthy that approximately 39% of attendees were working with older people where problematic substance use is thought to be increasing (Blazer, 2015) and difficult to identify. Finally, 86% of our sample was working in the statutory sector where the eligibility criteria for accessing

Table 1. Characteristics of sample attending the workshop.

Characteristics	$N = 36$
Current role	
Student social worker	1
Qualified social worker	15
Social care worker	17
Other/No response	3
Years of experience	
1–5	9
6–10	11
11+	14
No response	1
Having direct management responsibility	
Yes	13
No	21
No response	1
Current area of practise	
Children & families	5
Learning difficulties	4
Physical disabilities	3
Mental health	8
Problematic substance use	2
Older people	14
Sector	
Voluntary	5
Statutory sector	31

services tends to be based on have a very high threshold of need. There were no participants from the private sector.

Results

Four main themes emerged from the qualitative data from both the survey responses and from focus group discussions. These were: perceptions of the social work/social care role in responding to alcohol problems; ethical concerns; time conflicts and the possibilities and problems of delivering IBA; and the role of training. We discuss each of these in turn.

Responding to alcohol-related harm in social work and social care

From the pre-workshop survey responses, most participants reported encountering clients with alcohol-related harm and over half (20/36) said that this was ‘frequent’ or ‘regular’ with another 14 participants saying ‘occasionally’. They recognised, therefore, the relevance of alcohol issues. Within the focus groups, whilst making positive links between IBA, the new provision of the Care Act (Department of Health, 2014) and their role in public health and prevention, participants were almost exclusively working with people whom they considered to have established dependence at the point of referral and judged these situations to be too entrenched for BIs to be a useful tool. Some participants commented that service users using alcohol to cope with stress or to binge were not seen as having a problem.

Most pre-training survey respondents ($N=25$) had received no formal training on working with people with alcohol issues. Table 2 shows the challenges that participants identified in the pre-survey responses. On the practical side, when discussing the challenges they experienced in responding to a service user’s alcohol issues, social workers in the focus groups expressed concerns about having to manage demands on their time which meant that responding to alcohol issues could not be prioritised. Limited time to undertake assessments meant fewer opportunities to offer adequate support with alcohol issues. Underlying their practical concerns were more fundamental questions concerning role perception, role boundaries and who they considered to be responsible for working with alcohol-related issues. By working mostly with people with dependency, participants believed that building a long-term relationship with a service user with alcohol problems was a vital key to supporting them. This support was usually offered through referral to services and participants in the focus groups often expressed a lack of necessary knowledge and understanding of alcohol problems to provide appropriate support themselves. Moreover, working across a broad remit of social and health care, social workers in the focus groups resisted being ‘jack of all trades’. They also drew a distinction between the assessment function and the ‘enabling’ (support) function of their work. The complexity of issues associated with alcohol use, particularly where these involved a mental capacity assessment or were related to safeguarding concerns including self-neglect, were seen as the most challenging. Apart from feeling inadequately prepared to deal with alcohol problems themselves, concerns over relationships with clients were often voiced in the focus groups. It was felt that raising issues

Table 2. Main challenges identified in the pre-workshop survey.

Pre-training ($N=35$)	No
Engaging people with services/resistance to treatment	11
Capacity issues (including mental health and learning disability)	6
Risk of harm/challenging behaviour (to self and others)	5
Getting appropriate support	5
Understanding the addiction	4
How to approach people/skills	4
Health and social issues linked with problematic alcohol use	4
Assessment for support/services	3
Others	7

inappropriately could potentially jeopardise relationships by damaging the rapport and trust that had been built up. This could become more significant when supporting families from cultures where drinking might be ‘hidden’. Some were also concerned that raising alcohol issues might create further anxieties over and above issues already identified with service users and for which support was being provided:

sometimes you’ll be talking to families from different cultures where alcohol is banned but you know full well that your client does smoke and drink. So you know you have to be very tactful in approaching those questions . . . you know sometimes you have to have old fashioned social work and just bring these things up when it seems appropriate and when it goes well with the client, without causing too much emotional damage really to your working relationship. (Children’s social worker – focus group)

Social workers noted the limited guidance on how to manage risks and assess competencies for those with impairments particularly relating to cognition, judgement and function common in co-morbid mental health issues. Fluctuating capacity was a particular dilemma where greater emphasis on creating a safer environment to support any self-determination was critical. Coding of the open commentary in the pre-workshop questionnaire revealed the participants’ acknowledgment of the importance of being able to signpost and refer people to specialist support. Many, however, also observed the impact of frequent restructuring and changes to the commissioning of services which affected their own confidence in being able to do this efficiently and confidently.

Ethics and conspiracy theories

Concerns about being on the receiving end of disclosure in a preventative encounter were seen as sometimes being in conflict with the statutory role that social workers carry in relation to their risk assessment and safeguarding roles. Social workers felt that by encouraging service users to articulate risk associated with increased use of alcohol would trigger a more substantive or risk adverse intervention which did not sit comfortably with a role of screening and the giving of brief advice. Providing information and brief advice was seen as much more of a responsibility than it initially appeared to be and one which was conceptualised as primarily lying with the

voluntary sector. Social workers saw the role of screening for alcohol-related harm as tenuous and in tension with what they understood by preventative work. They used expressions which reflected concerns about the importance of building trust – building rapport – the importance of being led by service users, of being seen as being transparent and honest. Raising issues about alcohol use which resulted in the giving of advice only was clearly a source of conflict or omission:

It's not ethical, it would be unprofessional because if you imparted that information to me, I have a right, I have a . . . a duty to follow that up. So if you have children in your care, I have to be on that phone and I have to contact the children and families teams. . . . It would be very dishonest of me to go into that assessment and have a person tell me all these things and not have told them before certain things you answer may lead to such and such. (Children's social worker, focus group)

One focus group participant recognised the potential application of IBA with young people in care and in school environments and was very positive about using the tool with young people.

For those working in adult social care, there appeared to be less conflict involved in raising issues where there was risk involved:

I work with the carers of the service users and some of them have got unsafe levels of drinking because of their caring role and they are not prepared to access services because then they fear we'll raise a safeguarding on them. But if I can deliver that information at the best level, especially the encouragement, the motivation you know, that would be great. (Social worker with adults, focus group)

This person went on to say that whilst they observe physical signs of effects of drinking, they would feel more confident to pick up on these triggers and the relationship of drinking behaviour on caring and then to go on and give advice. This may highlight the potential for empowerment and self-determination when blending BIs into social workers' roles. The earlier comment reflects increased recognition of the role of family carers in supporting adults with social care needs which may be overlooked or unmet. Social workers with adults reflected a permissive and optimistic approach, however, as one participant stated:

. . . they might come to me because they're a hoarder or because they've asked for re-housing, but if I go in there and there are bottles or cans around or they're having money problems, I'll ask them what they're spending their money on. So alcohol can be brought up without them actually bringing it up, it will be obvious to me and then I'll have a conversation with them'. (Social worker with adults, focus group)

Within the focus groups, some stereotyping was noted in the language used to describe service users with problematic

alcohol use, for example, as being 'not good liars' was one example. Service users using alcohol to cope with stress or to binge was seen as a consequence of inflexible services:

the fact of caring maybe putting her at risk of going to binge at a weekend because that's the only time she can drink, whereas if there is support for her from the family support team, then she can be able to drink sensibly and take reasonable time off because she's got this support for a couple of hours to go and have a good social life.

Similarly, whilst carers were seen as a potential target group given their vulnerability to problematic use of alcohol associated with the stress of caring, some respondents also noted the usefulness of IBA with other older people. This included those with memory loss where a reduction in alcohol is believed to slow either the process or the impact on their symptoms. Participants referred to older people being admitted to hospital where their alcohol use was not seen as problematic or not given enough attention before they went back out into the community. They suggested that there was potential to use IBA at these points of discharge and in arranging support:

Yeah because depending on how you come in, they look for certain signs like if you've fallen over or something like that or whatever and then they flag it up and then they get you to speak to this alcohol liaison nurse. And if you're dependent then you might end up speaking to somebody like me afterwards, but it depends what you want to do, or they might refer you to the alcohol team back out in the community. So yeah, I think if you've got a low level of alcohol use you could really go there and leave and nobody would really know'. (Social worker with adults, focus group)

Participants also acknowledged the suspicions held by older people about social workers' role on behalf of the 'State'. This meant that community-based or age-specific services were seen as better placed to provide low-key alcohol advice. Data sharing protocols were acknowledged as promoting effective communication and working relationships between social workers, service users and agencies and could help improve outcomes. They were, however, particularly concerned about the potential of sharing information for creating anxiety for service users about how the information could be used. Others were more explicit that 'the State' was using social workers as a means of surveillance and control. Taking on the screening role embedded in IBA was seen as another ideological step in agreeing to perform this 'surveillance' which ultimately conflicted with social workers' values:

some local authorities are using gym passes for people who are overweight and saying that they have to go to that or they'll lose their housing benefits and things like that. So we are starting to make a lot of social control over what we are actually making judgements about and instead of the underlying reasons for why people drink too much, or why someone is overweight . . . I understand why certain things

can lead onto gathering more information, but I think when we're doing it just blanket and I feel like a lot of the assessment now in the Care Act has moved more to a medical model, more about information gathering and I'm a bit worried about where that goes'. (Children's social worker, focus group)

These types of conspiracy theories arise from time to time in contemporary discourses about the changing role of social work from concerns about increasing managerialism and the loss of macro thinking in social work (Hafford-Letchfield & Cocker, 2014). Two participants were completely averse to recording information about service user's alcohol use. They saw this as a move towards privatisation with which social workers should not comply:

we have to have more conversations about it as social workers because I'm also concerned about this leading onto an insurance model, health and social welfare system where that information could then be used against giving people insurance because you know the kind of market is being primed a bit for things like that in the privatisation and more of an American model of care and health'. (Social worker with adults, focus group)

Time conflicts and accessibility of the IBA tool

Other issues identified by focus group participants in relation to implementing IBA were time conflicts and contextual pressures, both of which led to uncertain and frequently unstable environments. Where services were in transition, this made roles even more unclear and boundaries difficult and some participants talked about the problem of bolting more tasks onto their job, particularly those which involved more layers in record keeping, as IBA involves in the screening phase:

I need to meet targets as a service and when we are trying to deliver this brief intervention and knowing just to keep in mind that I might have to do another referral on top of that. It may not be that brief basically'. (Social worker, focus group)

There was an acknowledgement that routinely asking about underlying issues in referrals such as problematic alcohol use could be useful for pre-empting problems for example with those presenting with financial problems or being unable to meet charges for their care:

It's a big problem for people paying for their care, . . . most of their income might go to vodka but that is not what we would class as an expense and they're not going to change that and then they end up with big debts of care needs or their care gets stopped'. (Social worker adults, focus group)

Again, this raised issues about perceived role boundaries and role legitimacy in these particular contexts especially if they were not going to see service users again.

In summary, whilst the participants recognised, valued and welcomed the IBA tool, they were cautious about

standardising it within their everyday assessment practise. They described excessive bureaucracy in assessment recording making IBA an additional burden. They were not, however, able to be clear about how these issues were alternatively covered in their current assessment practise and there was a general cynicism concerning a lack of consultation on changes introduced to the assessment tools. Some suggested more autonomy in undertaking IBA; for example, if it seemed appropriate, and service-user led, then a possible 'drop-down' option in the standard tool could trigger intervention. This was in direct contrast to one practitioner in a focus group who felt that IBA was a good example of 'evidence-based interventions' which she saw as core to her role and valuable as a short intervention which could increase impact.

The link between collecting information about alcohol use and community-based commissioning was recognised as essential to the accurate delivery of support services. Some participants held valuable informal knowledge about strategies used to encourage or discourage access to alcohol in the community. One example was given where individuals were able to buy it at a shop shared with the post office and another where one locality had banned the sale of 9% proof lager which was subsequently being obtained elsewhere. Practitioners largely welcomed the use of leaflets that they could leave with people and particularly the use of an App which service users could be directed to. This was seen as beneficial for those using smartphones, particularly young people.

Personal benefits and training needs

In the focus groups, all touched briefly on the personal benefits of having had the training and some participants made passing references to being aware of their own use of alcohol and how there might be potential conflicts in providing advice given their alcohol intake. One group discussed the stress of working in social work and social care and the challenges of being able to discuss this in the workplace:

I have got colleagues who have come to me and said; listen my drinking is not good and actually I'm experiencing some physical signs you know and we can sit down and assess, do this and plan'. (Social work supervisor, focus group)

Participants talked about how the training had inspired and increased their confidence in being able to have more informed conversations with service users using the system of measures and threshold levels to assess risk in alcohol use. Those social workers active in practise education highlighted the value of IBA as a tool for learning and teaching. They stressed the importance of students learning about alcohol use given that this was not sufficiently integrated into professional training even though it came up often in their placements:

I think for me, for good awareness . . . it's definitely something we can talk about as a team'. (Social care worker, focus group)

In relation to future possibilities, nearly half of respondents to the post workshop survey saw IBA as useful in health promotion and health prevention generally, indicating some success in raising awareness of early intervention approaches. Four participants said that they found it useful for people with learning disabilities and another four found having access to an AUDIT tool generally useful. Two people found it most useful for increasing awareness amongst staff and had already cascaded the approach and six said that it was useful but did not elaborate further. One person said that they had not used it yet.

Respondents in the post-workshop survey also identified additional learning and development needs for working with people with alcohol issues as a result of the workshop. These were mostly concerned with working with long-term resistant drinkers and second, accessibility of IBA for people with complex needs such as learning disabilities and the need for easy read information and materials. This latter requirement was stressed as important for increasing levels of community participation and community inclusion where access to alcohol and the potential for developing problems was becoming a real issue challenging the health of people with learning disabilities (see Slayter, 2010). Respondents also specified the need for a clearer referral pathway once issues had been identified:

I feel the awareness needs to spread far and wide among professionals ... A lot of people have very shallow knowledge about the impact of alcohol in individuals' health and well-being and signposting them to appropriate services for support'. (Post-workshop survey)

When asked to spell out the advantages of using IBA in their work, 19 out of 20 respondents gave a very positive response:

... previously I was only discussing alcohol use when I had a cause for concern. Using IBA means that I can tell the people that I work with that I'm trying to make it a routine discussion and therefore it is less stigmatising'. (Post-workshop survey)

Similarly, post-workshop survey responses identified what gets in the way of using IBA in their day-to-day work; reasons included, time, particularly for preventative work; 'paper-work'; length of the tool and accessibility in relation to language and learning disabilities; perceived lack of co-operation or lack of disclosure of service users or the need to build rapport first:

The customer has normally got a problem that they want to be resolved. It therefore may be difficult to find the time to resolve/plan an intervention with doing additional preventative work around their health and wellbeing'. (Post-workshop survey)

Nearly half of the respondents reported that they actually used the training between attending the workshop and completing the post-workshop survey although it was not clear exactly how. Five respondents clarified that they had

since discussed IBA within their team and service and one reported initiating a successful conversation around alcohol with a service user which she found encouraging and motivating. When asked about the single most important thing that needs to be developed to help respondents work more effectively with people with alcohol issues; responses included having more confidence to share information which supported the use of '*expertise in this area of work and above all partnership working from different professionals involved with the customer*'.

Discussion

Existing evidence about alcohol-related harm in the day-to-day work of social workers was reiterated by many of the participants in this small qualitative study. Despite this, views about the potential of IBA as a tool were very mixed and were discussed in relation to the roles and remit of social workers.

The challenges were seen as particularly acute in situations where drinking was associated with risk assessment and where there was a need to balance active prevention with the likelihood of triggering further intervention, for instance in child protection cases (see Forrester, McCambridge, Waissbein, & Rollnick, 2008b). The prospect of integrating IBA highlighted the tensions experienced by practitioners in trying to move to a more preventative role and the range of operational issues that reduced the salience of IBA for some groups of service users, especially children. This made the prospect of IBA highly nuanced and fraught with inconsistencies including ethical ones. At the same time, participants also recognised opportunities to develop coherent and tailored BIs for situations where forward-looking goal setting motivational approaches could facilitate behaviour change. This was more aligned to practise with adults.

The barriers to providing services for people with alcohol-related problems and encouraging help-seeking are widely acknowledged (The Association of Directors of Social Work (ADASS/ADCS, 2011). Houmøller, Bernays, Wilson, & Rhodes (2011) highlighted the social stigma attached to parental problem drinking which often leads children and families conspiring to keep their problem a secret or to accept this as normal (see also ADASS/ADCS, 2011, p. 17). This study echoed such messages where individualistic rather than holistic approaches to care may over-emphasise confidentiality; the fear about a lack of resources to respond and not wanting to 'scare people off'. There were also contradictions, for example, not wanting to raise alcohol as an issue in case it identifies a safeguarding concern. However, given the clear evidence that alcohol is related to safeguarding concerns in social work practise (Forrester et al., 2008b), identifying and responding to those concerns may be vitally important.

There was considerable role uncertainty from the participants about whose job it is to deal with lower level concerns about problematic drinking, thus making it difficult to assess what level of drinking merited intervention. This study highlights how the use of any preventative tools needs to go hand-in-hand with the development of capabilities in social work and social care to work with problematic substance use, particularly regarding preventive identification and interventions. Some of the participants' concerns about the lack of

trust and ethical issues could be resolved if they were trained and supported in raising issues about the use of alcohol without causing offence (Forrester et al., 2008a, 2008b). However, the type and mode of training is also an important question (see Fitzgerald, Molloy, MacDonald, & McCambridge, 2015). According to Rishel (2014), the social work profession has long embraced the ecological, person-in-environment perspective as its hallmark approach to practise – and is well equipped as well as expected to lead the shift towards a prevention approach.

Further barriers were identified around the issue of information collection and sharing. There is increasing interest in collecting data that estimates the return on investment in treatment of people with problematic substance use (Public Health England, 2016). This study reflected concerns about sharing such information and anxiety about data sharing protocols which may impact on relationships between social workers and service users and other helping agencies.

Systemic barriers, time, resources and organisational cultures were shown in this study to be impacting on the ability of practitioners to incorporate prevention models into their everyday practise (Rishel, 2014). The study findings illustrate the need for greater integration of acute, primary and social care services, with more support delivered in the community. Effective social work support requires the ability to combine a number of roles, including assessment, local knowledge, and being able to provide counselling and/or ongoing support. Screening and giving brief advice could be a significant tool within these processes. For those working in social work and social care, it may generate more positive attitudes towards recognising and responding transparently and effectively to people who have problematic use of alcohol. Despite the many and ongoing recommendations to include these issues in the education curriculum (Galvani, 2013, 2015; Galvani & Allnock, 2014) it would appear that there is still a significant way to go. Simpson (2002) drawing on the work of Backer (1993) identifies four conditions required for educational transfer to be effective that might be relevant here: (1) appropriate innovations must be brought to the attention of organisations and be made accessible for dissemination; (2) evidence must show use of the innovation is feasible and effective; (3) resources must be adequate and (4) interventions must be provided that encourage individuals and organisations to change (Backer, 1993).

Introducing IBA from a broader perspective has to address barriers such as frequent organisational change, fragmented pathways of care and lack of attention to education and training. These may limit practitioners' ability to use evidence-based prevention models such as IBA or similar. Future interventions to identify and respond to alcohol use in practise at the time of this study are not likely to be 'evidence-based' as the results of this and other studies have demonstrated (Fitzgerald et al., 2015). The responses from this study point to the need for evaluation given the potential for both positive and negative effects in both the relationships and transactions formed in practise as well as the ability to impact on changing practise. Persistence of risk averse and managerialist cultures may also influence social workers attitudes and created suspicions about the motivations for

such interventions. Notwithstanding, interventions to prevent alcohol-related harm may offer the greatest opportunity to avoid substantial costs to individuals, families, and society that alcohol-related problems entail.

Conclusion

The aim of the study was to provide an overview of the perceptions of social workers and social care workers on the feasibility of using IBA in their day-to-day work. This case study drew on a convenience sample from a local metropolitan area and is not necessarily typical of the UK. The study was not designed to change practise and the resources for the study did not permit a long-term follow up of the implementation or impact of those who said they were intending to use IBA in their practise settings or look at the implications for those managing services. The study findings corroborate and add to insights from previous research (Fitzgerald et al., 2015; Thom et al., 2016b). Training interventions can have an impact on those working in social work and social care in terms of generating more positive attitudes towards recognising and responding to alcohol-related problems. However, they also support research findings highlighting the problems social workers face in putting their training into action. In particular, this case study drew attention to the ethical dilemmas facing social workers and social carers in trying to incorporate a new function that seemed to them to be in conflict with some of the core principles of their roles and that was perceived as undermining the fundamental structures and working practises of social work.

It is important, therefore, not to assume that a health-based model of IBA would be appropriate to transfer to social work settings. It might be preferable to start with current practise approaches and design a BI or range of interventions supported by care pathways that would address the barriers and navigate the concerns raised.

Note

1. The pre and post workshop survey and topic guide can be made available by the authors on request.

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Declaration of interest

No potential conflict of interest was reported by the authors.

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