

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

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Key findings

- There is sufficient evidence to support current optimism about the potential for alcohol IBA to be delivered in a range of health and non-health settings.
- Online IBA models have potential to reach individuals who may not access health or support services
- Organisational, professional and context- specific challenges impede implementation and, in particular, the sustainability of initiatives over the longer term
- Training has an important role to play in improving the knowledge and skills level of staff; however, on its own, it does not guarantee delivery of IBA.
- Evaluation and monitoring should be built in to new initiatives to ensure appropriate use of resources and to promote a culture of learning from practice

Research team

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Background

There is good evidence for the effectiveness of alcohol IBA (identification and brief advice) to address harmful drinking among patients in primary care and, to a lesser extent, in hospital settings (Kaner et al., 2007; Wilson 2011). Based on this evidence, there is a drive to expand delivery of IBA into other health and non-health contexts. Although the evidence is less clear, research in pharmacies (e.g. Khan et al., 2013) and in criminal justice settings (e.g. Skellington et al., 2013; Coulton et al., 2012) has indicated the feasibility of delivering alcohol IBA in these contexts. Some studies in university settings (largely from the USA) have also indicated a role for IBA in efforts to reduce harmful drinking (Seigers and Carey, 2010), with web-based approaches providing a possibly effective delivery mechanism (Bewick et al., 2013). There is, as yet, little evidence to indicate that alcohol IBA can be delivered and have an impact in health settings such as dentistry or in non-health contexts such as workplaces, services for young people and the homeless or social work settings. Despite the lack of good evidence, there is enthusiasm to roll out alcohol IBA in a wider range of community settings (NICE, 2010). In Scotland, for example, delivery of ABIs is a significant component of the Scottish Government Alcohol Strategy (2009). Although the focus is on mainstreaming delivery of ABI (alcohol brief intervention – the term used) in three priority settings - primary care, accident and emergency and antenatal care – implementation of ABI is also encouraged in wider contexts, including non-health settings (Stead et al., 2014).

While evidence points towards the potential effectiveness of IBA in diverse contexts, the literature also provides accounts of the many challenges and barriers to implementation of IBA both in health and non-health settings. Some of the problems have been recognised for many years (Shaw et al., 1978; Heather, 1999) and the fact that they are still relevant today, indicates the difficulty of securing change and the need for long-term vision. This is particularly important when considering the potential for widening IBA delivery beyond core health care settings.

As part of a larger study examining the role of training in delivering IBA in non-health contexts, a review of the literature and scoping of current IBA projects in the UK was undertaken. The main aims were to:

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

Methods

A mixture of approaches was employed to identify relevant literature and projects. CINAHL, Medline, IBSS databases and Google Scholar were searched for published literature on the use of IBA in health and non-health settings. Other relevant publications were identified by the project advisory group and by researchers who commented on sections of the report. Grey literature was identified from websites, notably, the Alcohol Learning Centre website, NHS Scotland website, Drug and Alcohol Findings website and the Alcohol IBA Blog. Other approaches – a twitter request for information and a circular to members of a relevant Google group were also tried. A search of the Alcohol Learning Centre website, local initiatives page, was undertaken to identify studies on the provision of alcohol IBA training in non-health settings. The NHS Scotland website yielded information about relevant ABI projects.

There is a wealth of published and grey literature on IBA and a considerable body of research studies, especially research undertaken in primary care and hospital departments. This influenced our selection strategy as we did not want to duplicate reviews of primary studies or provide a comprehensive review of delivery of IBA in core health settings – already available elsewhere. A main objective of the work was to extract insights on the challenges, barriers and facilitators of alcohol IBA delivery; to consider their relevance for non-health contexts; and to address the implications for the role of training. For core health settings we relied as much as possible on reviews, meta-analyses and classic or very recent publications and aimed to sketch out the main findings and the main challenges to IBA delivery identified in that literature. Similarly, in looking at pharmacy, criminal justice and educational settings, where there is also a considerable body of research, we drew on reviews but included a greater number of primary studies, giving some priority to studies employing quantitative methodologies (such as randomised controlled trials). For some contexts – social services, homelessness services, youth services, workplaces, there was very little to draw on and we used whatever studies were available.

With little published literature on IBA implementation in non-health settings, we undertook a small scoping exercise (using the NHS Scotland website) to identify projects which were being tried in local contexts. The aim was to find out whether they were seen as successful and sustainable, what had initiated and facilitated the project, what problems, if any, had been encountered, and whether they were still operating. This was done through email correspondence.

Examination of the role of training in IBA delivery in non-health settings is a main aim of the project as a whole. For the purposes of this overview and scoping, preliminary comments are based on a limited

literature search, information on local initiatives found on the Alcohol Learning Centre website, and contact with a few relevant informants identified in the course of the search. This aspect of the work will be expanded at a later date.

Findings

There is good evidence of the effectiveness of IBA in primary care, and to a certain extent, in hospital emergency departments. This is increasingly used as part of the argument for broadening the base of IBA delivery to other contexts although the evidence base for effectiveness has not been established.

Feasibility studies indicate the potential for successful alcohol IBA approaches in pharmacies, criminal justice settings and in schools and universities. However, as IBA delivery may not be seen as part of the 'core business', staff may need to be convinced of the value of IBA and may need support to optimise implementation of IBA into their usual practice.

Evidence for IBA delivery in other contexts is lacking. The workplace has been proposed as a promising context with potential benefits for both employees and employers. Where there is an occupational health service within a company, there may be an appropriate framework for introducing and embedding IBA within the company's health and wellbeing policies. 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.

In both health and non-health settings, some financial incentives may increase the chances of IBA delivery but it is unclear how much the incentive needs to be to have an effect.

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.

Even in health care settings there are still considerable barriers to mainstreaming IBA within professional practice and within organisational structures. Greater resistance and more barriers to IBA delivery are likely to arise in services and contexts further removed from core health care services. Barriers to implementation of alcohol IBA arise from:

- Lack of strategic and organisational commitment to implementing IBA
- Professional feelings of lack of role adequacy and role legitimacy, lack of knowledge and skills
- Perceptions of workload pressure, including lack of time and resources, and perceived lack of support
- Patient/ client/ staff reluctance to engage – in some circumstances because of concerns about confidentiality

There is some evidence that within primary care and hospital settings, issues of role legitimacy and role adequacy have become less important as barriers to professional engagement with patients' alcohol problems. However, in other contexts, these attitudes are still reported as influencing professional behaviour.

Training has an important role to play in improving the knowledge and skills level of staff; however, training, on its own, does not guarantee delivery of IBA.

There is little evaluation of IBA projects and little monitoring of activity and outcomes following allocation of resources to training opportunities and to alcohol IBA and alcohol awareness promotion.

Implications

In promoting further roll out of alcohol IBA in contexts beyond core health services, the findings from this review and scoping suggest that:

- Financial incentives may provide a lever to encourage IBA implementation
- There is a need to consider the potential role of evaluation and monitoring in fostering implementation and demonstrating activity, and to justify the allocation of resources to IBA projects
- Training and support for implementation should be tailored to the specific needs and cultures of organisations, professionals and client groups
- Longer- term planning may be useful to ensure that organisational and professional commitment is sufficient to meet the challenges

Conclusion

There is sufficient evidence to support current optimism about the potential for alcohol IBA to be delivered in a range of health and non-health settings beyond primary care and hospital departments. However, future attempts to broaden the base of IBA delivery need to address organisational, professional and context- specific challenges that impede implementation and, in particular, the sustainability of initiatives over the longer term. Evaluation and monitoring should be built in to new initiatives to increase the chances of appropriate allocation and use of resources and to promote a culture of learning from practice.

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