



The role of training in delivering alcohol IBA in non-medical settings:

Broadening the base of IBA delivery

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June 2016

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Introduction

1.1 Background and rationale for the research

Identification and Brief Advice (IBA) has been advocated by health organisations such as NICE (National Institute of Clinical Excellence) to promote a range of lifestyle health behaviours, for example physical activity and smoking cessation, and to encourage early intervention in risky or problem behaviours, including alcohol use (NICE 2013; 2006). Other related terms are SBI (Screening and Brief Intervention), OBI (Opportunistic Brief Intervention) and ABI (Alcohol Brief Interventions). Typically alcohol IBA includes use of a validated screening tool such as AUDIT - Alcohol Use Disorder Identification Test (Babor et al., 2001), followed by brief advice:

'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).

As alcohol IBA has been found effective in medical/clinical/specialist settings (Kaner et al., 2007), there has been a drive to expand its use beyond these contexts into a range of other settings, to encourage wider groups of professionals – such as pharmacists, educationalists, youth workers, social workers and criminal justice professionals to incorporate IBA approaches into their everyday practice. However, whilst there is good 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 continuing problems implementing IBA even within the traditional health care contexts (see: Thom et al., 2014 for a review of the literature).

One of the most common responses to address apparent barriers to delivering IBA is to provide training or to suggest additional, improved training for professional workers in touch with population groups who are likely targets for IBA intervention. While there are numerous training activities and programmes, very few have been well described and evaluated (Thom et al., 2014). It is recognised, however, that training alone is not sufficient to ensure that IBA will be delivered (Babor and Higgins-Biddle, 2000; Coogle and Owens, 2015; Schmidt et al., 2015; Thom et al., 2016a). Training may contribute to changing professional behaviour and providing the knowledge and skills necessary to deliver IBA; but organisational factors, what Cruvinel et al. (2013) have called 'organisational climate', specific work context, and the wider environment are all important determinants of IBA delivery (Nilson,

2010). In other words, the emphasis has been on changing professional behaviour and more effort is needed to understand and respond to the bigger challenges posed by the need for organisational and systems change.

1.2 Research aims

The aim of the research reported here was to investigate the role of training in broadening the base of IBA delivery beyond primary care and hospital settings. Drawing on the literature mentioned above, this entailed considering three main related implementation dimensions:

1. An assessment of the effects of IBA training delivered by a major UK charity on individual professionals' attitudes and working practices.
2. Assessment of organisational factors: organisational commitment to mainstreaming/sustaining IBA approaches and the links, if any, between training of individuals and organisational commitment to deliver IBA.
3. Consideration of the importance of a systems approach compared to an individual behaviour change approach to promoting IBA delivery in non-health settings.

While the initial intention of the research was to examine training and the contexts within which training might support IBA delivery, the importance of considering individual and organisational behaviour change within a systems approach emerged over the course of the work and questions broader than training quickly came to the fore. These questions became as, if not more, important than the original focus on training. They centered on the extent to which the 'classic' IBA approach was appropriate to the working practices of different professional groups, and in addition, raised questions regarding the extent to which IBA could be adapted and still be considered as IBA. Clearly, these concerns have implications for the content and delivery of training. They generated additional research questions:

1. What are the views of different professional groups regarding the appropriateness of IBA for their client group?
2. What do different professional groups perceive as the facilitators and barriers to delivering IBA as a part of routine practice?
3. How do professionals see IBA fitting in to the existing systems of care/ services within which they are employed?

The research questions were explored from the perspective of a) professionals attending training courses and b) 'experts' (researchers, trainers, service managers) in touch with organisations and groups

interested in delivering alcohol IBA in non-traditional health settings (i.e. outside general practice and hospital contexts).

1.3 Structure of the report

The next section provides a broad overview of the methods used to collect and analyse the data. This is followed by a summary account of main themes and issues emerging from the literature review, the expert witness workshop, the case studies of housing, probation and social work delivery contexts, and the studies of the role of training in securing IBA delivery. Full accounts of the different studies are available elsewhere (see below: 5: Outputs from the project). The conclusion draws together main findings and considers some possible ways forward.

Methods

2.1 Introduction

The intended study design and approach required considerable adaptation as the study progressed and this, in itself, was instructive, indicating not only the difficulty in researching this topic but also the problems of implementing IBA. The intention to conduct a number of case studies in particular organisational settings (to explore organisational factors) was abandoned as we were unable to gain sufficient access to conduct meaningful research. Instead we conducted the three occupational case studies described below. It was expected that follow up of individuals who had received training would be difficult and this proved to be the case. The response to the survey (as to other surveys of its type) was low and attempts to follow up respondents to the survey, to gain access to managers and trainees for interview, was largely unsuccessful. An attempt to mount a workshop to discuss the issues with relevant individuals (e.g. managers, occupational health workers) in different workplaces also had to be abandoned. Instead, we ran an expert workshop that successfully explored many of the wider issues around delivering alcohol IBA. The research is biased therefore towards a 'best scenario' picture in that it reflects the views of people who were interested enough to attend training sessions and interested enough to reply to surveys on IBA delivery.

The methods used in the research are described briefly below.

2.2 Literature review and scoping

The focus of the review was 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. A comprehensive review of the published literature was conducted searching for peer-reviewed articles on delivery of IBA and on training delivery for IBA in non-health settings. 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. Insights from research findings on IBA delivery in primary care and hospital settings were also more marginally included using literature reviews.

It was hoped to find additional projects described in grey literature and we attempted to identify others by using scoping approaches. These searches focused on studies carried out in the UK. A number of websites were examined and email enquiries were sent to individuals identified as possibly involved in IBA projects. (see Thom et al., 2014 for full details).

2.3 Expert witness seminar

A number of key questions around the drive towards wider implementation of IBA were debated at an expert workshop in Birmingham in November 2014:

1. What are the challenges and barriers to broadening the contexts in which alcohol IBA is delivered?
2. How can these challenges and barriers be addressed?
3. Should delivery of alcohol IBA in wider contexts (mainstreaming) be a policy goal?

Professor Nick Heather, a member of the project advisory group, chaired the workshop. The 18 participants included researchers, trainers, practitioners and policy makers. Short presentations led the discussion. The proceedings were recorded and transcribed with agreement from participants. (see Thom et al., 2015 for a full account).

2.4 Case study of impact of training on professional practice

Mixed methods were used to collect data on perceptions of the role of training to influence delivery of IBA: an on-line survey, and interviews with trainers and with trainees.

Survey

A list of individuals who had attended training sessions delivered by a major UK charity between 2012 and 2014 was used to group trainees into two categories: those coming from core health and health related organisations (primary care, hospital, pharmacy) and from specialist alcohol services, who were omitted: and those (n=462) attached to other organisations (in the main, youth services, housing, probation, police, social services, local authorities), who were included. They were approached by email, informed about the study, and asked to complete a questionnaire by using Bristol Online Survey (BOS). An anonymous structured survey, including a few open comment questions, was used to gather the views of individuals working within relevant settings. The survey focused on perceptions of the training and of its impact on the trainee and on their working practices after training. They were asked to supply an email (for researcher use only) if they were willing to participate in an interview following the survey. The survey was used to generate descriptive statistics.

Interviews

Interviews with the two trainers provided a description of the content and methods of the training sessions and reflections on IBA training in general. Taped, open discussion interviews were held with five trainees, identified from survey respondents who had agreed to a follow up interview, and two managers of services whom we approached through the trainees. The interviewees worked in varied contexts: police, general counselling/ psychotherapy, social work, midwifery, parenting in a youth offending team, family organisation support, supported living (people with learning difficulties). The open discussion interview schedules were adapted depending on whether the respondent was a service manager or a practitioner but the following domains were explored: the extent to which alcohol problems are a factor in the respondent's work context; whether the individual worker feels it is appropriate to identify and respond to clients' alcohol issues, knowledge of IBA and perceptions of its use/ appropriateness in the respondent's work context, perceptions of the role of employer organisations/ agencies in responding to alcohol problems among clients, the degree of support/ commitment for addressing alcohol issues from respondents' organisations/ agencies, the role of training in addressing individual commitment and organisational adequacy to respond. These interviews sought to expand on themes emerging from the survey. (See Thom et al., 2016a for an account).

2.5. Case studies of specific occupational contexts

2.5.1 The three settings

Housing

Social landlords are local authorities (councils) or not-for-profit housing associations; they provide a wide range of housing services, from properties for rent at low cost through to highly supported accommodation for people with complex needs. The role of social landlords is an evolving one and they have moved from simply providing 'bricks and mortar' towards a more interventionist role. Considering the health and wellbeing of residents has become part of the housing agenda, alongside other aims, such as helping people into training and employment, and some social landlords provide high-level support for individuals with complex needs. Social landlords have not yet been involved in IBA intervention but they have been noted as one of the sectors and professional groups potentially relevant to delivering IBA (Herring et al., 2016). Housing staff are being trained to deliver IBA (Thom et al., 2016a). This case study aimed to explore perceptions of the relevance of IBA approaches and its applicability to the social housing sector.

Probation

A limited though growing body of research has examined the potential for implementing alcohol IBA within criminal justice settings. While there is some support for implementation in probation settings (Coulton et al, 2012) there is less for prison settings (Sondhi et al., 2016), and considerable challenges and barriers to delivering IBA in criminal justice contexts have been identified (Thom et al, 2014; Blakeborough and Richardson, 2012). However, probation settings have been seen as 'promising' at least and some services have invested considerable resources in introducing screening and brief intervention. This case study provides an example of a probation sector where IBA had been introduced and efforts made to embed its delivery across the service but where the process of implementation and embedding was disrupted. Disruption occurred when part of probation was outsourced to private contractors. The case study offered an opportunity to examine perceptions of the effects of disruption to IBA delivery within an organisation and the issues that arise in the transition period. It illustrates the importance of considering issues of sustainability when introducing new tools or working practices.

Social work

Alcohol related harm has been shown to have a significant impact upon the day-to-day work of social workers and is associated with adverse outcomes for the diverse range of service user groups coming into contact with social work and social care practitioners (e.g. Dance

at al., 2014; Galvani et al., 2013). Whilst problematic substance use has been an ongoing concern within social work, and social workers do respond to alcohol-related problems among their clients, the struggle continues to provide a coherent framework for social workers with the right level of knowledge and skills to work effectively with these issues. In theory, IBA could provide such a framework and a useful tool. This case study sought the views of social workers and social carers regarding their experiences of addressing alcohol issues with clients and regarding the feasibility and acceptability of incorporating IBA within everyday practice. (For a fuller account of the case study findings see: Thom et al., 2016b)

2.5.2 Methods

The three case studies used similar methods. A qualitative approach was considered as most suited to exploring views on the appropriateness and feasibility of delivering IBA in housing, probation and social work contexts. The method of data collection drew on Appreciative Inquiry (AI). This is a change philosophy and methodology that focuses on developing an organisation's core strengths rather than seeking to overcome or minimize its weaknesses (Cooperrider and Srivastva, 1987). In line with the principles of AI, the focus groups sought to *discover* perceptions of current 'best practice' in relation to alcohol issues, *dream* about what in an 'ideal world' respondents would like see in place to address alcohol related harms within their resident group, think about and *design* how that could be done (Cooperrider, Whitney and Stavros, 2003). The limits of the research project meant that we did not engage with the *destiny* stage of the AI model, which entails translating the design into action. Key research domains that guided the discussion within the AI framework were:

1. Current exposure to alcohol issues: How, if at all, are alcohol consumption and related harms raised/ discussed/ responded to within current working practice?
2. Understanding and perceptions of IBA: What is understood by alcohol IBA? Is IBA (screening element, advice element) seen as appropriate for use with clients in this sector? What are the perceived barriers and challenges?
3. Role perception: *Ideally*, what would participants *like to see* implemented by way of addressing alcohol related harms in their client group? What do they consider as 'best practice' regarding addressing clients' alcohol related problems?
4. What is needed to work towards implementing best practice (IBA? Other interventions?).

The housing and probation studies used a combination of interviews and focus groups; social work used focus groups and a survey before

and after a training session. Interview and focus group schedules were directed but schedules were sufficiently flexible to allow new issues to emerge.

The interviews and focus groups, with permission, were audio-recorded and transcribed in full. The data was collected and analysed by two researchers for each case study. Verbatim transcripts were coded and thematic content analysis used to identify key themes (Robson, 2011). The researchers worked closely, discussing emergent themes and categories at each stage of the process to facilitate the identification of key themes, discuss and resolve any differences in opinion; double coding was used at the start of the coding process to ensure consistency (Lincoln and Guba, 1985).

2.6 Ethical approval

Ethical approval for the research was granted by Middlesex University's Ethics Committee. All participants were provided with written (and verbal) study information, assured that confidentiality and anonymity would be preserved and consent was obtained from all participants. Broad labels are used on quotes to protect the identity of individuals. No difficulties regarding ethical issues arose over the course of the project.

Key themes

3.1 Introduction

The majority of research evidence for alcohol IBA comes from primary care and to a lesser extent, hospital departments. Generally, in primary care settings, the approach has been accepted as cost-effective. 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. Other contexts, considered promising but with little or no research, are the workplace, housing, youth work and social work. A scoping exercise (UK only) identified a considerable number of projects delivering alcohol IBA or similar approaches, such as alcohol brief advice, 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 had 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 a lot of support for the use of screening and brief intervention approaches and it is a valuable tool in the armoury of 'promising approaches' to prevent and reduce problem alcohol use. However, there is no doubt that even in primary care settings where efforts to deliver and evaluate IBA have been greatest and shown most evidence of effectiveness, there remain challenges in initiating and sustaining delivery. There was considerable consistency across the different studies we carried out regarding the challenges faced when trying to implement alcohol IBA in non-health contexts. Four main challenges are addressed below: 1. the nature of IBA itself and the extent to which it could be adapted to different working contexts; 2. the relevance of IBA to professional roles and work contexts; 3. ethical dilemmas arising from tensions between main roles and responsibilities and the requirement to deliver IBA; 4. the importance of organisational contexts for the delivery of IBA. These challenges are discussed in more detail in the public output from the project (see section 7 below). Each has implications for the provision and delivery of training and this is discussed in section four. Finally, it is argued that training needs to be seen as a cog in a much bigger wheel and that a shift is needed from a focus on encouraging behaviour change at an individual level (facilitated through training) to a systems approach which looks at the impact on professional and individual practice of organisational networks and systems as well as the wider health and social care and regulatory systems.

3.1 The nature of IBA as an approach

The expert workshop, in particular, highlighted concerns that there was a lack of shared understanding about what was involved in delivering IBA, what the core content was and whether various adaptations, or minimal IBA approaches could be delivered and still count as IBA. The fidelity of IBA intervention has received little attention. It was suggested that in many settings what was being delivered did not conform to the classic IBA approach. This is not to say that such interventions are ineffective but without better knowledge about what is being delivered, in what circumstances and to which groups it was impossible to assess the quality or potential effectiveness of interventions delivered in many non-health contexts. The discussion highlighted the need for future exploration of the key components of IBA/'brief intervention' approaches. Identifying the active ingredients in IBA becomes especially important when moving away from traditional IBA towards IBA 'light' (which is generally necessary outside health care settings). In considering either 'classic' IBA or an adapted form, it is useful to separate out the identification element and the advice element. Most

participants in the research said that they did give advice. But a common view was that identification did not work in many particular settings, with some types of clients, or in some areas of service provision. For example, interviewees and survey respondents often said that they did assess a client's drinking but not using a formal tool (considered to be inappropriate); others noted that by the time they saw the client an assessment had (or should have) already been made by a referring agency or another worker in the system of care. Thus, although there are good reasons for recommending the use of a standard tool for assessment, discussion of a broader range of identification and assessment methods and possibly recognition of the validity of less formal identification approaches might be more helpful for professionals working in non-health contexts. These findings imply that training programmes (whether they are seen as IBA or not) need to be clearly targeted and developed with the needs of specific groups in mind, preferably with development input from those groups.

3.2 Relevance of IBA to professional roles and work contexts

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. The importance of role and context relevance emerged strongly, from the expert workshop and from the case studies in particular. IBA, it was felt, could not always be appropriately integrated into some work contexts (e.g. working in leisure settings with young people). This issue was emphasised in the case of youth work, social work, housing and some criminal justice settings where the encounter was not particularly appropriate for 'formal' screening and intervention or where dilemmas arose from a perceived tension between the primary role of the professional and perceptions (professional and client) of IBA delivery as a form of 'control'. The possible advantages of adapting training content and training delivery to take account of differences in professional needs and work contexts was clearly indicated in the study. Examination of the factors influencing IBA delivery have focused to a large extent on the individual and on securing change in individuals' professional behaviour to the neglect of work context and environment or organisational factors. At the same time, training may not have paid sufficient heed to professional (occupational or institutional) 'socialisation' acquired from professional education, training and regulations, working experiences, institutional embedding, and relationships with clients. These issues have clear relevance for those commissioning or organising training programmes.

3.3 Ethical dilemmas in delivering IBA

Going beyond the practicalities of implementation and delivery of IBA, participants in both the expert workshop and in the three case studies raised concerns about ethical issues in widening IBA delivery into contexts outside health and clinical settings. The legitimacy which medical professionals were afforded to raise patient's drinking as a health concern was not felt to be available to those working in non-health contexts. As voiced strongly in the expert workshop, it cannot be taken for granted that the ethical norms people expect in a health setting will be honoured in other contexts. Issues of confidentiality and consent may present barriers to IBA delivery in wider settings and there is a burden of proof on those who advocate IBA in new contexts to assure the public that their concerns about confidentiality and consent will be respected. Moreover, practitioners in some occupational groups (in this project, especially social work and social care practitioners) faced ethical dilemmas around delivering IBA and executing aspects of their statutory role, namely their 'safeguarding'¹ role. Again, there are implications for the content of training especially if programmes are developed for specific groups of practitioners who may have different professional ethical codes and practices and varied experiences of role tensions arising from their dual roles. Finally, it was felt by some participants in the project that there were ethical issues around the use of resources and that provision of IBA training and decisions to encourage IBA delivery in non-health contexts, need to be looked at in relation to the best, most cost-effective use of resources, given the multiple demands on service budgets.

3.4 Organisational contexts

In considering organisational elements of the equation, two aspects in particular emerged as relevant: the extent of organisational commitment and support for the implementation of IBA; and taking account of the organisation or agency as part of a bigger system and network of service provision.

As well as individual and professional factors and work contexts, organisational support and commitment to integrating policies and interventions to address alcohol issues into strategies and work programmes were often reported as difficult. Although employers were generally eager to take up offers of training and were prepared to give staff time to attend training courses, reports from survey respondents and interviewees suggested low commitment to ensuring that organisational structures were in place to support staff to put their

¹ 'Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It's fundamental to high-quality health and social care' (<http://www.cqc.org.uk/content/safeguarding-people>, accessed 27th April, 2016).

training into practice, and little thought was given to sustaining IBA delivery following staff turnover or organisational change. In some instances, employers are likely to need incentives and to be convinced of the business case for supporting staff to take on IBA. In cases where IBA has been integrated into working practices, major organisational or systems changes may dismantle supportive structures and processes so that IBA delivery risks being lost in the pressures and tensions arising in transition periods, as became evident in the probation case study. Even when there are no major organisational upheavals, staff turnover and mobility mean that organisational commitment is a necessary element if training and other efforts to broaden the delivery of IBA are to be sustainable.

This research project also found a lack of attention to the wider organisational structures and systems within which individual organisations and agencies were located. Most agencies or organisations in the social care, housing, probation (and other service) areas are part of wider organisational networks, structures and systems of welfare or control; as a result, there may be considerable diversity between different parts of the system or network with implications for the development and delivery of training. The organisational unit of implementation is an issue rarely addressed but important in planning widening IBA training and delivery into new, non-health contexts. Although training cannot address these wider contextual influences, they have clear relevance for those commissioning or organising training programmes since resources spent on training are wasted if those trained are not able to put their training into practice.

The role of training

4.1 Training does not result in IBA delivery

As expected from findings reported in the literature review, there were clear indications that training staff, on its own, does not guarantee delivery of IBA. There was no doubt that training was valued and eagerly taken up when offered.

The training received by those answering the survey, and by participants in the social work case study, was very favourably evaluated and most respondents reported that it was useful for their work. At the same time, very few had put their training into practice. The study findings clearly indicate that training for IBA delivery in non-health contexts needs to be adapted and flexible, which means that both the content of training and the delivery methods should be reviewed with the particular target group and work setting in mind.

4.2 Training content and delivery approaches need to be flexible

We have too little information about what is being delivered currently in IBA training courses and whether it is adequate to meet the training needs of professional groups outside traditional health settings and working in agencies which are frequently part of complex networks of service provision. It may be that IBA (in its intended form) is not suited for use in all work contexts or by all practitioners.

Those attending training did not always know what IBA was and some suggested that (although they appreciated the training) it was not really what they needed – alcohol awareness or how to deal with dependent drinkers was mentioned by a few people as more suited to their working situations. Some aspects of IBA were considered as more acceptable and more useful (especially if adapted) than other aspects. In general, trainees were less likely to carry out screening than to provide advice; some practitioners were already using assessment tools other than AUDIT (or other recommended IBA tools); and some felt that their working situations required more subtle forms of questioning and ‘conversations’ about alcohol rather than formal, or structured, approaches. In short, survey responses and the case study accounts clearly suggest that consideration needs to be given to the content of training programmes. This research (and the findings from other research) indicates that a standardised ‘classic’ IBA approach (use of a screening tool and the provision of structured brief advice) is unlikely to be implemented in many non-health settings. A shift away from a standardised ‘manual’ approach towards a more flexible menu of optional contents and methods of delivery may be required to suit the diverse and changing needs of non-health practitioners and their organisations. Whether this should be considered as IBA training or not, depends on what is seen as the key core elements of IBA intervention and whether they can be retained within more flexible adaptations; this is an issue for further consideration.

Training delivery methods and approaches were not a focus of this research and warrant further attention. Most survey respondents stated that they preferred face-to-face rather than online training approaches; but this may have been a case of preferring what was actually received. There is a growing impetus to develop online approaches and this is a development that warrants future examination. As mentioned above, training often takes place in mixed groups where participants have different occupational backgrounds and different work situations, and are employed by different agencies and organisations. This can have an advantage in that it encourages learning within a wider spectrum of knowledge and experience; but, as

several survey respondents noted, more time may be needed with practitioners working in similar contexts and facing similar problems.

4.3 Main lessons

A number of main messages, which echo and augment findings from other research, emerge from the study.

- IBA, in the form delivered in health care settings, may not be practicable, acceptable, or appropriate for non-health contexts. There is a need, therefore, to consider what the core elements of an IBA intervention are and the extent to which IBA can be adapted to suit different contexts and working practices.
- A shift away from a standardised 'manual' approach towards a more flexible menu of optional training contents and methods of delivery may be required to suit the diverse and changing needs of professional groups and their organisations.
- As well as imparting knowledge and skills, training content may need to pay more attention to: aspects of role security and role relevance which may need strengthening; issues around ethical dilemmas; and the current working practices of potential trainees.
- Training needs to be related more directly to organisational cultures, behaviour, and development needs as well as retaining its focus on professional attitudes and behaviour. Prior to delivering training, efforts may be needed to assess and incorporate organisational factors into training programmes.
- Successful training that translates into practice depends, at least partly, on planning and commissioning. Delivery of interventions post training may stand a better chance if, at the commissioning stage, consideration is given to: what kind of training is best suited to the target group/ work context; the extent of organisational support for the translation of training to practice; the potential to enhance supportive structures and facilitate the sustainability of post training intervention.
- Understanding the structure of an organisation and its position within complex local and national networks of services and care/control systems is relevant both to identifying the potential uses of IBA and to developing appropriate training.
- Policy makers, commissioners, managers and employers as well as practitioners need to be convinced of the value of IBA to the client

group. Different arguments, evidence and incentives are likely to be needed to appeal to those groups.

- In promoting further roll out of alcohol IBA in non-health 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.

Conclusion

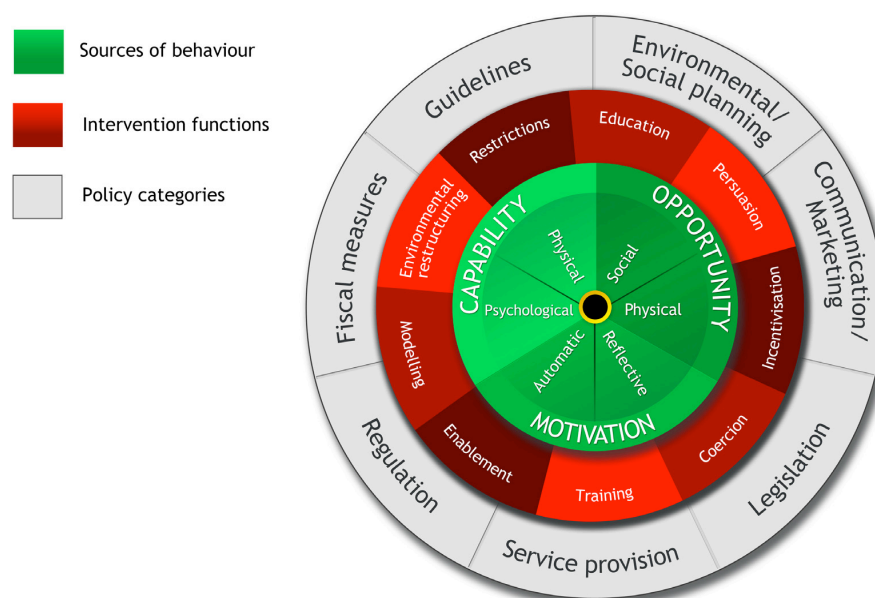
5.1 IBA training and implementation: Where's the theory?

This research study did not begin with an over-arching conceptual framework to guide the design and data collection. It was informed by the literature on IBA delivery and outcomes, by the literature on training, and by the arguments and rationale for providing IBA training to enhance delivery in non-health contexts. Theories and conceptual frameworks were often lacking in the literature or were implicitly rather than explicitly used. When research, evaluation studies or guidelines and manuals did mention theoretical frameworks, they generally referred to the cycle of change (Prochaska and Di Clemente) and elements of brief interventions such as FRAMES and motivational interviewing (see for example: Babor and Higgins-Biddle, 2001; WHO 2010). O'Neill et al. (2015) state that they used normalisation process theory (NPT) and the theoretical domains framework (TDF) to understand how health professionals can be supported to adapt their behaviour and clinical practice, thereby ensuring that the social system is considered (NPT) as well as individual influences on behaviour (TDF); but they do not illustrate specifically how the theories informed the study. What the literature as a whole indicates, therefore, is that work on IBA (even in the best researched primary care field) emphasises individual behaviour change – patient/ client or professional/ practitioner behaviour – but does not draw on the wider range of change theories which help to link individual behaviour change with organisational and systems change factors. There are many theories of change, some seeking to explain change at international, cross country level, some at national, local, organisational and individual level; and a theory of change can be used in multiple ways, for instance, for strategic planning, for programme planning, for monitoring implementation and for looking at the factors that influence outcomes (e.g. see Rogers, 2014; Stachowiak, 2013). These wider theories and conceptual frameworks

are vital for contextualising IBA training within individual behaviour change approaches and for understanding how multiple factors operating at very different levels may impact on delivery of an intervention, including IBA.

In a review of frameworks for behaviour change interventions Michie et al. (2011:3) found that, "Even when one or more models or theories are chosen to guide the intervention, they do not cover the full range of possible influences so exclude potentially important variables". Their review identified 19 different frameworks, which the researchers used to develop a 'behaviour change wheel' for use in designing behaviour change interventions. The wheel consists of three central conditions (capability, opportunity and motivation) clearly relevant to individual change processes, nine intervention functions (training along with other functions such as incentivisation, coercion, environmental restructuring) aimed at addressing deficits in the three central conditions, and seven policy categories (e.g. guidelines, service provision, fiscal measures). This comprehensive model of behaviour change has parallels with wider change theories and is in line with adopting a systems approach to intervention; it clearly demonstrates the role of training as an element in the process, but also emphasises the need to integrate training for IBA and delivery of IBA within a broader framework of understanding on how and why behaviour changes (see figure 1).

Figure 1: The behaviour change wheel (From Michie et al., 2011:7)



5.2 Towards a systems approach

The fact that training does not appear to have much impact on IBA delivery does not mean that it should be abandoned. As Heather (2016) argues, despite the lack of research evidence for IBA implementation in non-health contexts, the critical question for evaluating the effectiveness of ABI might be: “What kind of brief intervention, delivered in what form, by what kind of professional, is most effective in reducing alcohol consumption and/or problems in what kind of excessive drinker, in what kind of setting and circumstances?” The question is complex and the answers will be equally complex, which implies that the development and delivery of training needs to respond to a more complex model of behaviour change than has been the case to date in most IBA training and delivery. The findings from this project suggest that a more complex model of behaviour change requires inclusion of at least the organisational and systemic factors that are likely to influence the potential for individuals to change their behaviour. This applies to practitioners and their agencies as much as to the clients they seek to influence.

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Outputs from the project

Publications

Thom B., Herring R., Luger L and Annand F. (2014) *Delivering alcohol IBA: Broadening the base from health to non-health contexts. Review of the literature and scoping Report to Alcohol research UK*, available at <http://alcoholresearchuk.org/alcohol-insights/delivering-alcohol-iba-broadening-the-base-from-health-to-non-health-contexts/>

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Thom B., Herring R., Bayley M. and Hafford-Letchfield (2016, submitted to Alcohol Research UK) *Delivering alcohol IBA in housing, probation and social work settings: Opportunities and constraints*

Herring R., Thom B. and Bayley M. (2016) *Delivering alcohol Identification and Brief Advice (IBA) in housing settings: a step too far or opening doors? Drugs: education, prevention and policy* (open access publication)

Thom B., Herring R. and Bayley M. (2016 in press) *The role of training in IBA implementation beyond primary care settings in the UK Drugs: education, prevention and policy* (open access publication)

The above papers: Herring et al., and Thom et al. are part of a special focus issue from the project. The issue also includes: Sondhi A, Birch J, Lynch K, Holloway A, Newbury-Birch D. (2016, in press) *Exploration of delivering brief interventions in a prison setting: A qualitative study in one English region Drugs: education, prevention and policy*; and an editorial from Nick Heather, a member of the project advisory group: Heather N. (2016) *Spreading alcohol brief interventions from health care to non-health care settings: Is it justified? Drugs: education, prevention and policy* (editorial, 2016), open access

Presentations

- Thom B. (July 22nd. 2016) *The role of training in IBA delivery in non-health contexts* seminar to Public Health England.
- Thom B., Herring R., Bayley M. and Hafford-Letchfield T. (16th. May, 2016) *Should we be training (everyone) to deliver alcohol*

Identification and Brief Advice IBA (everywhere)? Open evening seminar. Middlesex University, London.

- Herring R. (joint with Alan Rogers, CEO Cobalt housing) (20th. November, 2015, Liverpool) *Housing issues and research developments* North West Public Health Alcohol Conference. 'Break out' session which drew on the housing case study and on a study of IBA in housing settings for PH England.
- Herring R. (4th. November, 2015) *Alcohol identification and brief advice (IBA) in non-health settings*. Seminar, study day for visiting Danish MA students (European Masters in Drug Alcohol Studies), Middlesex University, London.
- Herring R. (6th July 2015): *Alcohol identification and brief advice (IBA) in non- health settings: Is there a case for a wider roll out?* Department of Mental Health, Social Work and Integrative Medicine 1st Annual Conference. Middlesex University, London.
- Herring R. (11th June 2015) *Alcohol identification and brief advice (IBA) in non- health settings: think before you leap*. Keynote presentation, Launch of the Drug and Alcohol Network (DARN), Queens University Belfast.
- Herring R. (8th June 2015) *IBA in non-health settings* Public Health England – Greater Manchester, seminar on Alcohol Identification and Brief Advice.
- Herring R., Bayley M. (20th April 2015) *IBA in non-health settings*. Workshop, Alcohol Academy Conference, Birmingham Alcohol brief intervention: where next for IBA?