

Alcohol brief intervention: where next for IBA?

Lessons, ideas and actions for advancing alcohol brief interventions

Executive summary

In April 2015 the Alcohol Academy organised a conference event to explore 'Evidence and issues facing Identification and Brief Advice delivery for 2015 and beyond'.

This briefing sets out some of the key messages from the conference, but also aims to identify possible ideas and answers to the key question of 'where next?'. As such it explores what the 'vision' should be for the future of IBA delivery; what are the key challenges to be addressed from research, policy and practice; and finally, what key actions or ideas will help push this important agenda forward?

Key messages

- Despite significant attention to the issue in recent years, the current national position of IBA delivery still requires significant investment to achieve 'success'
- Some basic level issues still remain, including understanding of what brief intervention actually involves, and the role or not of specialist services
- Issues still exist over Primary Care as the key setting, particularly in identifying both the quantity and quality of IBA reportedly taking place, and the impact of the recent removal of the 'DES' incentive
- Indications that 'minimal' or 'lite' approaches to IBA delivery may be becoming the norm need careful consideration given the limited evidence for these
- Other key questions include which further settings IBA should be undertaken in, and the precise role of innovative and digital 'IBA' approaches
- The current IBA agenda may be considered at a 'turning point' – if further efforts to embed IBA are not continued, longer term implementation may 'fail'
- Policy makers, commissioners, academics and potential deliverers of IBA all have crucial roles to play – and must do so in a coordinated way

6 'key ideas' to advance IBA implementation?

The briefing also suggests a number of possible 'key ideas' which could boost the IBA agenda and help address challenges and opportunities:

1. Create a 'national centre' for IBA delivery

The smoking intervention agenda has the National Centre for Smoking Cessation and Training (NCSCT) to support implementation and standards. A national centre for IBA should be established to deliver national monitoring, leadership, innovation, accreditation and engagement to support IBA implementation and standards.

2. No IBA without 'quality assurance'

Whilst relatively little is known about the actual number of alcohol brief interventions being delivered, even less is known about how many would meet a 'minimum standard' of delivery. If interventions being delivered are not in line with the evidence, what value do they have, if any? All commissioning and monitoring of IBA should ensure 'quality assurance' of IBA fidelity. This may be particularly important given indications of diluted or excessively 'minimal' approaches becoming the norm.

3. MECC Matters

'Making Every Contact Count' (MECC) encourages health care professionals to initiate short health behaviour conversations. Alcohol IBA clearly fits within a wider 'healthy conversations' agenda, and should benefit from well developed MECC programmes. However the MECC agenda may also pose risks – for instance are alcohol conversations viewed less favourably, and does the MECC approach encourage further over-simplification of alcohol brief intervention?

4. Focus on the front line

National policy and local commissioning to facilitate IBA are essential, but ultimately quality IBA comes down to the beliefs, motivations and skills of the practitioner. Further attention to the messages, resources and support that really win the 'hearts and minds' of front line roles is required.

5. Avoid the 'one in eight'

IBA is often misquoted as working for 'one in eight' drinkers, but this is misleading and likely to underestimate the benefit. More accurately quoted, the 'one in eight' Number Needed to Treat (NNT) would highlight that one in every eight drinkers receiving IBA would reduce to within lower risk levels, but others may also reduce their drinking. However the source of this NNT is a study that gave no reference to NNTs. Considering the mis-interpretations associated with this figure, more robust effects such as average weekly reductions should be cited instead.

6. Take IBA 'direct' to the public

Whilst efforts to ensure IBA delivery amongst health and social care roles should not be abandoned, further opportunities to reach at-risk populations directly should be utilised. Whilst online or app based interventions are proving popular, their effectiveness must not be assumed and must undergo further rigorous research evaluation. Other face to face opportunities exist outside of more traditional settings. For example, one recent project has found that offering 'IBA direct' in busy public places is highly feasible and may be effective in targeting groups less likely to visit healthcare settings.

IBA – a vision for the future?

What would 'success' for the IBA agenda look like? The long term goal may be to achieve a significant shift in public understanding where all at-risk drinkers had recently received - or at least been offered - quality alcohol brief intervention. As such, not only would there be a widespread understanding of 'risky' drinking, but the public would also expect IBA to be a regular invitation across a range of feasible settings. This routine offer would be made by a range of roles able and confident in brief intervention skills beyond simple feedback and advice.

“ less than 7% of risky drinkers recall being invited to discuss their alcohol use, compared to 50% of smokers ”

Whilst potentially achievable, this would require continued national momentum around the IBA agenda. Sustained investment to secure meaningful buy-in would be required, and it would take many years to embed. Despite a long history of IBA research, the current 'implementation' phase is arguably still in its infancy. Whilst some progress has been made, the translation of regular 'identification' to high quality brief intervention is clearly still some way off, even in key primary care settings.

To back this up, recent research from the UCL Alcohol Toolkit Study¹ has identified that less than 7% of risky drinkers recall being invited to discuss their alcohol use, compared to 50% of smokers. Separately, HSE surveys² report that the number of people recalling an alcohol conversation with a health professional in the last year has remained stable over the last decade.

Whilst ensuring the delivery of quality IBA by those on the ground is the ultimate ambition, there is of course further work for researchers, policy leads and commissioners to enable this. Future research needs to be practically focused, helping further answer key issues such as how valid different brief intervention approaches are, and in what settings. Policy leads need to ensure further buy-in from key professions and build recognition of alcohol within many cross-cutting agendas. Local commissioners need to ensure IBA projects are considering the quality of interventions - not just quantity being recorded.

“ Local commissioners need to ensure IBA projects are considering the quality of interventions - not just quantity being recorded ”

In some regards, this could be a crucial stage for the IBA agenda. If its momentum cannot be sustained, recent investment in the agenda could fade and leave a failed legacy for 'IBA'. Achieving the vision for high quality routine delivery may still be some way off, but over time, continued efforts across the field mean it is achievable. The need to do more in terms of prevention is increasingly recognised in debates on the future of the NHS, and associated agendas such as 'Making Every Contact Count' (MECC).

However the real world implementation challenges cannot be underestimated. This briefing warns that without sustained national and local leadership, efforts to embed IBA and the chances of achieving this vision could be in vain. As such, this report aims to offer the most practical 'next steps' and recommendations to take the IBA agenda forward and build on the work so far.

Messages from the conference: IBA research, implementation and next steps?

Below highlights a summary of some of the content from the presentations, workshops and discussions, with links to the full presentations where available.

Lessons so far and 'what works'?

One crucial issue that persists is the question over what constitutes an effective 'brief intervention', and whether current interpretations are in line with the available evidence.

Reviewing the history of Primary Care IBA, Dr Amy O'Donnell identified a number of gaps in the research that may be holding implementation back. For instance, there is some evidence suggesting brief multi-contact interventions may be most effective, and other studies have not found a significant difference between short, simple and longer, more complex interventions. However, despite a need for conclusive evidence on the optimal length and frequency of effective interventions, a general trend towards pursuing 'minimal' brief intervention approaches appears evident in local area projects.

Whilst minimal approaches may be driven by practical pressures to keep things short and simple, further work is also needed to really understand what aspects of brief intervention 'work'. Dr Jacques Gaume from the University of Lausanne presented on a review of the evidence of 'mechanisms of action', exploring what is known about each of the commonly cited 'FRAMES' components.

Firstly, 'Feedback' in particular appeared effective; perhaps expected given the process by which IBA aims to inform a drinker of risks they may not have been aware of. On 'Advice', whilst described in one study as the "essence" of IBA, the range of 'advice' within the research and indeed mixed findings mean firm conclusions on the true value of 'advice' per se are hard to draw.

On 'Motivational Interviewing' (MI) skills, interventions using MI had been found to predict greater reductions in alcohol-related problems. However since three of the FRAMES elements are considered MI based skills, to draw further specific conclusions requires more complex methods to disentangle the exact effect of each aspect. This line of research is in development and will add to this emerging literature in the near future.

Studies on 'decisional balance' approaches – for instance using scales to assess pros versus cons – tended to find a detrimental effect. Instead, evoking and reinforcing 'change talk', or commitment to change goals, indicated efficacy. Seemingly in line with this, findings consistently showed 'sustain talk' (i.e. stating reasons against change) were a predictor of poor outcomes.

'Self-efficacy', i.e. the drinkers' confidence in their ability to change, lacked specific evidence for IBA, despite being considered a crucial component of MI. Enhancing discrepancy through MI however (whereby the drinking behaviour is seen as at odds with broader life goals or values) was correlated to positive outcomes. For instance, where a drinker has sports or fitness ambitions, further attention to the detrimental effect of alcohol on these goals could enhance change.

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Regarding 'social norm' perceptions, evidence also suggests that those with more accurate assessment of drinking norms had better alcohol outcomes. As such, helping drinkers to understand that most people drink within lower risk levels could be considered a positive element of IBA.

In conclusion, the evidence for 'feedback' suggests this must be a fundamental part of any form of IBA. Positive associations with many other FRAMES aspects including MI styles, along with the wider research, suggest that many drinkers will benefit from further brief intervention elements beyond simple advice if offered correctly.

Gaume however highlighted that understanding of the 'active ingredients' of brief intervention is still relatively unknown, so was attempting to summarise findings from a still under-developed evidence base. Further work in this area will be important in influencing how IBA should be delivered.

- See here for Dr Amy O'Donnell's presentation: [The story so far: key lessons from IBA research in primary care \[pdf\]](#)
- See here for Dr Jacques Gaume's presentation: [What works in 'brief intervention' Mechanisms of action - Jacques Gaume \[pdf\]](#)

“ smokers are seven times more likely than risky drinkers to receive brief intervention ”

Implementation issues: quantity, quality and sustainability?

Whilst in England incentives ostensibly triggered Primary Care 'IBA' for new registrations and health check patients, whether this resulted in routine quality interventions is highly questionable. Now the former 'DES' payment for screening new registrations has been replaced by a requirement within the GP contract³, further questions will be asked as to the actual delivery of IBA on the ground. NHS England will reportedly monitor recorded activity⁴, but whether this will lead to any further meaningful understanding of Primary Care IBA activity and quality remains to be seen.

Patient experience also indicates the still limited level of IBA delivery in Primary Care, as Dr Emma Beard demonstrated through the UCL 'Alcohol Toolkit Study'⁵ presentation. Based on a survey of 15,253 adults, just 6.5% of risky drinkers recall being invited to discuss their alcohol use, compared to 50.4% of smokers. As such, smokers are seven times more likely than risky drinkers to receive brief intervention.

These estimates are similar to indications from previous research, and also demonstrated men with higher AUDIT scores were more likely to receive IBA.

What else could be done though to initiate more through Primary Care IBA? Scotland's 'ABI' approach includes a national target, monitoring and sharing of best practice, as presented by the Scottish Government's ABI Programme Manager Kirsty MacDonald. Whilst the national targets for the number of interventions delivered were exceeded in the priority settings of Primary Care, A&E and antenatal, common challenges were consistent with elsewhere in the UK and beyond. Key learning demonstrated the value of networks and importance of investing in a skilled workforce. Also crucial is the need for building suitable data systems and monitoring processes from the outset. Looking forward, ensuring the quality of the interventions and their sustainability are key issues.

Important lessons may also be taken from the ODHIN trials, a large European programme testing different implementation approaches in Primary Care. As identified in the ODHIN workshop, all of the tested strategies increased reported IBA activity:

“ Looking forward, ensuring the quality of the interventions and their sustainability are key issues ”

financial reimbursement (i.e. incentives), training & support, and referral to electronic IBA (eBI) resource. However incentives, especially when combined with training & support, were the most effective implementation strategies, leading to significant modelled cost savings. The implication is that a more robust approach to training and support and financial incentives are the most powerful strategies for furthering Primary Care IBA.

What about identifying the actual 'quality' of IBA? Few projects have sought to assess how IBA delivery takes place outside of research trials, and identify whether 'real world' delivery comes close enough to the known evidence base. Despite some interest in the potential for 'mystery shopping' approaches to explore the 'quality' question, no formal projects appear to have tested IBA in this way.

However one project has sought to fully understand clinical application of the IBA delivery by observing consultations in a number of primary care practices. The Health Innovation Network (HIN), the Academic Health Science Network for South London, invited multiple London boroughs to participate in a project which aimed to understand how best to support innovation. Through direct observation within the practices, IBA delivery was mapped so that gaps between observed delivery and evidence based implementation of IBA could be better understood. Results were fed back to both clinical staff and local authority alcohol leads in a collaborative but non-critical style. Recommendations on how best to support training, electronic systems and improving the use of data are being developed⁶.

- See Dr Emma Beard's presentation on [Implementation of primary care IBA - a comparison with smoking \[pdf\]](#)
- See Kirsty MacDonald's presentation: [Learning from the Scottish ABI programme \[pdf\]](#)
- See Colin Angus' slides [Overcoming low delivery of IBAs in primary care: Results from the ODHIN project \[pdf\]](#)
- See Julia Knight's presentation [Assessing IBA quality in primary care AM workshop - Julia Knight \[pdf\]](#)

Implementation issues: new settings and 'novel' approaches?

Perhaps the most open question in the brief intervention debate is within which wider settings should IBA implementation be sought. NICE PH24 advocates IBA in all health and social care settings, whilst many areas are seeking to implement IBA in wider contexts such as workplaces, public places, or gyms.

A review into IBA in non health settings was presented by Mariana Bayley and Rachel Herring, researchers from Middlesex University. The research highlighted that despite the very limited evidence, there are many attempts to implement IBA in a variety of non-health settings. Whilst broadly speaking, IBA skills may be transferable, many other factors raise questions for feasibility as well as effectiveness. For instance, what does a potential lack of organisational commitment mean for each setting, and how will the intended workforce perceive or prioritise IBA? Training alone, just as with health settings, should not be assumed to lead to delivery, and a wide range of levers and influences need to be considered on many levels.

“ Training alone, just as with health settings, should not be assumed to lead to delivery ”

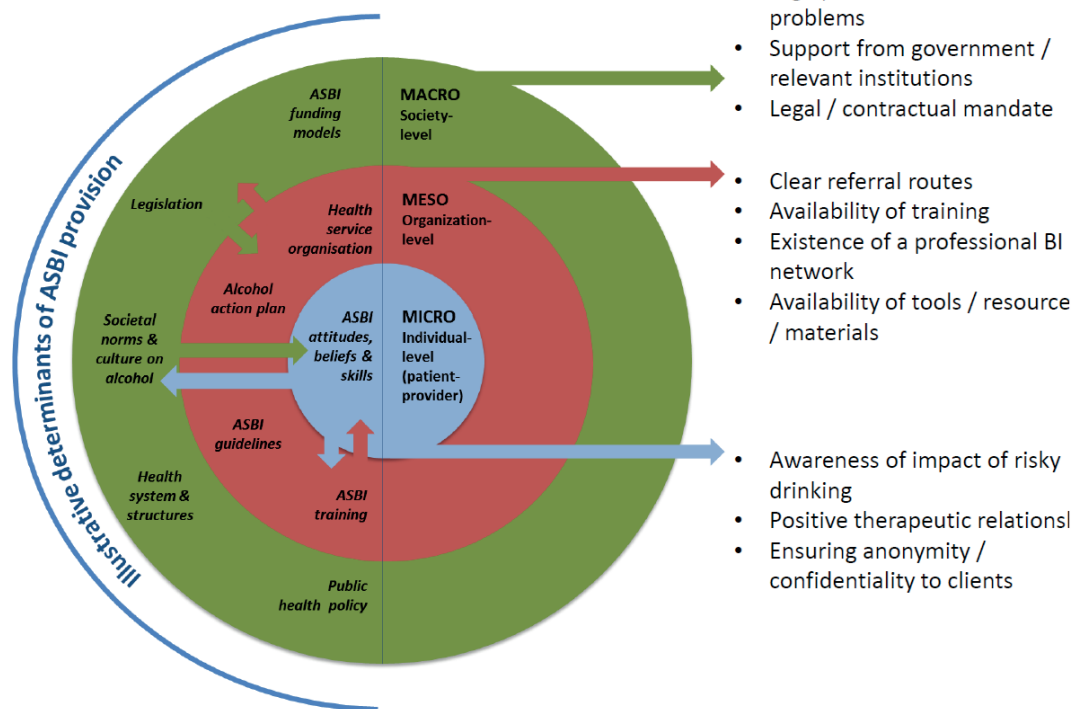
“ IBA should embrace the MECC agenda and its opportunities ... However important questions exist, such as how full alcohol brief intervention may be blurred or diluted ”

Many of these considerations were also demonstrated in a presentation of preliminary findings from the European 'BISTAIRS' research project⁷. Dr Amy O'Donnell highlighted the key lessons and issues facing IBA implementation in Emergency Department (ED), Workplace and Social Service settings. Whilst each of the settings had many setting specific variables and recommendations, thematic multi-level factors influencing the likelihood of successful implementation could be made across all.

Implementation questions also exist in the context of the wider 'Making Every Contact Count' (MECC) agenda, whereby professionals are encouraged to start conversations about a range of health behaviours. The role of alcohol IBA in the context of the MECC agenda was explored in a workshop led by behaviour change specialists Deryn Bishop and John Harkin.

Multiple cross-overs with other health behaviours of course mean that IBA should embrace the MECC agenda and its opportunities. Indeed key IBA delivery mechanisms may be considered MECC approaches, such as NHS Health Checks being offered to all adults aged 40 – 74 years of age. Additionally a culture shift whereby patients and professionals expect such conversations will benefit both agendas alike. However important questions exist, such as how full alcohol brief intervention may be blurred or diluted within the more simplistic MECC approaches. For instance smoking interventions typically follow the simple 'Ask, Advise, Act' method, whereby only a simple yes or no is required for 'identification', and standard smoking advice may be shorter than even 'minimal' IBA brief advice approaches.

Factors facilitating ASBI implementation



“online interventions should not be considered a replacement for face to face IBA, but may well prove useful as part of the intervention mix”

Significant attention is also rightly being given to the role of web or app based 'online' IBA approaches. A popular workshop on the subject led by researchers Zarnie Khadjesari and Christopher Sundstrom explored the evidence and potential future considerations. The advantages are seemingly obvious; using widely accessible technologies to reach users at their own convenience. Disadvantages too though are apparent; a 'digital divide' still presents access issues whilst the 'non verbal' approach may exclude some effective components of IBA.

Nonetheless, the evidence base for online interventions is growing in health and non-health care settings, with a future focus on novel methods of implementation in the general population. Certainly online interventions should not be considered a replacement for face to face IBA, but may well prove useful as part of the intervention mix.

Another approach to brief intervention delivery was that of 'IBA direct', whereby face to face brief interventions are delivered straight to the public in busy places. A workshop led by behaviour change agency Resonant looked at work in South London to test 'IBA direct', aiming to target young at-risk drinkers less likely to visit health care services. Although other areas may have already delivered forms of 'IBA direct', such as at community events or during Alcohol Awareness Weeks, the project aimed to test the effectiveness of different approaches and messages. An independent evaluation⁸ of the project has been undertaken to inform to what extent 'IBA direct' may contribute to the agenda.

Another question also explored was the potential for IBA type approaches for drug use, explored in a workshop led by Luke Mitcheson, a clinical psychologist. Unlike for alcohol and tobacco, for which the case for universal screening is clear, there is limited research in the area of brief interventions focused on drug use. NICE 51⁹ however advocates offering an approach based on Motivational Interviewing (MI) for those with little or no contact with services, with a goal of exploring use and potential for treatment engagement. Whilst some logical scenarios may be suitable for drug focused brief intervention, it should not be universal and the potential for negative impacts on alcohol or smoking IBA implementation must be considered.

- See Mariana Bayley and Rachel Herring's workshop presentation [IBA in non health settings \[pdf\]](#)
- See Zarnie Khadjesari & Christopher Sundström's workshop presentation [Online interventions - what do we know? \[pdf\]](#)
- See Amy O'Donnell's presentation [Implementing IBA beyond primary care Preliminary findings from the BISTAIRS research project \[pdf\]](#)
- See Deryn Bishop and John Harkin's presentation [Exploring MECC & physical activity programmes: opportunity or threat for IBA? \[pdf\]](#)
- See Luke Mitcheson's workshop presentation [Brief Interventions for other drugs AM workshop \[pdf\]](#)
- You can read more about '[IBA direct](#)' [here](#).

Next steps for the field?

Clearly IBA still remains a central component of alcohol strategy approaches across the UK. However a number of issues present very real challenges to achieving effective implementation in both the short and longer term. Some of these challenges reflect a fundamental conflict between a pragmatic desire to implement IBA as widely as possible, versus research limitations in our understanding of what effective IBA includes, and the extent to which it genuinely takes place in practice.

It is clear that some delegates felt a degree of frustration about the limitations raised by research gaps, whilst others felt the evidence is already sufficient and resources need to be focused on implementation. A number of people expressed a desire for further visible leadership and commitment from national bodies such as Public Health England and key organisations such as the Royal Colleges. Comparisons with the perceived successes of the smoking agenda are often cited, where a national overseeing body provides training accreditation and other coordinated activity.

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A real desire amongst those in the alcohol field to resolve the 'real world' challenges to the IBA agenda exists though. For instance, comments suggest the attitudes of many key front line staff are still considered a significant challenge that needs to be addressed. However careful consideration over the messages and strategies to be taken is needed. For example it may now be considered a cliché to bemoan GPs' general lack of willingness around the issue, but it must be noted that the majority of recorded IBA in General Practice will be delivered by Practice Nurses or Health Care Assistants.

Very legitimate questions exist over how realistic it is to expect non-health roles to routinely implement IBA, especially where there is no organisational commitment or support beyond one off training. Participants cited many practical responses such as including IBA responsibilities within supervision or team meetings as part of ensuring organisational culture shifts. Many other practical examples or innovative approaches appear to be taking place, yet capturing and sharing these requires further coordination.

6 'key ideas' to advance IBA

The following 'ideas' suggest possible ways to encourage new or innovative actions that might offer further improvements in delivery.

1. Create a 'national centre' for IBA delivery

The smoking agenda has the National Centre for Smoking Cessation and Training (NCSCCT) which aims to establish and monitor standards of delivery for smoking interventions. Given the identified challenges for implementation, a dedicated co-ordinating body to support improvements in this area could bring crucial significant leadership and support.

A 'national centre' for IBA – perhaps the NCIBA – could undertake a number of key roles in supporting the agenda such as:

- Championing the case for IBA to ensure all key bodies and organisations are properly supporting IBA delivery and monitoring
- Develop and co-ordinate national targets and monitoring to support routine quality IBA delivery

- Supporting the development of IBA training through accreditation of available IBA training (either face to face or online)
- Supporting research, innovation and best practice in the field

It should be noted that some of these responsibilities are already resourced to some degree – for example online IBA training and resources exist through the Alcohol Learning Centre. Other bodies, including the Public Health England alcohol team and a range of other organisations are also seeking to support local IBA implementation, but without a unified or clear national support framework.

As such, unifying and building on these resources could provide valuable economies of scale and added leadership required to address some of the many challenges facing quality implementation.

Success for a national IBA centre could be about achieving the longer term vision where there is evidence that quality IBA is routinely offered. As such, ensuring IBA forms a core part of health care provider business, with ongoing monitoring demonstrating activity and quality. Following in the path of Scotland and securing clear national targets could also be considered a core part of this success.

2. No IBA without 'quality assurance'

Whilst only limited data around the level of IBA activity across settings is available, almost none exists around the fidelity i.e. 'quality' of IBA taking place. If the standard of interventions being reported is not in line with those conducted in research trials, is there any value to them at all? As such, future IBA commissioning and monitoring must seek to ensure that 'quality assurance' is included as a central component.

The need for quality assurance is particularly strong in Primary Care, where anecdotal reports have identified a range of insufficient practices being undertaken under the guise of 'IBA'¹⁰. Reports include screening tools being handed out without any follow up, or attempts at 'brief advice' from practitioners with poor knowledge of units or understanding of brief intervention principles. This indicative lack of quality also appears to reflect the commonly reported difficulties in engaging Primary Care roles in IBA training or referral.

This issue may also be reflected by the popularity of approaches such as 'scratch-card IBA', which is also highly questionable in terms of the conversion rate to proper brief intervention. Whilst scratch-cards may be a useful engagement tool for 'identification', there is no evidence to suggest what proportion of the many thousands used have been followed up with the offer of sound brief advice. Similar issues are likely to present in all settings, particularly those where using motivational behaviour change skills are new terrain for staff.

How can proper 'quality assurance' of IBA be achieved? To understand IBA quality in the truest sense, observing delivery by practitioners in their real environment may only be achieved through 'mystery shopping' approaches. Whilst informal 'mystery shopping' anecdotes may be popular within discussions about IBA implementation, there are few if any examples of a formal IBA 'mystery shopping' approach being undertaken. The goal though should not be to catch out or name and shame insufficient practice, rather than to better understand the true picture and build a dialogue for delivering and supporting any improvement needed.

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“ assessing the real world fidelity of interventions will be crucial to the longer term success – or otherwise – of the IBA agenda ”

Other ways to try and assure quality of delivery are more achievable, although subject to other biases. Good practice models may include 'case study' reporting, as enacted by one local hospital trust as part of a IBA'CQUIN' contract¹¹. Other approaches have also demonstrated the value of assessing 'quality', such as the South London HIN project¹². Opportunities for other innovative or new approaches to ensuring IBA standards must also be actively developed and shared, as called for by a recent review of implementation efforts in Primary Care¹³.

Success for ensuring 'no IBA without quality assurance' would therefore mean that any IBA activity being commissioned or undertaken ensures that some process is in place to review or assess the quality of delivery. This may vary from setting to setting, and in many cases will rely on self-selected or self-reported information, but further projects assessing the real world fidelity of interventions will be crucial to the longer term success – or otherwise – of the IBA agenda.

3. MECC matters

The IBA agenda may have much to benefit from the 'Making Every Contact Count' (MECC) agenda. A shift whereby health professionals and the public expect routine conversations about health behaviours clearly fits the wider IBA vision. Individual's alcohol use and motivations are also often closely entwined with other health behaviours – capitalising and supporting the MECC agenda therefore clearly makes sense.



“ MECC also appears to present possible threats as well as opportunities ”

However MECC also appears to present possible threats as well as opportunities, particularly when considering the key implementation issues of quality alcohol IBA. The simpler approaches of 'very brief' interventions may further add to the popularity of minimal or 'lite' IBA approaches, despite lacking in evidence for alcohol misuse. It is also not known whether common reluctance¹⁴ to talk about alcohol could leave the alcohol part of MECC conversations being overlooked in favour of other domains.

A number of bodies including the Faculty of Public Health have also been highlighting the potential for the wider public health workforce in delivering 'healthy conversations', offering further potential support for IBA implementation. As such, those seeking IBA implementation must seek to engage those involved in the MECC agenda to ensure that the value and importance of alcohol brief intervention is not overlooked.

4. Engage the 'frontline'

Whilst national level vision and leadership is crucial, good IBA delivery ultimately relies on front line roles to believe in the value of it. Although common practitioner barriers such as time, attitudes and skills are largely recognised, the views and experiences of practitioners are rarely heard in discussions about IBA implementation.

Further attention should be given to identify the right messages, resources and levers to win over the 'hearts and minds' of front line roles with the opportunity to offer IBA. For instance, rather than frequently cited 'numbers needed to treat' (NNT) figures, real life case studies of successful IBA are more likely to persuade busy front

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line roles of its value. Videos such as the smoking brief advice agenda's '30 seconds to save a life' have reportedly been powerful advocacy tools for practitioners – no equivalents exist for alcohol IBA.

This goal may be particularly important for settings such as Primary Care, where a contractual requirement is in place but poor implementation still seems the norm. Although this frustration may often be expressed as 'GPs not doing IBA', in reality it is Practice Nurses, Health Care Assistants and indeed Pharmacy Staff that are most likely to deliver IBA within Primary Care settings.

As such, whilst IBA training may be effective in persuading front line roles of its value, a wider range of practitioner-tailored messages and strategies should be developed to remind, encourage and support the diverse range of front line roles being asked to deliver IBA. Important lessons may be taken from the Welsh 'Have a word' approach in engaging a wide range of roles in brief intervention.

"When I first became involved in brief interventions I was completely cynical. I didn't see how a chat could lower a person's alcohol consumption. Then I saw it with my own eyes, the person reflects on their behaviour. In order to deliver nurses need to believe it works, that's why I reinforce this idea with my staff"

Practitioner perspective highlighted in 'Tackling Alcohol Misuse Through Screening and Brief Interventions: A Knowledge Transfer Partnership'¹⁵

"One guy had a health check and his cholesterol was up, he was drinking most days, now he has cut out drinking through the week. I told him his attitude was great. He had never thought about it until he came to the GP, he is sleeping better, he feels better. He thanked me and it made me feel good."

Practitioner experience highlighted in a Primary Care IBA review of Cruddas Park Practice¹⁶

“ a 'Number Needed to Treat' (NNT) of around one in eight ... underestimates the benefit since some drinkers may reduce their drinking following IBA, albeit not to within lower risk levels ”

5. Avoid the '1 in 8 NNT'

IBA is often quoted as 'working for one in eight' drinkers which is misleading. There is some evidence to suggest the effectiveness of IBA may have a 'Number Needed to Treat' (NNT) of around one in eight for reducing risky drinking to *within lower risk levels*. However this underestimates the benefit since some drinkers may reduce their drinking following IBA, albeit not to within lower risk levels.

The evidence behind the 'one in eight' cited NNT however is tenuous at best¹⁷. The Moyer 2002 study does not include any reference to NNTs, rather to an average level of reduction in drinking.

It is also unknown what effect NNTs have on the motivation of practitioners who are being encouraged to implement IBA. Whilst a one in eight NNT may be regarded as positive by academics or policy roles, it may be that some front line roles will feel de-motivated by the prospect of most brief interventions not resulting in reduced drinking to lower risk levels. As such, more robust effect size quotes should be favoured, such as average weekly reductions. The Whitlock et al 2004 review indicates an average reduction in weekly drinking by between 13% and 34%, and may also be complimented by reductions in individual health consequences:

On average, following intervention, individuals reduced their drinking by 15%. While this may not be enough to bring the individual's drinking down to lower risk levels, it will reduce their alcohol-related hospital admissions by 20% and "absolute risk of lifetime alcohol-related death by some 20%" as well as have a significant impact on alcohol-related morbidity

The Evidence of Effectiveness & Minimum Standards for the Provision of Alcohol Identification and Brief Advice in Community Health Settings¹⁸

6. Take IBA 'direct' to the public

Whilst the evidence around IBA mainly involves healthcare professionals as delivery agents, some projects have been exploring more direct options. Whilst web or app based interventions may be considered 'direct' to population, a London project has been using specially employed roles to engage and deliver IBA direct to key target groups in public places.

In some regards, face to face IBA direct to the population has already been taking place via locally led activity such as Alcohol Awareness Weeks. However little is known about the feasibility or best approaches to engage the public in open spaces. Cutting out the healthcare professional as 'middleman' and undertaking 'IBA direct' approaches potentially removes many of the key barriers to delivery. Lambeth's 'IBA direct' pilot has been evaluated by the South London Health Innovation Network and found to be highly feasible and well-received by 'IBA direct' recipients. The project was branded as the 'London Challenge' following consultation and co-design stages with the identified target group. Offering 'mocktails' was found to be highly effective in engaging passersby¹⁹.

As such, 'direct' to population approaches may offer significant opportunities to improve the reach of IBA, especially to at-risk drinkers less likely to visit more common settings for delivery. An additional advantage may be that 'quality assurance' can be more readily built in and assessed. What remains to be further determined is how scalable and indeed cost-effective such approaches may be.

With thanks to...

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To get in touch with the Alcohol Academy please contact [James Morris](#) on **0208 296 0134** or James@alcoholacademy.net.

- ¹ Brown J et al 'Comparison of brief interventions in primary care on smoking and excessive alcohol consumption in England: a population survey' *British Journal of General Practice* 28/04/2015
- ² Statistics on Alcohol, England, 2015 [NS] Publication date: June 25, 2015
- ³ See the 2014/15 GMS Contract Guidance and audit requirements which removes the DES but states it is a 'contractual requirement for all practices to identify newly registered patients drinking alcohol at increased or higher risk levels'
- ⁴ The General Practice Extraction Service (GPES)- see <http://www.hscic.gov.uk/gpes>
- ⁵ Brown J et al 'Comparison of brief interventions in primary care on smoking and excessive alcohol consumption in England: a population survey' *British Journal of General Practice* 28/04/2015
- ⁶ Recommendations will be included within a forthcoming IBA commissioning toolkit to be released by the HIN
- ⁷ BISTAIRS is the 'Brief interventions in the treatment of alcohol use disorders in relevant settings', funded from the European Commission Public Health Programme (2008–2013)
- ⁸ The IBA direct evaluation has been carried out by the South London Health Innovation Network and will be made available shortly
- ⁹ 'Drug misuse – psychosocial interventions' NICE guidelines [CG51] Published date: July 2007
- ¹⁰ The Alcohol IBA blog '<http://alcoholiba.com/2012/09/12/mystery-shopping-experiences-the-good-the-bad-and-the/> Accessed 05.15.15
- ¹¹ St Thomas's hospital in London included regular case study reporting as part of its IBA CQUIN for 2014/15
- ¹² See summary of the Health Innovation Network (HIN) project under 'Implementation issues: quality, success and sustainability'
- ¹³ Implementation strategies to enhance management of heavy alcohol consumption in primary health care: a meta-analysis Keurhorst M et al, 18 SEP 2015, *Addiction* doi:10.1111/add.13088
- ¹⁴ Health professional surveys often identify alcohol as a less favourable or harder subject to address, e.g. the RSPH, 'Healthy Conversations and the Allied Health Professionals' 2015
- ¹⁵ Cardiff University and the Welsh Government (WG) in collaboration with Public Health Wales, Paul Jordan & Jonathan Shepherd, 2013
- ¹⁶ 'Identification and Brief Advice (IBA) Alcohol Evaluation Cruddas Park Practice' Caron Walker, Locum Public Health Consultant, Newcastle City Council, March 2014
- ¹⁷ Typically cited as 'Moyer et al 2002', referring to 'Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations' Anne Moyer, John W. Finney, Carolyn E. Swearingen & Pamela Vergun
- ¹⁸ Released by the London Alcohol Misuse Prevention group (LAMP) 2015
- ¹⁹ For more on 'The London Challenge' IBA direct project see www.resonant.agency/ibadirect/