



Delivering alcohol IBA in housing, probation and social work settings: opportunities and constraints

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June 2016

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Introduction

Identification and Brief Advice (IBA) has been advocated by health organisations such as NICE (National Institute of Clinical Excellence) to promote and 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; 2013), 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 and Thom et al., 2015 for report of an expert workshop).

As part of a larger study, we conducted three case studies to examine the issues that arise in attempting to introduce and sustain the delivery of IBA into everyday practice in housing, probation and social work contexts.

Research aims

While the initial intention of the research as a whole was to examine training and the contexts within which training might support IBA delivery, other questions quickly emerged as the work progressed. These questions became as, if not more, important than the original focus on training. They centred around 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 are their experiences of initiating and delivering IBA?
3. What do different professional groups perceive as the facilitators and barriers to delivering IBA as a part of routine practice?

In the study as a whole, the research questions were explored from the perspective of a) professionals attending training courses who replied to an on-line survey; b) 'experts' (researchers, trainers, managers) in touch with organisations and groups interested in delivering alcohol IBA in non-traditional health settings (ie outside general practice and hospital contexts); and c) three case studies which sought the views of

specific occupational groups. This report presents the findings from the three case studies. The case studies represent occupational groups with different histories of involvement with clients' alcohol consumption and different histories of engagement with IBA delivery. Housing is 'the new kid on the block', probation has recently attracted considerable attention and some research as part of attempts to test the use of IBA in criminal justice settings, and social work has a long history of resistance to taking a more active role in addressing clients' drinking unless the individual is dependent.

Methods

The three case studies used similar methods. As there is little research (beyond health settings) on professionals' views of alcohol IBA and the potential to incorporate IBA into everyday practice, a qualitative approach was considered as most suited to exploring views and experiences 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 alcohol issues, *dream* about what in an 'ideal world' respondents would like see in place to address alcohol related harms within their client 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 research team 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).

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.

Structure of the report

The following sections present accounts of the housing, probation and social work case studies. The conclusion draws together main findings from the case studies of these occupational settings.

Housing

Case study led by Rachel Herring

Introduction

The role of social landlords¹ is an evolving one and they have moved from simply providing 'bricks and mortar' towards a more interventionist role. In recent years, considering the health and well-being of residents has become part of the housing agenda, alongside other aims, for example, to get people into training and employment. Social landlords provide a wide range of housing services along a continuum from accommodation for rent through to high-level support for individuals with complex needs. Despite moves to broaden the 'gaze', the focus for social landlords and their staff is still on the core business of housing, i.e. that rent payments are up to date, properties are in a good state of repair and the maintenance of cordial relations between residents. 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) and housing staff are being trained to deliver IBA (Thom et al., 2016). This case study aimed to explore perceptions of the relevance of IBA approaches and its applicability to the social housing sector.

Methods

A whole day workshop was held in London in February 2015 attended by 10 staff working in the social housing sector in a variety of roles (support, management) and settings (general housing, supported

¹ Social landlords are local authorities (councils) or not-for-profit housing associations and they provide a

housing and hostels). They worked in various locations across London and the South East of England.

Four sessions were held, each of which built upon the previous one to explore:

- How alcohol consumption and related harms are raised, discussed and responded to within current working practice
- What is understood by 'alcohol IBA' by housing staff
- The perceptions of staff on the appropriateness and acceptability of IBA for their residents
- The opportunities, barriers and challenges to delivering alcohol IBA in housing settings.
- Ideas around 'best practice' regarding addressing residents' alcohol related problems
- What participants would like to see implemented to address alcohol related harms in their resident group

The workshops were facilitated by two researchers and the proceedings, with permission of the participants, were recorded and transcribed. Thematic analysis was undertaken of the data. Two people working in supported housing were interviewed and the transcripts of these interviews were analysed using the same procedures. For the purpose of clarity the term resident will be used, although within the workshop and interviews a variety of terms were used including client, tenant and resident.

Findings

Three main themes emerged from the analyses: alcohol risks and responses to the risks within the social housing sector; the roles and

working practices of staff within the sector; respondents perceptions of alcohol issues, alcohol IBA and the need for training.

Alcohol: risks and responses

For participants working in supported settings such as hostels, alcohol was built into broad routine risk assessment as part of the 'substance misuse' section, with each topic rated on 'likelihood' and 'severity' of the risk and in terms of risk to self and others. In addition, residents are often referred by another agency that will have carried out their own risk assessment. This information is recorded on a central database and used to make decisions about the acceptability of the resident into a service and the type/level of support required.

One of the staff interviewed, explained how the housing association (which provides supported accommodation) had changed procedures following alcohol IBA training for all staff. Prior to the IBA training staff had conducted a risk assessment very much as described above and would have made a note only if alcohol was a known problem. Following the IBA training, the AUDIT questionnaire had been incorporated into the risk assessment procedure:

"They (staff) do the AUDIT as a matter of course to be fair to them. It's all part of risk assessment now, because rather than just doing it when, because you feel that someone has a drink, we do it with all kinds whether they've had a drink or not... it's incorporated at the start of the, at the (first) meeting, so the resident knows where you are coming from first and foremost, because it's a bit like professional boundaries, you've got to treat them obviously with respect, but you are the support worker, you're there to provide support to them and these are

the rules of engagement if you like.” (Manager, Supported Housing)

Thus there had been a shift, from responding to alcohol if it was an “issue” to screening all residents.

Conditions are placed on tenancies, often related to (un)acceptable behaviour which can mean that the tenant is in breach of their tenancy or licensing agreement². Whilst some supported accommodation is ‘dry’ (i.e. no alcohol permitted), many places allow alcohol consumption within ‘private’ space i.e. tenant’s room, but not in ‘public’ space i.e. communal lounges, dining room:

“..but basically people can sit and drink themselves to death in their room if they chose, but the point is to control that behaviour and the staff team working on those issues around the abuse of alcohol”. (Senior Support Worker, Supported Housing)

Staff from supported settings noted that alcohol use was often a factor in incidents of unacceptable behaviour (e.g. violence or aggression towards staff and/or residents) and changes in behaviour, as one participant commented:

“...with alcohol some of them want to fight the world, some of them want to go and sit in the middle of (name of road) Road which is a very, very dangerous road”. (Support Worker, Supported Housing).

² A licence agreement is a legal contract which is used for temporary accommodation or shared housing. It gives the licensee (the person occupying the accommodation) the right to stay in the room or property under certain circumstances e.g. if homeless and awaiting rehousing. The licence agreement also gives the landlord the right to ask the licensee to leave if their behaviour has been unacceptable.
http://www.ncha.org.uk/assets/_managed/cms/files/Training/1-4%20-%20Different%20Types%20of%20Tenancy%20Agreement.pdf

Alcohol was recognised, by those working in general needs settings, as a key factor in anti-social behaviour cases and among tenants who found difficulty in sustaining a tenancy e.g. via rent arrears, deterioration of property etc. However, alcohol use and misuse was not routinely considered, with alcohol issues only coming to the attention of staff when raised as a 'problem':

"Nine times out of ten it's going to be a negative occasion, ASB (anti-social behaviour) reports or some kind of concern from a neighbour, somebody gets in contact with (name of housing association)." (Manager, General Needs).

On other occasions, it may be that the customer care line had 'flagged up' that access has been refused to do routine visits, such as gas service checks, maintenance/repairs or there are rent arrears. Importance was placed on following up these neighbourhood management "niggles" and a manager would investigate and visit:

"You go and try and knock on the door, they may or may not open for example. You become aware of a property and then you start looking on your own file and start digging out in terms of seeing what the history is, if there's any history available there...You can obviously sometimes just tell, signs in terms of going looking outside and seeing cans all over the place or in the garbage area or in in the back communal garden or in the hallways, you can generally get some information usually from the property, from the neighbours." (Manager, General Needs).

The key 'risk' was thus to the tenancy and if there are concerns about possible alcohol misuse then tenants were 'signposted' to additional

help, either from within the housing association e.g. Tenancy Sustainment Officers (TSO) or an external agency, e.g. local alcohol service with the aim of sustaining the tenancy. TSOs receive referrals mainly from managers or the Incomes team³. They work with residents to identify what step could be taken to reduce the risk to tenancy and undertake a broad assessment including having a “conversation” about substance use, mental health, and alcohol and establish whether the person is engaged with any services. The TSOs in the workshop emphasised that theirs was a pragmatic not a therapeutic role, as one noted:

“It’s a practitioner trying to identify and resolve some difficulties and maybe give that person time to deal with their alcohol”.
(workshop TSO).

However, the provision of support often required managing multiple needs – with alcohol just one element of a complex range of problems experienced by the resident and the neighbours and requiring solutions to take account of conflicting needs. As the case example in Box 1 illustrates, managing multiple and conflicting needs also entailed dilemmas for staff who had to juggle housing management responsibilities with responsibility for the health and wellbeing of residents.

³ Income teams deal with rent collection, rent arrears and can provide advice on benefits.

Box 1: Case Example

Managing multiple and conflicting needs

One Tenancy Sustainment Officer (TSO) was working with a resident – 'Sarah'-who had been moved by the housing association as a result of domestic violence. The TSO was working with Sarah to help her resettle and manage her tenancy. It was soon apparent, that in addition to known mental health issues, she was also experiencing problems with alcohol. There were restraining orders in place in relation to her seeing her former partner and to accessing her son. Sarah was in a new relationship and her new partner had been violent towards her. At the same time, a number of issues arose in relation to her tenancy; problems accessing her flat to carry out repairs (and consequently damage to another flat), specific complaints from neighbours and incidents of ASB. The TSO then received a call to inform him that Sarah was on remand. As the TSO explained:

In terms of trust, I feel I've built a relationship of trust with her, but you have, you know, this conflicting issue, you've got a variety of data sources and you've got Front Office which is reporting repairs and ASB and we've also got another process North Gate which is about incomes, which is recording housing benefit and rent arrears and you've got a neighbourhood manager who is trying to manage complaints from three different neighbours

As the TSO noted there was thus a series of 'crises' for the housing association -for the neighbourhood manager, the Incomes Team, the Asset Management team – and him as TSO trying to support a woman facing her own 'crisis':

So I think there's lots of different things that do need to get pulled together that don't necessarily get pulled together and so who defines what the crisis is?

The multiple issues that were being flagged up e.g. ASB complaints, repairs etc were being dealt with a housing management 'hat' on, not in terms of care, support or health, which presents a challenge:

How do you then make referrals across to make sure that all of the warning signs that are building up, that this could be, not only a failed tenancy, but a person reaching crisis and/or misusing alcohol and drugs to a greater extent than they perhaps did

before ...It's how do you get that information because we have a lot more contact with people across a lot more different fields than say a GP would.

So whilst there is a potential for crisis prevention, concerns were raised that the current system does not allow those connections to be made and the 'tipping point' for action is usually at (or heading towards) 'crisis' point. In addition, the housing staff were striving to manage what at times were the conflicting needs of Sarah and those of her neighbours and the local community more broadly.

Roles and ways of working

There was a general consensus that the role of social housing staff had altered over time, with a shift from simply being about 'bricks and mortar' to a broader focus on the neighbourhood and on supporting residents to maintain their tenancies. It was thought that as a result of cuts to public services that housing staff are now working with people with far more complex needs and moreover, that housing staff are often the cornerstone of support for that individual and/or family.

Being 'good cop, bad cop': managing enforcement and support roles

Participants acknowledged the evolving role of social housing and consequently housing management, from being "about enforcement, enforcement it's now more about support and enforcement" (Manager, General Needs). Support and enforcement are seen to go 'hand in hand':

"So it's more about how can we support our residents to sustain their tenancies and obviously part of our role, to enforce a tenancy is to ensure that were are trying to support people as well". (Manager, General Needs).

However, the ability to sanction people was viewed as an important tool and for some people, the possibility of eviction was seen to act as a 'catalyst' for positive change.

For some participants, this 'two hat' role was seen to hold inherent tensions, with the same worker having to be both 'good cop' and 'bad cop', which can create conflicting demands for the staff and can be confusing for the tenant. Moreover, this dual role was thought to create barriers to communication and disclosure:

"It adds barriers doesn't it for somebody, if you are dealing with their antisocial behaviour and then they want come to you about another repair issue for example, it's just, do you know what I mean because you are having to enforce something with them then it stops them from accessing you." (Workshop participant).

Managers highlighted that they are required to look at the "bigger picture" and provide support to neighbours and the neighbourhood, as well as individuals, which can create tensions and challenges (see Box 1 above, for an example).

Signposting and supporting change

Housing staff viewed their role as to 'signpost' individuals with alcohol-related problems to specialist services. This 'signposting' function is not specific to alcohol related issues rather it reflects the broader role of housing staff to refer on for additional support either from within the housing association or from external specialist services. Managers pointed out that general housing staff already have a heavy workload and are being asked to take on additional roles, for example, around health and wellbeing, without relinquishing any other part of their role.

Thus, there are limits to the level of support they can offer as they simply do not have the time or resources. 'Signposting' thus reflects the limits of their roles and resource constraints but also acts as a mechanism to maximise the support an individual/family receives:

"I think what most people need to understand about all our roles is there is just so much we can do and so much involvement we can have in people's lives or to make those significant changes at that moment. As it stands, we have so many referrals we make, employment, child poverty, troubled family, tenant welfare, safeguarding, Don't Walk on By, ASB, it's just endless".
(Manager, General Needs).

Workshop participants highlighted that a basic requirement of housing staff is to ask questions about sensitive subjects (e.g. mental health, alcohol and drug use) and so they need to be equipped with the necessary skills and knowledge:

"I think generally we're confident and comfortable enough to ask these questions. I'd say because we're quite front facing, you know we're, everyone has natural interpersonal skills to be able to accommodate the role, it's a key kind of requirement I think for the role. So we're quite comfortable working with people or speaking with them and engaging with them. But I think it comes down to the training and being well equipped to be able to deal with this efficiently or effectively. I think that is a core requirement". (Workshop participant).

Those participants working in supported settings and roles described how they use motivational interviewing techniques in their day-to-day work to support individuals to make changes in their lives. The

importance of establishing a relationship, based on trust with residents (across all settings) underpinned the discussions throughout the workshop.

Understanding IBA and the need for training

Participants had all undertaken alcohol awareness training, the majority attending a half or full day 'basic' course. Housing managers suggested that for the majority of their staff, alcohol awareness was the most appropriate training as their main role was to signpost to additional help and be aware of referral routes. Several staff with specialist roles had undertaken more comprehensive training; for example, one had completed a specialist course for working with residents with alcohol-related problems that ran twice a week for six weeks. None of the participants in the workshop had been trained to deliver alcohol IBA but the two housing staff interviewed as part of the wider study had both been on IBA training.

Within the workshop participants had an opportunity to familiarise themselves with and discuss the AUDIT C and full AUDIT questionnaires and an example of the leaflets used when delivering alcohol IBA. Some staff thought IBA could be a valuable tool, and in particular, liked its structured nature:

“That looks really good. It helps along...because humans being humans it's always fraught with errors and things like that, a risk of questions like that, if a support worker was assessing a resident or whatever, around substance misuse or alcohol, I would love it if a support worker started asking questions around that, in that sort of format. Some staff do, they're brilliant, but some don't and that would help that along. And even one of the best things for

doing that kind of stuff, it often generates an insight into the resident themselves.” (Workshop participant).

Whilst others were more cautious, expressing concerns about acceptability to residents and also the purpose of gathering such information:

“So if it’s about asking questions we can do that. But for me it’s more about actually what do we do with that information and what’s the purpose of us actually asking those questions, will the residents see us as confidants to disclose such information. You know all that kind of personal, it’s quite personal these questions.” (Workshop participant).

Linked to this was the issue of expectations, in particular on the part of the resident, once housing staff have raised alcohol as an issue. Questions were also raised about the practicalities of delivering alcohol IBA to general needs residents who may have limited contact with housing staff and its utility to staff and residents; and it was thought that there may be a risk that alcohol IBA could become a ‘tick box’ exercise if made mandatory. However, other participants felt that there were opportunities to deliver alcohol IBA to general needs residents, for example, at the ‘welcome’ visit or tenancy review.

One of the staff who had undertaken IBA training, explained that the decision to train all staff was largely in response to a change in the profile of the residents:

“... over the last five or six years with we’ve got a lot of residents who seem to be drinking a lot more alcohol, whether that be mental health residents, certainly a lot of mental health residents

do drink a lot of alcohol, but certainly a lot of elderly residents are drinking a lot more these days and we're having a lot of problems with residents who have got alcohol issues". (Manager, Supported Housing).

Whilst a small proportion of residents were identified as having a 'primary' alcohol need (around 5%), it was estimated that alcohol was a 'secondary' concern for about a third of residents and a need for training was identified to allow staff to support these residents. Furthermore, in recent years there has been a move away from specialist support workers to generic support workers and staff undertake a broader range of training than in the past to equip them to support residents with more complex needs. The housing association is paid for the hours of support they deliver, so if they are unable to support residents and the care of the resident has to be taken over by another organisation, then the Housing Association stands to lose money:

"Our contract is 612 hours a week and if I have to offload 30 residents because we can't support them with alcohol issues then we start losing money." (Manager, Supported Housing).

Thus, for this housing association an important factor in deciding to embark on training all staff was the financial implications of not doing so. The training also led directly to changes in policy and procedures. For example, staff working alone, are no longer permitted to enter a property if the resident is drunk or has drunken visitors. Residents are made aware that they have to be sober when staff visit or else the appointment will be cancelled and rearranged. As noted above, the AUDIT had also been incorporated into the routine risk assessment carried out on all residents.

Whilst training was viewed as important by participants there was also recognition that a wider culture change was required if providing support around health and wellbeing issues, including alcohol, was to become part of the 'everyday' role of housing staff. Participants noted the shift from the focus being solely on enforcement to a combination of enforcement and support and the challenges that presented, especially around managing potentially conflicting roles.

Conclusion

Although this case study is limited by small numbers and the restricted sample, it highlights a number of issues relevant to attempts to import the use of IBA – or indeed any form of screening and intervention – into the everyday work of staff in the housing sector.

Social landlords provide a wide range of housing services along a continuum from accommodation for rent through to high-level support for individuals with complex needs. They are increasingly being asked to address health and wellbeing issues at individual and neighbourhood level and interest in the potential for alcohol IBA to be delivered in housing settings is part of this broader movement.

For housing staff working in supported settings such as hostels, alcohol use is likely to be a central factor in incidents of unacceptable behaviour (e.g. violence, aggression) and a key factor among tenants who find difficulty in sustaining a tenancy (e.g. via rent arrears, deterioration of property). Within a general needs setting, alcohol use and misuse is less likely to be routinely considered, with alcohol issues only coming to the attention of staff when raised as a 'problem'. Housing staff expect to 'signpost' residents with additional needs to

specialist services, either within the organisation or from external agencies. This can include help with income management, gaining employment and addressing alcohol/drug misuse.

Although many staff may be open to receiving some form of awareness and training regarding responding to alcohol use among residents, when it comes to intervention, they face similar issues regarding feelings of role legitimacy and the risks of endangering relationships with residents as noted in studies of other professional groups (see examples in Thom et al., 2014). The dual role of manager and 'enforcer' requires especial consideration and, again, reflects similar dilemmas to that observed elsewhere (e.g, Sondhi et al., 2016).

Clearly there are opportunities and advantages in considering the use of IBA; as mentioned, a simple structured tool and guidelines could support staff and boost knowledge and confidence in identifying and responding to alcohol problems. However, the responses from this study, indicate that the introduction of screening and brief intervention into a new non-health setting such as housing, requires prior work to establish what kind of intervention would be acceptable to staff and residents, when it might best be delivered and under what circumstances. Although staff training is an important element, a broader organisational and professional culture change is also required. Training content and deliver, too, requires examination to assess its relevance to context, professional working practices and the nature of the core relationship between professional and, in this case, resident.

Probation

Case study led by Mariana Bayley

Introduction

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). 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, Community Rehabilitation Companies (CRCs). The case study offered a unique opportunity to examine perceptions of the effects of disruption to IBA delivery within an organisation and to consider how alcohol IBA training might be developed in future within this sector. It illustrates the importance of considering issues of sustainability when introducing new tools or working practices.

Methods

A qualitative approach was adopted for data collection so that emerging issues could be fully explored. One metropolitan area was chosen as the case study site as this provided an opportunity to conduct interviews with sufficient numbers of staff working in a variety of roles. We wanted to include participants who had been employed

prior to the split in service as that they could discuss its effects on their delivery of IBA. Data was collected via a workshop with a trainee probation officer, a senior probation officer and an engagement worker. Though the workshop was widely promoted internally, this was fewer than we had hoped for; low turnout was explained as a result of significant work demands following the recent organisational changes. The same set of issues as covered in the housing case study were explored:

- How alcohol consumption and related harms are raised, discussed and responded to within current working practice
- What is understood by alcohol IBA by probation staff
- The perceptions of staff on the appropriateness and acceptability of IBA for their clients.
- The opportunities, barriers and challenges to delivering alcohol IBA in probation settings.
- Experiences of and responses to training in IBA.
- Ideas around 'best practice' regarding addressing alcohol related problems in probation.
- What participants would like to see implemented to address alcohol related harms within probation.

The questions and themes raised in the workshop were further explored in subsequent in depth interviews with two managers and two senior probation officers all with specialisms in various areas of probation including substance misuse. Content analysis was undertaken following the main themes set out above but leaving room for new categories to emerge.

The findings from this case study need to be analysed within the wider context of organisational change. The next section sketches out the

changes in the probation service that were reported as having an effect on IBA implementation. Results from the research are then reported and discussed.

The context: Delivering IBA pre- and post restructuring

Prior to 2012, external specialist alcohol service providers were contracted by probation trusts to deliver IBA to offenders drinking at increasing and higher risk levels. Dependent drinkers were referred on to local treatment services. In 2012, the services were decommissioned and treatment was transferred to local authority public health teams under a new model of alcohol intervention delivery. From April 2012 delivery of IBA shifted from external providers to Offender Managers (Probation Officers⁴) whereby offenders with alcohol problem issues came under the care and supervision of probation officers.

Since January 2013, the probation service in England and Wales has undergone significant changes in its structure, organisation and operation in response to the Ministry of Justice Transforming Rehabilitation Programme (Ministry of Justice, 2013). Under the new structures, the National Probation Service (NPS) has responsibility for court work, pre-sentencing requirement assessments and high risk offending. Most of the rehabilitative requirement i.e. Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirements (ATRs) was outsourced, from June 2014, to CRCs. Complex and high-risk cases are still retained by local arms of NPS and all others i.e. low to medium risk of harm cases have been transferred to CRC management, including prisoners released with a short-term sentence.

⁴ For the purposes of this report, the role description of 'Probation Officer' (PO) also includes 'Probation Service Officer' (PSO) as there is overlap in job roles and many of the latter have fulfilled the qualification requirements of Probation Officers.

Identifying and assessing alcohol misuse can currently occur at different points within the probation process:

- Pre -sentence report - Oral report at court
- Initial Sentence Plan - includes risk assessment (OASys)
- Induction
- Supervision programme

A risk assessment is carried out as part of an individual's sentence and supervision plans using OASys (Offender Assessment system), a software tool used to record and calculate the risks and needs of offenders. Included is a section covering alcohol use whereby alcohol as a criminogenic need can be identified. A score is calculated in the system taking account of previous convictions to predict the likelihood of a further offence. Clear pathways and procedures are evident for identifying, responding to and supporting clients where alcohol is linked to their offending or risk of harm, and when the client involved is on an ATR. An ATR is a court-enforced treatment targeted at dependent drinkers who are then referred on to alcohol services. For other drinkers who may not meet the criteria for an ATR, after being sentenced at court an AUDIT forms part of the induction process so that everyone is screened early on. In this way probation officers are potentially alerted to issues which might suggest an alcohol IBA intervention. If possible dependence is identified among these drinkers, this should result in referral to alcohol treatment services. Under the new probation service split, an element of the new contract with CRC involves Payment by Results (PbR) for reductions in re-offending across the whole community order and licence framework including ATRs.

Findings

IBA early days

Commitment to IBA was high in principal among substance misuse managers and leads because of the convincing evidence linking reduced alcohol misuse with decreases in reoffending.

“We had the SIPS finding at that point... it’s cost effective and it actually reduces drinking, you know within our cohorts and it also reduces reoffending which is obviously the big tick, you know our overall objective” (Manager).

When delivery of IBA shifted from external providers to Offender Managers (Probation Officers) in April 2012, the Alcohol Use Disorder Identification Test (AUDIT) was selected as the screening tool for use within the service and staff were trained to deliver alcohol IBA via a one-day training package⁵. After a successful pilot, the IBA package was mainstreamed into the area’s training programme.

“... basically managers and staff, what we call, SPOCs, Single Points Of Contact were trained and then it was rolled out as part of a train the trainer programme. So they’d go into the local office and train all the other staff how to use the AUDIT form, etc., that was being done at the start of sentence or at the start of first contact with the probation service, so that we could obviously identify those that needed brief advice and those that needed further referral.” (Manager).

⁵ On the whole, practitioners felt able to deliver IBA following training except in cases where offenders did not want to change their drinking behaviour or were treatment resistant. Two training courses were subsequently delivered in 2013, one covering treatment resistant drinking, the other motivational interviewing within alcohol misuse, both with IBA add-ons for staff needing a refresher.

Despite its success, the initial pilot along with other research findings (personal communication in unpublished document) highlighted challenges in the delivery of IBA focusing on:

- the need for strategic and organisational commitment;
- a drop-off in IBA implementation after training;
- lack of resources in delivering IBA, e.g. time needed alongside existing work demands.

A series of recommendations followed, advising on:

- clarity required in how the evidence base links to community criminal justice setting;
- a need to establish community pathways and build on existing pathways to incorporate pre-arrest opportunities;
- the potential role of alcohol IBA champions;
- the creation of bespoke tools e.g. IBA toolbox for working within the criminal justice sector;
- the development of an IBA network among criminal justice practitioners;
- performance monitoring, quality assurance and follow-up for supporting staff trained in IBA.

These recommendations led to a concerted effort to embed alcohol IBA into working practice.

Embedding IBA into probation practice

It had become apparent from the case management system used in probation (DELIUS) that fewer IBA interventions were being recorded than had been expected. Although this could be attributed partly to logistical challenges in recording, it suggested that IBA training alone was not enough to ensure successful implementation and that greater

support was needed to arrest the drop off in delivery after training. Most POs' caseloads focused, and continue to do so, on clients with ATRs who are likely to be dependent drinkers and where intervention pathways are clearly established. Staff noted that less attention was paid to working with clients at increasing risk.

“We work closely with them (external service providers) to manage the ATRs and DRRS for the drugs but there has always been a bit of a gap really in terms of working with the binge drinkers, because they don't necessarily meet the criteria for an ATR. So they are kind of the ones which maybe haven't, um kind of fallen by the wayside a little.” (Probation officer).

Embedding was deemed to require more visible organisational support and better leadership – possibly through using 'alcohol champions'. Key recommendations from the Department of Health SIPS study and from a review of IBA in criminal justice settings (Gecko, 2012) suggested that strategic and organisational commitment, alongside the appointment of local front line champions, were required for successfully implementing IBA.

Early efforts to address the shortfall in delivery and to embed IBA into probation included promoting the evidence base for IBA. The area's probation service hosted an alcohol symposium designed to share knowledge and experience from specialist alcohol workers, service users and staff in a variety of roles across probation, including representation at board level. Opportunities and challenges in delivery were explored together with the kind of support needed to optimise delivery.

Probation Officers (POs) with good knowledge of best practice and partnership working in their local areas were identified as alcohol champions. Their role focused on promoting and improving the quality and delivery of IBA within their boroughs.

“ ...You know it (IBA) wasn't really happening. There were a lot of new processes not policies as such...but just - this is the process that you should follow. If somebody comes in, do the screening, if they are 20 plus, refer out to the community agency for an assessment, pre-sentence or post sentence, and if they are below, then deliver brief advice. So we needed the champions to kind of, you know, there was a lot of confusion, a lot of, you know, kind of changes going on, so we used the champions to attend team meetings...” (Manager).

Alcohol champions were tasked with encouraging their peers to deliver IBA, supporting and advising staff and attending team meetings. Monitoring delivery and recording of IBA and the use of AUDIT were part of their remit alongside responsibility for circulating materials complementing brief advice e.g. alcohol wheels, age related materials etc.

Training provision was also refined and improved. After POs' initial training in IBA, a rolling programme of bi-monthly refresher training sessions was adopted early on with flexibility to organise sessions in a shorter time frame in line with staff demands for training and as resources became available. Meetings with senior probation officers acting as substance misuse drug and alcohol leads were also convened on a bi-monthly basis. These meetings provided a useful feedback and support mechanism ensuring that alcohol would remain on the agenda.

In one borough, a manager spoke of a lack of knowledge and understanding of alcohol issues among some officers and, as a result, opportunities for interventions were being missed. An alcohol worker was engaged to address this need by encouraging officers to deliver IBA and by promoting greater understanding of alcohol issues among them. Although not specifically brought in as an alcohol champion, the alcohol worker performed a similar role and fostered improvements in communication and practice, captured in the following comment:

“So ‘the officers’ and the alcohol worker would be talking to each other about cases and gradually we started to see the knowledge and the confidence around alcohol misuse, increase. So I mean for us what we found was that there was a disconnect before that, but with the alcohol worker now kind of working consistently at the office, the bridge if you like has been lessened.” (Manager).

Participants’ reports generally indicate that IBA had been well received by staff and early observations of delivering IBA suggested promising results. A manager spoke of a threefold increase in IBA sessions recorded in the case management system though, due to technical issues in recording, numbers may have been even greater. Some elements essential to the process of embedding IBA into the organisation were therefore either in place, were being initiated or were being further developed prior to the disruption.

“So I think it (IBA) has a place in probation work and I think IBA initially was very, very effective at the pre-sentence report stage. I remember staff telling me that it was, you know, when you are talking about alcohol, even if it’s for 5 minutes with someone, just

to remind them about, you know, 'Are you aware of the impact that binge drinking can have on you?' because some people don't, they are not aware." (Probation Officer).

Engaging clients in IBA

The ethos of engagement underpins everyday working practice within probation. Effectively engaging with offenders has been shown to reduce reoffending, and a priority at the heart of Skills for Effective Engagement and Development (SEED), is the importance of the relationship between service user and supervisor/PO (Ministry of Justice, 2012). The model involves core training of practitioners, for example, in motivational interviewing (MI) supported by managers (either Offender Managers or SPOs) with follow up training sessions. SEED aims to bring about cultural change in enabling practice with a focus on quality outcomes and reflective practice. Trying to fulfil these aims was highly visible in managers' and officers' accounts of working with clients. As with other occupational groups, including housing officers discussed above, there were issues raised regarding clients' perceptions of the legitimacy of the role with respect to addressing alcohol, the risk of disrupting the client PO relationship, the willingness of clients to discuss alcohol and the appropriateness of screening tools and the IBA approach in some work contexts.

To assist POs in engaging clients a new role of 'Engagement Worker' (EW) was created in some areas. They are ex offenders working with POs and recruited to offer informal support to clients identified as having difficulties in engaging. Emphasising the engagement aspect of the role may help to reduce possible tensions arising from tensions between probation officers' roles as agents of enforcement and 'counsellors'. This tension can become accentuated if POs need to

breach someone, or when disclosing personal information about a client to other agencies.

"...the first point of contact would be through a referral by a probation officer, or it can be like a general chat like 'Oh I've got this guy at reception, can you just see him? He's not engaging well' or 'There's something that's missing'...It could be like a gender thing or it could be like the service user feels like he can relate to you a bit more...all the engagement workers have been through the criminal justice system. So that helps service users to open up a bit to know that I can have a bit more empathy what they're going through and what not, which might help them open up or it varies...Sometimes I will just have a conversation with someone, but it's not like a formal conversation, I couldn't say it wasn't a formal conversation."
(Engagement worker).

While POs (and EWs) may strive to explore issues that are important to the client at the assessment stage, a delicate balance needs to be achieved in not alienating or offending an individual by prying into their personal affairs too early on. Issues are interlinked and likely to include accommodation, employment, relationships etc or in the words of one officer, 'a spider's web of everything', with alcohol as an apparent or hidden problem among clients whose alcohol misuse is linked to their offending behaviour. Staff noted that it was rare for clients themselves to raise their drinking as a concern; they were often reluctant to disclose and tended to minimise their drinking early on. A client's reluctance to talk about their drinking arose partly from a common perception that problematic drinking is associated with dependency. Respondents noted that many clients do not recognise that their drinking is linked to their offending behaviour and therefore it

is not seen as problematic. Equally, while discussing alcohol is a familiar part of a PO's role, much of the focus was still on individuals whose needs are most apparent and whom they have most experience in supporting, namely dependent drinkers, those who have relapsed and those whose drinking has escalated.

"I suppose they (clients) don't necessarily want to accept there's a problem and because they're not, I find because they're not saying they drink every day, they've got it in their heads, well there's nothing wrong with me. I haven't got that much of a problem because I don't need a drink in the morning but yet I'm going out every weekend and getting into trouble." (Probation officer).

"I think it's something that they (POs) are familiar with, that they know that it's something that they should be aware of when they're looking at risk assessments for the service users. It's something that we would consider in terms of risk escalation if someone has relapsed or has started drinking more than they normally would. I think officers are in tune with that...I don't think there's a culture about generally discussing alcohol as part of your case management cases across the board. I think it's more if you've got the need then we are going to deliver that information." (Probation officer).

Reluctance or resistance among clients at increasing risk to disclose or discuss their drinking was noted among almost all staff and this led some to adapt the ways they used the AUDIT tool. Staff experienced in working with substance misuse often chose not to use the paper form and in keeping with building up the client-practitioner relationship,

opted for a less formal approach to discussions about their client's drinking.

"It's a bit scary I guess. So just a few kind of probing questions I guess just to sort of, maybe some comments about how maybe they're presenting and any concerns they may have, doing it in a bit more of an investigative way I guess, just to get them to disclose, because obviously some people do come here, you know they don't want to be on probation so they shut down and they don't want to tell you anything." (Manager).

According to accounts, screening via the AUDIT tool therefore did not follow a systematic and standardised format especially with clients who are risky or heavier drinkers. There is likely to be variation in the level and depth of probing among staff. As a result of clients minimising their drinking, initial assessments on alcohol intake are likely to be inaccurate for some clients. However, despite variations in how AUDIT is used, early screening for alcohol using AUDIT formally or informally was valued as it helped to open up conversations about drinking. Having a structured tool and set procedure was helpful in assessments where attention might get diverted from drinking or where officers needed to remember numerical facts. For less experienced officers, AUDIT provided a useful checklist. Monitoring and reviewing practice are integral aspects of some staff roles, particularly managers', so AUDIT was felt to work well as a benchmark that can be revisited at later dates during supervision. AUDIT as a point of reference was felt to be at its most effective in Integrated Offender Management (IOM) where most individuals coming into the service have reoffended; clients are often familiar and their alcohol histories alongside other issues are already known to staff.

Disruptions in embedding and delivering IBA: 'We've pushed the pause button a little'

Following the disruption to probation services, a state of flux and uncertainty regarding future developments was evident in participants' accounts. A number of interconnected impacts affecting IBA implementation were described. It should be noted that some impacts may continue to affect the delivery of IBA in unpredictable ways and new issues may emerge as the service strives to adapt to the demands of re-organisation. A couple of participants mentioned being part of working groups set up by the new company who were consulting with staff to better understand current working practices with the aim of identifying best practice.

"I think we're at the very early stages of service delivery. They are actually consulting. They've got working groups at the moment.....I think they're still trying to understand the business and what probation is. I mean they're looking to learn from us at the moment." (Manager).

Inevitably, changes in service organisation and delivery incurred problems and disrupted the systems set up to sustain and embed implementation of IBA into routine practice. Equally, in the transition phase, there was considerable uncertainty and some anxiety about how the new organisation would incorporate previous working practices. Issues arose concerning the effects on staff – especially workload - and the effects on the services they delivered.

Effects on staff

Participants reported considerable staff churn as a result of reorganisation. In addition to creating anxiety about keeping their jobs,

organisational changes added significantly to POs' workload. Training in new legislation was needed as well as coming to grips with redesigned service delivery involving training in new processes that are time consuming and can initially be confusing. These factors were considered to have contributed to a slackening in IBA delivery. One manager reported that his portfolios (i.e. areas where he was the lead) had doubled since the division into NPS and CRC; prior to the split there were four managers in the cluster compared with two within CRC. The impetus to keep IBA on the agenda had tailed off in light of current changes although some participants viewed this as temporary while staff adapt to new developments. As a manager and probation officer observed:

"I'm concerned to be honest with you at the moment with transforming rehabilitation...We have now, because of budget cuts again, we have split and a lot of those champions have moved either to one side or the other.....People may have moved in or moved out or moved area.....At the moment I'm not overly optimistic, I think there are so many new processes with the splitting of both organisations that I've actually backed off for a little while and left staff... get their head around it... We have a senior management meeting so I've still gone there and kind of flown the flag for substance misuse.." (Manager).

"I think it (IBA) can add a big impact but it's just unfortunate that the transfer, I mean caseloads were transferred and staff had other things going on and I think it lost its impetus a little bit."
(Probation officer).

The consistent, continuous process of revisiting various aspects of a client's life, such as their emotional wellbeing or behavioural issues,

including their drinking, can provide officers with insight into offending behaviour. This requires considerable time and experience, however, and it was reported that current work pressures had squeezed out the capacity to explore alcohol misuse, particularly among more moderate drinkers. Senior staff pointed out that they had to work hard at getting less experienced officers to understand that the relationship between alcohol or substance misuse and offending behaviour was not necessarily straightforward and there were almost always underlying issues to be tackled.

Effects on service delivery

As already mentioned, service delivery is in the early stages of being redesigned and staff mentioned the possibility of moving from managing a generic caseload to working with a cohort based system, for example working with offenders with mental health issues or women offenders. Moves are already underway in some areas to implement this. Some staff welcomed and were excited about working in specialist areas as partnerships and resources could be built in line with the needs of the specialist group and also officers' interests. A lot of POs' time was currently spent managing a wide remit so in-depth understanding of issues and level of skill were sometimes inadequate. In the event that cohort based working is introduced more broadly, this would have significant implications for training in and administering IBA.

"I think it would be best to wait until things are defined in terms of the new cohort. So when you look at which groups of people you want to try to target because there's going to be an 18 to 25 and they're the group that you may want to target IBA in terms of binge drinking perhaps...So I think it may be best, I think there definitely is a place and I think staff would welcome the option and the resource...I think the message would be lost right now

because I think there's too much, there's just simply too much going on." (Probation officer).

There were however, some negative aspects to the management shift. One of the most significant effects commented on was the loss of alcohol champions. Many had left the service or moved to another area within the service. They had provided an organising point of communication, knowledge base and focal support for local probation teams and a result of the staff churn this specialist and localised knowledge was lost.

Another significant change since the split in services was observed by several participants. While oral reports in court are intended to include an assessment for alcohol, they noted that there was no guarantee that alcohol is assessed nor that reports are always accurate. Staff spoke of a decline in ATRs in some areas where numbers were expected to be greater. Disclosure of alcohol issues was often constrained, with assessments made on the basis of information taken at face value. This was reported as being partly due to the high volume of reports passing through the courts and the tight time frames involved in processing the turnover since dividing up the service. Furthermore, it was suggested that the division in services may, at least temporarily, increase the likelihood of administrative errors, such as appointment paperwork going astray between the courts and probation services. One participant highlighted cases where clients had appointments for probation but no information had been provided about their alcohol misuse, mental health or other issues at their first meeting.

There was some concern that recent initiatives such as PbR might encourage a shift back to measuring performance in terms of outputs and losing the focus on quality outcomes which were much harder to

measure. Because IBA outputs are recorded numerically, this would be consonant with a shift back to performance measuring.

"...we might lose sight of the fact that we need to be delivering outcomes... because it's an AUDIT form, because it's a matrix if you like, it will be how many IBAs have been completed – well what happened to that person, where did they go, what was their outcome? Now I could do 100 IBAs a month if you wanted me to, but does that really address needs." (Manager).

A significant administrative impact of dividing the service, noted by most staff we spoke to, was a break in continuity in the case management system used to store and retrieve information on use of IBA. Staff reported that CRC are addressing shortfalls in this system and IT systems generally; however, the monitoring mechanism that had previously shown significant increases in IBA delivery has been lost.

"...what happened then is Delius the case management system we used went national so NOMS rolled it out to all Probation Trusts, the codes were changed and then we were no longer able to draw down or extract information... that was all through 2013 that those changes were in place. So up until late summer we had it recorded which showed a threefold increase and then the system went national and then we kind of you know we lost that." (Manager).

Training in alcohol issues and IBA

Managers and senior probation officers spoke of training needs being recognised across NPS and CRC generically and top down via strategic and substance misuse leads, as well as at local level e.g. through local authorities. Substance misuse leads can therefore

perform the role of alcohol champions in driving forward and sustaining the alcohol agenda.

"...we work closely with local agencies and we do get offered a lot of training (IBA) by the local authority and this particular training is coming through the local authority, they're funding it and I think just because I'm sort of involved in various boards and things like that, I've managed to kind of swing it for probation locally to get this." (Probation officer).

Officers with substance misuse leads, or specialising in the field, and who work regularly with offenders with alcohol misuse felt confident and competent in their roles. They understood how alcohol may be implicated in other issues concerning their client and commented that any training in alcohol misuse would need to reflect it as a cross-cutting issue. They highlighted the challenges and support needed for staff who were less confident and who might not have such a substance misuse specialism or were newer in post. In these cases, training alone was not enough to meet the needs of inexperienced staff who needed more opportunity to put their training into practice. Similarly for officers working in other specialist teams, such as domestic violence, mental health etc, opportunities to address alcohol misuse were more limited as issues of greater concern took precedence during supervision. There was thus little scope to improve practitioners' knowledge and skills to build up confidence and experience in dealing with alcohol misuse.

"...there's specialist teams, so we have like a domestic violence and mental health team, a young adult's team, community payback and then the substance misuse team, so we probably would associate with the substance misuse team really doing most of this type of work. And there's probably less, not

completely no opportunities, but less opportunities in maybe some of the other teams, because maybe they are dealing with other factors that might take over, you know the primary focus. So they may feel that they have less opportunity to practice it because maybe it's not always, if someone is presenting with an acute mental health issues then that would kind of take over really the context of your supervision appointments and maybe alcohol use might not necessarily be top of the agenda in some ways." (Probation officer).

In terms of future developments, training in general was envisaged as playing a significant role within the redesigned service as part of the drive to embed theory and evidence into practice.

"I think they're still trying to understand the business and what probation is, I mean they're looking to learn from us at the moment...I went to a recent road show and I think they were quite clear that training is going to be a massive part of you know the way they see probation in the future. So I would hope substance misuse will have a big part to play." (Probation officer).

There was some uncertainty among staff about how substance misuse and specific IBA delivery might be developed in future. One officer suggested that training in alcohol IBA is to be rolled out across the service with the possibility that it would be mandatory. The design of the training was being discussed during our fieldwork period and there was some consideration of tailoring training in line with a possible move to cohort working.

“I think going forward if the new requirements become available to all, then everyone is going to need to be trained up to some level, so they can be delivering the IBA on a regular basis. I think we should all start seeing more of those types of orders and alcohol use being more of a, well working with alcohol users more kind of accessible I guess for all the officers.” (Probation officer).

Conclusion

Over the last couple of years, probation has undergone significant changes in its structure, organisation and operation as part of the service has been outsourced to private companies (CRCs). As sections above have reported, prior to the split in the service, efforts had been made to roll out IBA delivery across the service through providing training, improving organisational commitment to addressing problems of alcohol use, identifying alcohol champions to raise the profile of alcohol issues and promote IBA. A recording system was put in place and, despite technical difficulties, an increase in IBA activity was recorded.

Following organisational changes a number of impacts on IBA delivery became evident. Study participants associated the impacts with increased pressures on the staff in terms of workload and adapting to new organisational processes and procedures that drew attention away from alcohol and IBA delivery. In particular the loss of IBA champions – who moved within or away from the services – was felt to have had a negative effect of sustaining alcohol and IBA on the agenda. With the change in service, the number of oral reports passing through courts was seen to have increased and staff believed that alcohol issues were not being identified at the pre sentence stage thus

losing opportunities to screen and offer support at this early stage. Concerns were voiced that recent initiatives such as PbR could encourage a shift to measuring performance in terms of outputs which are easy to measure; frequency of delivering IBA would be consonant with a shift in this direction but this might erode the effort to deliver harder to measure quality outcomes.

Some issues existed both before and after the organisational changes and appear to be linked to the type of work context and to the lack of professional experience and training in dealing with clients with alcohol problems: the perception of alcohol problems as dependency – which misses early problem drinking and results in the processes of identification, pathways for support and referral being clearer for dependent offenders than for those at increasing or higher risk; variable use of the AUDIT as a screening and monitoring tool – linked to the experience of staff in dealing with problems of substance misuse; and the need to find ways to engage clients and overcome their reluctance to discuss their drinking.

On the other hand, the use of AUDIT was valued as a tool for monitoring and reviewing client status, there was still considerable support for developing IBA and the possible redesign of service delivery to shift from generic client caseloads to cohort based caseloads was viewed as possibly bringing advantages since it may make IBA delivery easier if focussed on relevant groups.

Considerable effort had been made to train staff in IBA although it was recognised that training alone was not enough to secure delivery. It was felt that training was needed but that future training would have to be tailored to changes in the organisational structures and service provision. In addition, the case study highlighted that knowledge and

understanding are initiated but not gained by being taught during an IBA training course; comments from interviewees supported the importance of experience – knowledge and understanding is developed through discussion and reflection on experiences in practice - with the support of professionals like alcohol specialist workers or champions. It is necessary to create the spaces for this to happen by initiating and then sustaining a 'culture' of discussion and reflection about alcohol issues in their practice, and, in this way, 'embedding' it.

This case study supports the findings from the housing case study that there is potential to deliver IBA effectively in non-health contexts but that there are considerable difficulties to overcome from the point of view of both agency staff and clients. In particular, it illustrates the need for strong, visible organisational commitment and highlights the vulnerability of relatively new areas of practice in times of organisational change. Training is only one element in sustaining efforts to deliver IBA; it needs to be on-going, and training content and delivery methods need to be adapted to changing organisational contexts, staff requirements and staff experiences.

Social work and social care

Case study led by Trish Hafford-Letchfield

Introduction

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. Anderson et al., 2009; Dance et al, 2014). Whilst problematic substance use has been an ongoing concern within social work (Galvani, 2013), there has been a continuing struggle to provide social workers with the right level of knowledge and skills to work effectively with these issues (Loughran and Livingston, 2014). Studies have reported that social workers and social care practitioners tend to underestimate the frequency of problems, often fail to recognise signs of problematic use until it has a significant impact on health and social care functioning, and are hesitant in initiating any discussion with service users (e.g. Dance at al., 2014; Galvani et al., 2013).

There have been periodic calls to increase the education and training received by social workers (Amodeo and Fassler, 2000; Wiechelta and Okundaye, 2012; Loughran and Livingston, 2014); national drug and alcohol strategies (H.M. Government, 2010) have acknowledged that social work has a 'key role' in intervening in problematic alcohol use; and reforms to social work education in England, gave rise to the development of a specific curriculum guide being commissioned by The College of Social Work (Galvani, 2012) for social work education and training in this field. It appears, however, that social workers are still

ill prepared to deal with this complex area of practice. For example, social care workers interviewed by Galvani et al (2013) were unable to indicate appropriate assessment or intervention tools.

Given social workers proximity to alcohol related issues, Schmidt et al. (2015) suggest BI as a useful framework within which to coordinate their interventions. However, from their review of the literature, they conclude that the limited studies identified showed mixed results for the effectiveness of BI in social work settings. They state that BI in social service settings shows “promise, although the findings should be interpreted with some caution”, adding that, “the social service setting and the service user population varied widely, making it difficult to generalise the findings beyond very small sub-groups”, and that there are crucial gaps in the literature “with important settings and populations not yet considered” (Schmidt et al., 2015:1044). They highlighted the need for further studies on BI in social work statutory settings within the British context.

As part of the bigger study, this case study aimed to provide an overview of the views of a sample of social workers and social care workers on the feasibility of using IBA in their day-to-day work.

In the sections below, we present a brief overview of the methods used to gather and analyse the data. We then discuss the findings from the case study under four headings: 1) perceptions of the social work/social care role in responding to alcohol problems; 2) ethical concerns; 3) the possibilities and problems of delivering IBA; and 4) the role of training.

Methods

The study design incorporated mixed methods with an emphasis on gathering in-depth qualitative data directly from practitioners.

Training workshop

Given that social workers and social care practitioners may not be familiar with ABI, they were invited to participate in a three hour workshop delivered by a specialist trainer not previously known to the participants. It was also hoped that the offer of training would act as an incentive to participate in the study. The sample was purposive and convenient in that it drew from a wide range of known networks in a locality within the South East of England. A flyer with details about the study and the offer of the training workshop was sent to contacts who were invited to apply for a free place in exchange for their participation in the study. The two planned workshops were substantially oversubscribed indicating the thirst for training in this area.

The training provided in the workshops covered the following topics (a) the use of alcohol in society and basic concepts around 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 to people with alcohol related problems, including motivational interviewing and sharing educational resources. The workshop was interactive and drew on the participants' own knowledge and skills. Those attending were given a range of learning resources and leaflets to adapt in practice including an app and online resources.

Online survey

An online pre- and post-workshop, largely structured survey, (available from the author) was utilised to gather demographic data and key information such as, level of knowledge about, and attitudes towards, working with issues associated with alcohol, as well as the nature of the work they may be undertaking in this area (pre-training survey), and their comments on training and actions following training (post-training survey); 36 people attended across the two workshops and of those 35 completed the pre-workshop survey; 20 completed the post-workshop survey which was closed 3 weeks after the workshop.

Focus groups

Each workshop was followed immediately by focus groups lasting one hour. The participants attending the first workshop were divided into 3 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: 2 mixed adult/ children social worker focus groups. A broad topic guide was used for the focus group discussions (similar to the topic guide used in housing and probation), the discussions were recorded and the data transcribed.

Data analysis

The quantitative data from the survey were abstracted and collated and used to generate descriptive statistics; the qualitative data from the open comments were analysed alongside the focus group data through coding and synthesising codes into themes (Braun and Clarke, 2006) by two members of the research team.

Sample characteristics

Table 1 below illustrates the profile of the sample in relation to the participants' role, service settings, length of experience and qualifications (Data are 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 where identification is often more difficult. Finally 86% of our sample was working in the statutory sector, an area where the eligibility criteria has a very high threshold of need in order to access services. There were no participants from the private sector.

Table 1 Characteristics of sample attending the workshop (n=36)

Characteristic		N
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 practice	Children & families	5
	Learning difficulties	4
	Physical disabilities	3
	Mental health	8
	Problematic substance use	2
	Older people	14
Sector	Voluntary	5
	Statutory	31

Findings

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

Perceptions of the social work/ social care role

Most workshop participants reported encountering clients with alcohol-related problems and over half (20/36) said that this was frequent or regular with another 14 people saying 'occasionally'. They recognised, therefore, that alcohol issues were relevant to their work.

However, in the focus groups, participants on the whole reported working almost exclusively with people with established dependence. Service users using alcohol to cope with stress or to binge were not seen as having a problem. Participants were aware of the significance of problematic alcohol use in their day-to-day work, but felt that the problems they were dealing with were too entrenched for brief intervention to be a useful tool. This is not surprising considering that most pre-training survey respondents (N=25) had received no formal training on working with people with alcohol issues.

The challenges they experienced in responding to a client's alcohol use shared many similarities with those mentioned by other groups of professionals. On the practical side, social workers in the focus groups expressed concerns about having to manage demands on their time which meant that responding to alcohol issues was not prioritized; there was already limited time to undertake assessments, and too little time to offer adequate support with alcohol issues. Some felt that the pressure to responding to clients' alcohol consumption was an

additional burden on their heavy workload. As one person commented, “we’re under pressure to have a high turnover of clients”. (Adult social worker focus group).

Underlying their practical concerns there appeared to be more fundamental questions concerning role perception, role boundaries and who they considered to be responsible for working with alcohol related issues. As they worked mostly with clients with alcohol issues linked to dependency and heavy drinking, it was not surprising that participants believed that building a longer term relationship with a client with alcohol problems was key to supporting them. This support was usually offered through referral to services and participants often expressed a lack of necessary knowledge and understanding of alcohol problems to provide appropriate support themselves to clients with alcohol issues. 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,

“..... in a lot of OT (Occupational Therapy), the assessor function maybe doesn’t necessarily ..., you know we’ve got a limited period of time, whereas enablers will be able to build a longer term relationship, they’re seeing that person more often and they may be able to be in a better position to raise these things and to go through the frame”. (Mixed social worker focus group).

Apart from feeling inadequately prepared to deal with alcohol problems themselves, concerns over relationships with clients were often voiced in the focus groups. Raising alcohol issues inappropriately had the potential for jeopardizing relationships with clients by damaging the rapport and trust that had been built up. This could

become a more significant issue when supporting families from cultures where drinking might be 'hidden'. Some were also concerned that raising alcohol issues might create further anxieties for their client over and above issues already identified and for which support was being provided.

“sometimes you'll be talking to families from different cultures where alcohol is banned but you'll 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).

Given the general lack of formal training among the pre-training survey respondents, it was not surprising that a third of them (12 people) expressed a lack of confidence in working with people with alcohol issues, although 24 respondents reported feeling at least fairly confident.

The main challenges mentioned by respondents in the pre-workshop survey are shown in table 2. It is notable that getting clients to engage with services and finding resistance to treatment were reported by 11 people, possibly reflecting the complexity and extent of client's alcohol problems and the fact that participants were likely to be identifying people with more severe or dependent drinking. The difficulty of dealing with complex sets of problems was noted by participants. As one person commented:

“People who have co-morbid mental health problems and alcohol issues. It can be challenging if an individual is anxious or depressed and drinks to cope. It can be difficult to get through to the person and challenge their beliefs”. (Pre-training survey respondent).

Table 2: Main challenges in working with people with issues with alcohol

	Pre Training (N=36)	
	No	%
Engaging people with services/resistance to treatment	11	31
Capacity issues (including mental health and learning disability)	6	17
Risk of harm/challenging behaviour (to self and others)	5	14
Getting appropriate support	5	14
Understanding the addiction	4	11
How to approach people/skills	4	11
Health and social issues linked with problematic alcohol use	4	11
Assessment for support/services	3	8
Other	7	19

Ethical concerns

Raising alcohol issues created ethical and moral dilemmas for social workers. The request to conduct more formal identification and intervention in clients' alcohol consumption was potentially in conflict with their perceptions of their own role boundaries, their need for role clarity, and their emphasis on building and maintaining trust relationships with service users. There was widespread anxiety among focus group participants about encouraging service users to articulate risk around increasing alcohol use. Participants feared that this would require them to intervene more substantially, a responsibility which did not sit comfortably with a role of screening and giving brief advice. More substantial intervention was seen as an important role for the voluntary sector and for those involved in signposting to specialist services.

In addition, providing information and brief advice was also seen as much more of a responsibility than it might initially appear to be and participants expressed a number of reservations about this role. Concerns centered around the importance of building trust and rapport with clients - of being led by service users. Raising issues about alcohol use and then being unable to offer clients full support – rather than just giving advice - was seen as a conflict for social workers.

“By using this intervention it flags up that you (the client) are at risk of being a problematic drinker; you're a carer, meaning if you've got children, if there are other vulnerable people that you have contact with I (the social worker) have a responsibility because you've given me that information and I have a responsibility to follow up. So it's not just as simple as you do this thing, and I say 'oh, you need to go to (name of service)', or 'you need to go to such and such'; it won't be as simple as that”. (Adult social worker focus group).

There was much concern related to the issue of disclosure in terms of the statutory role that social workers perform in relation to risk assessment and, in particular, they referred to how this aligned with their safeguarding⁶ roles.

“I work with the carers of the service users and some of them have got you know, and (un) safe levels or drinking because of

⁶ '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). Further details on safeguarding children and adults and promoting children's welfare within the safeguarding role can be found at (<http://www.cqc.org.uk/content/safeguarding-people>

their caring role and they are not prepared to access services because then they fear safe-guarding, we'll raise a self-guarding on them." (Adult Social workers focus group).

"It's not ethical, it would be (un)professional 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. So it does have, it could possibly have implications as to how much, I mean I have to be honest, I have to tell that person as well, this is what I have to do. 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 be to such and such." (Adult social workers focus group).

Social workers in the focus groups were worried that they might raise unnecessary safeguarding concerns among people who use alcohol to alleviate stressful situations and binge drink, for example. Their client's drinking behavior may reflect occasional occurrences rather than creating significant alcohol related risks to others.

"...the fact of caring may be putting her at risk of going to binge at a weekend because that's the only time she can drink and then come back, 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." (Adult social workers focus group).

There was also some concern that identifying safeguarding issues would create extra work in referrals which would prevent them from meeting their targets.

"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." (Adult social workers focus group).

Data sharing protocols were acknowledged as promoting effective communication and working relationships between social workers, service users and agencies and could help improve outcomes. Social workers, however, were particularly concerned that sharing information had the potential for creating anxiety about how the information could be used among service users. Some social workers referred to older people as potentially viewing the social worker as representative of the 'State' and that community based or age specific services were better placed to provide alcohol advice in a more low key way. Others were more explicit about the State using social workers as a means of surveillance and control and that taking on the screening role embedded in IBA signified another step in agreeing to perform this surveillance role which ultimately conflicted with social workers' values.

"You know like 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 take a lot of social control over what we are making judgments about, instead of understanding the underlying reasons for why people drink too much, or why someone is overweight and things like that - I find that more of an effective tool in social work, ... 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." (Mixed social workers focus group).

Two participants were particularly apprehensive about the recording and sharing of information about service user's alcohol use aligning this with privatisation and a USA style model of care. They believed that social workers should not be involved in practices where personal information could potentially be used to the detriment of the client.

"I think 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 I think" (Mixed Social workers focus group).

Delivering IBA: possibilities, doubts and difficulties

Possibilities

Post training, respondents to the survey were asked to identify the advantages of using IBA in their work (See table 3). Nearly half of respondents saw IBA as useful in health promotion and prevention generally, indicating some success in raising awareness of early intervention approaches. Similarly, participants in the focus groups had made links between IBA and the new provision of the Care Act, noting how IBA could fit into their role in public health and prevention.

“..it's absolute health promotion and they are two different things, intervention, clinical intervention and health promotion. So this was a proper update of health promotion which is a very important part of my job that I should be able to deliver health promotion as well as clinical interventions.” (Adult Social workers focus group).

Table 3: Advantages of using IBA at work

Advantages	Number of mentions
Useful for health promotion and health prevention	9
Useful generally/for me/families/people with learning disabilities	4
AUDIT/FAST/FAMES/tools generally useful	4
Increased awareness among staff/staff can cascade intervention	2
Other	6
Not used yet	1

A number of specific groups were identified where use of IBA may be particularly relevant. These included young people, carers, older people and those in difficult financial circumstances.

- One focus group participant thought that IBA could be relevant for young people in care and in school environments and was very positive about using the tool with groups of young people in a preventative way.
- IBA was thought to be of value to carers who were seen as a potential target group given their vulnerability to problematic use arising from the caring role.
- Two groups of older people were identified as potentially benefitting from IBA. Older people being admitted to hospital who

may not have had their alcohol use recognized as being problematic; and those going back into the community who may not have been given enough attention to their drinking or home situation.

- As seen in the housing sector where money might be spent on alcohol rather than rent, social workers identified service users presenting with financial problems as a vulnerable group due to their money being spent on alcohol rather than food. IBA could be used opportunistically in such cases, particularly when there were obvious signs of drinking.

There was a suggestion that incorporating IBA into routine practice could help to reduce the stigma of current practice where discussions tend to be targeted at more entrenched drinkers.

"I think that it was advantageous as 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 training survey respondent).

Using an assessment tool which collected information about alcohol use was also seen as a way to influence the commissioning of support services.

"That was also good for our CCG's (Clinical Commissioning Groups) when they're commissioning services; because they want to be able to yield all the statistics for our service to say we have a problem here, it is impacting heavily on our service. That is how we get the commissioners to put in more resources to support alcoholic interventions you know. And GP surgeries, ...

the service, you get drop-in sessions, so for us it's you know commissioning yeah." (Adult Social workers focus group).

Those social workers in the focus groups who were active in practice education roles highlighted the value of IBA as a tool for learning and teaching. They stressed the importance of students learning about alcohol use as this was not sufficiently integrated into professional training but came up often in practice learning placements.

Doubts

Within an overall positive response to incorporating IBA into practice, there were many doubts and reservations about the practicalities, the pressures and the ethical barriers that had to be addressed.

Some could see IBA fitting into their routine assessments as it stood.

"I think for families where it's (alcohol) not picked up, it's, the Audit tool, is really good to try and get them to talk about it and think about the increased risk, which I think is really good. So they either are in with services and if they're not, we can work with them on that....If we've got families coming through who aren't being targeted because of alcohol as an issue, but just using it as part of the assessment, they won't feel targeted and they are more likely to engage..." (Children's social work focus group).

Others commented that they would not use IBA in its standard format but would adapt it depending on their perception of their client's needs. They thought that the tool did not sit easily within naturalistic conversations and sensitivity was needed as to when to broach the subject of drinking. Some, however, felt the tool could be woven into

building rapport with the client and welcomed the structured approach.

"I'm not sure whether I'd actually use the tool completely, but as a guideline to start off with, I think it would be really useful.....I think some of the frames would be really useful, but then other parts of it, I'm not sure, maybe I'd make up my own sort of frames.....I'm not sure like with the Audit tool whether all of the questions would be applicable to my clients as in maybe you know supporting them..." and later *"....using a few of them I think would help and then you would be engaging more in conversation rather than another question after another question".* (Children's social work focus group).

Participants were not always clear about how alcohol issues were covered in assessment and they were not consulted when changes were introduced to assessment tools. Social workers reported experiencing a lot of bureaucracy in assessment recording. IBA was often seen as an additional burden and regarded as an add-on or optional. The need to be brief was frequently stressed.

"..in our local Memory Service we have a case load of around 100 people, so I have an hour to deliver an intervention and a lot of the service users they've got, they use alcohol, so to be able to deliver that in a brief time is really important." (Adult social workers focus group).

Although some social workers, particularly those working in hospital settings, appreciated the public health value of the tool, their work usually involved supporting clients with established dependency; IBA

was, therefore, not seen as directly relevant to their alcohol related work.

"...I think for my day to day practice, I can't see me being able to use it that much, because the work in hospital is quite brief, short pieces of work and intervention is quite short. And also a lot of the clients I work with have probably got more of a serious alcohol dependency problem." (Adult Social workers focus group).

The post training survey revealed concerns about being able to understand and support high risk groups such as longer term, resistant drinkers and having a clearer referral pathway once issues had been identified. As one commented:

"I feel the awareness needs to spread far and wide among professionals working with people. 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 training survey respondent).

Difficulties

Factors identified as challenges or barriers to using IBA in their day to day work, echoed those found in the literature and in the housing and probation case studies. As noted above, time, particularly for preventative work; 'paperwork' and clients' lack of disclosure and failure to engage were seen as important barriers to delivering IBA. Issues of access in relation to clients' language and learning disabilities was identified as a challenge and two respondents suggested having better tools suited to people with special needs (e.g. the provision of easy to read information and materials).

Social workers in the focus groups and the post-training survey commented on needing to feel supported and feeling able to raise and discuss alcohol issues as a matter of course both within the organization as well as with their clients. This was not always available. As one said:

“an understanding by everyone – inside and outside social care – that we are all there to help people live a healthier lifestyle and that we will be raising issues of this sort with our customers, even if they have not considered it as a concern. As would be expected from a visit to the GP/practice nurse”. (Post-training survey respondent).

A brief discussion took place in one focus group about the stress of working in social work and social care and the challenges of discussing difficult issues in the workplace. This highlights the importance of having a supportive work environment where staff feel able to disclose and seek help.

“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 which way” (Adult social worker focus group).

However, managers in social work were not seen as being informed or able to access training due to other work demands. A lack of understanding and knowledge of alcohol issues and IBA among managerial staff could be problematic in not providing core organizational support.

Respondents to the post-training survey offered a number of practical suggestions for answering the challenges and for delivering IBA in social work.

Because of constraints on time, six people mentioned creating a shorter, simpler and more accessible tool. Several people felt that a drop-down option within the assessment recording format could be included in web-based assessments bearing in mind that many social workers were directly inputting information during assessments. This would provide a more flexible approach to how and when it was used. Participants largely welcomed the use of leaflets that they could leave with people and particularly the use of an app to which service users could be directed, and which would be suitable for those with smart phones, particularly young people.

The role of training

Overall, the training was well received and appeared to improve confidence levels (see table 3 above). Participants in the focus groups suggested that training would help them to have more informed conversations based on their knowledge of the measures and threshold levels of risk. In particular, training helped to change perceptions of safe and risky drinking.

"I think our perception, or my perception what was safe and what wasn't safe because it's so embedded in our culture to drink excessively and to just think that's cool, so as a health professional you kind of base it on what is acceptable, unless it becomes a problem and then it's too late, well not too late but you know, having (sic) intervention is needed." (Adult social workers focus group).

“I think we think, always think of alcohol as ‘Oh, are they an alcoholic? Ooh, there’s big issues here.’ I suppose this training was very much about the increased risk.” (Children’s social workers focus group).

Nine respondents to the post-workshop survey said they had delivered IBA after the training session – although we do not know exactly what was delivered; 11 respondents had not delivered IBA in the three weeks since attending the workshop. With such a short follow up period, it is not possible to know whether training will encourage IBA delivery although the results from other studies, including a larger survey carried out for this research, suggest that training sessions, however well delivered and received, are insufficient to prompt sustained change (Thom et al., 2016).

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 design and resources for the study did not permit a longer term follow up of the implementation or impact of those who said they were intending to use IBA in their practice settings. The findings of the study corroborate what we already know from the literature: training interventions can have an impact on those working in social work and social care in terms of generating more positive attitudes towards recognizing and responding to alcohol-related problems; however, they are also in line with research which has highlighted the problems social workers (along with other occupational groups) 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 which seemed to them to be in conflict with some of the core principles of their roles and to undermine the fundamental structures and working practices of social work.

Conclusion: time to re-consider?

The aim of the wider project was to investigate the role of training in facilitating delivery of alcohol IBA in non-health contexts. Findings from a follow-up survey of 462 professionals who had received IBA training, and findings from other research (Thom et al., 2016), clearly indicated that training alone is unable to secure the delivery of IBA; and research has highlighted the many challenges to implementing IBA into the routine practice of professionals working in non-health contexts (reviewed in Thom et al., 2014). The case studies of three occupational contexts - housing, probation and social work – aimed to explore the views and experiences of a sample of professionals who are, increasingly, the target of expectations, training, and possibly pressures, to adopt alcohol IBA as part of their everyday work practices. The issues raised draw attention to five related elements that impact on the successful translation of training into practice.

Professional roles and individual behaviours: Most attention has been directed towards the development and improvement of professional knowledge and skills – and the provision of training is part of this. But difficulties relating to feelings of role legitimacy, role adequacy and the relevance of IBA to the individual's core role tasks continue to emerge as major challenges to IBA delivery. We have seen, for example, that there are considerable tensions arising around ethical concerns for housing officers and social workers, in particular. It is likely that a complex combination of factors underly these feelings – for instance, professional 'socialisation' acquired from professional education, training and regulations, working experiences, institutional embedding, and relationships with clients. The question arises, whether, and to what extent, training addresses these feelings on top of imparting the necessary knowledge and skills needed for IBA delivery? Given that

many training programmes are very short, many include individuals with different professional backgrounds and from different organisations, this is an aspect of training which may be neglected and difficult to incorporate.

The specific work context: Even where training is delivered to one professional group, or within an organisation, there is still the issue of the relevance of IBA in the specific context of an encounter. The use of a formal identification tool, in particular, was not always seen to be relevant or useful and could be disruptive of relationships. Other, less formal forms of assessment, and less structured forms of brief advice were frequently mentioned as more acceptable to client and professional and more appropriate to the circumstances of the encounter. This raises questions regarding what kind of training is needed and to what extent more informal approaches to identification and the provision of advice should be part of training, whether or not under the umbrella of IBA training.

The organisation or agency within which the individual works is recognised as an important context for IBA delivery although it has received much less research attention, possibly because of difficulties in accessing organisations for research purposes. The support provided at senior and line management level, and the extent to which organisational structures and working practices are conducive to incorporating and sustaining IBA intervention, emerged clearly from the case studies as a key requirement if IBA training is to be followed by delivery. Organisations and agencies appear to be eager to take up training (especially if free); but the indications from this research are that few appear to give much thought to the role of training in developing organisational capacity and approaches to clients. Training needs to be related more directly to organisational attitudes,

behaviour and development needs as well as retaining its focus on professional attitudes and behaviour.

The system of care/ service network within which the particular organisation/ agency is located: Discussion of organisational factors needs to look beyond the individual agency or organisation and recognise that 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. For instance, as in the housing sector, some organisations consist of groups of smaller agencies, which may differ according to local cultures, client groups, or services provided. The probation case study illustrates how changes in the wider system of service provision may impact on organisational structures, the workforce and working practices. Social workers and social care workers are part of the wider system of social welfare provision and subject to regulations, changes and pressures beyond those imposed by their immediate employing agency. While these factors go beyond issues of training, they are, nevertheless, important considerations that have implications for the provision and impact of training and the potential for training to result in delivery of IBA.

The nature of IBA: Finally, consideration needs to be given to what is delivered. The accounts above (and the findings from other research) indicate 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. (See Stead et al., 2014; Fitzgerald et al., 2014; Thom et al., 2015). 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 professional groups 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 is an issue for further discussion.

As Heather (2016) notes, despite the lack of research evidence, there are good reasons for attempting to introduce alcohol IBA into the working practices of professionals in non-health contexts. However, he also argues against routine implementation and suggests, instead, the development and careful evaluation of models of ABI (alcohol brief interventions), including methods of training as well as screening and intervention itself. The case study findings above suggest that training needs to be adapted in a number of ways to take account of the experiences of everyday working life and the specific contexts within which delivery takes place. However, as mentioned earlier, much discussion, research and training has focused on the development of individual knowledge and skills and has neglected both organisational factors and wider systems and service networks, which also influence what workers can achieve.

The insights from this research argue for a systems approach rather than an individual behavioural approach to improving the delivery of alcohol IBA. In other words, to promote the delivery of alcohol IBA beyond health care settings requires a strategic, holistic approach which sees the individual and the organisation/ agency as parts of a network of services and systems of care (or control) which may differ from one occupational setting or service context to another, from one geographical area to another, and over time. Thus, we need to consider whether to develop and evaluate not only different models of training and of IBA content and delivery, but also models that take on the challenge of linking an individual, an organisational, and a systems approach to promoting alcohol IBA in non-health contexts.

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