

North London Alcohol Hub
IBA workplace research

A feasibility study into delivering IBA within workplace settings

Final evaluation summary

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Methods

- ▶ Reporting on 26 IBA training sessions delivered to various workplace roles – August 2010 to June 2011
- ▶ Quantitative and qualitative methods
 - Pre survey – 202 respondents
 - Post survey – 96 respondents
 - FULL training – 76 respondents
 - LITE training – 20 respondents
 - Follow up in-depth interviews – 8 participants
 - FULL training – 7 participants
 - LITE sessions – 1 participant

Full IBA training

- ▶ Provides skills for
 - identifying alcohol misusers
 - responding with brief advice/referral for dependent drinkers
- ▶ Covers theory, evidence base, practical application of IBA
- ▶ Participants carry out optional self-screening / 'identification', semi-role plays, discussions etc

FULL training covers alcohol awareness AND provides skills to deliver IBA to others

A LITE (simple brief advice) session

- ▶ Provides simple skills to help understand alcohol awareness / misuse issues
- ▶ Introduces key concepts for responding to alcohol misuse in workplace
- ▶ Participants introduced to screening tool and simple options for at-risk Vs dependent drinkers

LITE focuses on alcohol awareness, sharing information /resources informally -rather than delivery of IBA

Findings

Positive feedback on training:

- ▶ Useful; information/methods presented professionally, knowledgeably and made accessible
- ▶ Provides practical skills (Full training)
- ▶ Training provides workplace roles with greater awareness, understanding and knowledge of alcohol effects
- ▶ Knowledge and understanding of support /treatment services rises dramatically after training
- ▶ Develops understanding and confidence in giving advice and delivering effective interventions

“We found it a very interactive session, a very educational session, and we felt again it really helped us in moving forward with education to the general employee about drinking, but also when we deal with people who are problem drinkers in the workplace as well, so for us, it definitely achieved what it set out to do”

(Occupational health role)

Effect of training on perceptions

Perceptions BEFORE

35% have a good understanding of treatment services / support

47% say there are appropriate referral procedures / resources available

20% have a good understanding of delivering alcohol interventions effectively

Perceptions AFTER

Increases to 82% for FULL, 70% for LITE

Increases to 84% for FULL and 85% for LITE

Increases to 70% for FULL, 60% for LITE



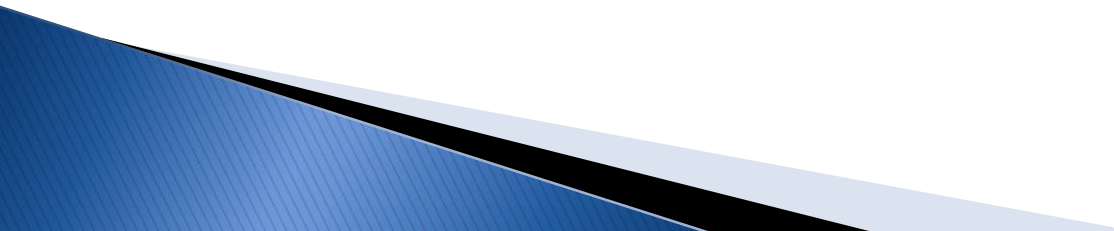
Handing out materials

- ▶ Materials are more likely to be handed out by those receiving FULL compared with LITE training
 - About half of those going through FULL training hand out materials compared with under a third receiving LITE training
 - The NHS booklet 'Your drinking and you' and alcohol unit information are most likely materials to be given out

Giving advice

- ▶ One in three people surveyed after training have given alcohol advice irrespective of type of training they received
- ▶ After FULL training about one in three of those who have given advice used the screening tool (AUDIT) to identify risky drinking
- ▶ A greater range of alcohol related information and advice is more likely to be given after FULL training compared with LITE training
 - General discussions about alcohol and referrals to Occupational Health more likely
 - More likely to give advice more frequently

Barriers to giving advice

- ▶ Screening is novel for many workplace roles
 - ▶ Problems in recognising IBA as early intervention – more diagnostic tool
 - ▶ Anxiety around disciplinary outcomes and misdiagnosis
 - ▶ Apprehension about introducing screening tool – managers lack confidence and opportunities
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‘Looking for fires’



“To me the screening tool is designed to achieve, to give you more information, and the person you’re talking to once something has been identified. I’m not going to go looking for fires that may not be there. I’m not going to say to everybody ‘Let’s look at the screening tool’”

(Health lead – manager)

“What you are doing is treading onto something that is actually not really, could be your concern...because you have to make it work-related....there is always a fine line because you are being told to mind your own business, or has it affected my work? – No, so what’s your problem? So those are awkward conversations”

- (Health lead – manager)



IBA implementation

- ▶ Follow up interviewees would like to deliver/integrate IBA into existing roles – occupational health / some counselling and support roles

“I give people the right tools and the right information and then they have a choice about what to do....alcohol training fits nicely in there”
(Occupational health role)

“I think the training is perfectly pitched to that kind of role (counselling), that is certainly how it felt to me..... (and later on) “It’s likely that if alcohol is a problem it will arise or come up in conversation but I still think we would be the most appropriate one (path)”
(Counsellor)

- ▶ Alcohol can be addressed in return-to-work interviews, health and lifestyle assessments e.g for new employees
- ▶ Alcohol awareness raising needed to address cultural norms around drinking

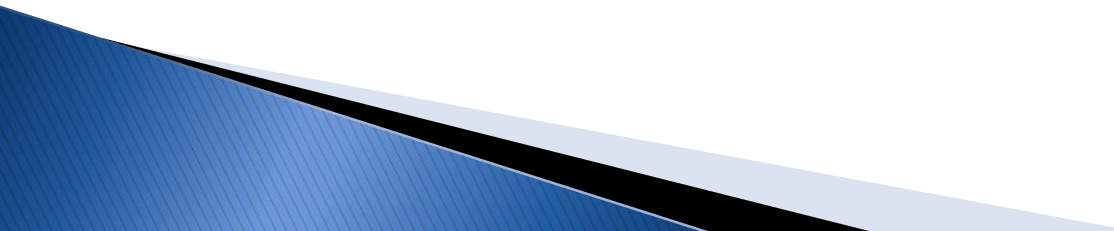
- ▶ Organisations may lack clear procedures for dealing with problems; managers need policies, guidelines and organisational support

“Some more direction I think from our Human Resources about what you do if this happens or if you suspect that someone has been drinking, you need to do this or this, would have, I suppose, I would have found helpful.”

(Health lead – manager)



Conclusions

- ▶ Occupational health is well placed to deliver IBA
 - ▶ Integrating screening tool into 'return to work' interviews; health screening for prospective employees suggested
 - ▶ High level organisational buy-in needed. IBA may need to be part of alcohol workplace policy in context of broader health and well-being agenda
 - ▶ Addressing / shifting organisational norms
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Some comments

- ▶ *“ The workplace is an ideal forum for education, particularly for the men, the men will not go to GPs. Men are very open to coming to us either attending our open sessions or they’ll come to us for a one-to-one about personal issues that they don’t want to talk to other people about”*
- ▶ *“It’s improved our knowledge base already for myself and the team. It gives us another OH assessment tool to use...sometimes in OH it can be quite hard to get factual evidence to build your approach on and tools help. They also add that little bit of weight and consistency so that we are all singing from the same hymn sheet and assessing for the same criteria”*

(Occupational health role)

Literature review – key points

- ▶ Relatively little literature found for IBA in workplace – especially UK studies
- ▶ Workplace context
 - Evidence for negative impacts of alcohol in the workplace – absenteeism, presenteeism (coming to work unwell), accidents
 - Workplace is ideal setting for alcohol prevention and interventions
 - Few workplace alcohol policies evident
 - Little management training on alcohol/drug issues on offer

Literature review

- ▶ IBA in the workplace:
 - Improved health and social outcomes, reduced costs
 - Significant savings to employer (UK and US studies)
 - High acceptability of IBA among employees

Ways of increasing IBA take-up include:

- Educating employers about cost benefits
- Training and expanding occupational health roles and other management/practitioner roles

Literature review

- ▶ Barriers to implementing IBA include:
 - Employer concerns about responsibility
 - Concerns about employee confidentiality
 - Accommodating IBA within existing work load
 - Lack of management/workforce commitment

Shift in attitudes needed in workplace – employers / employees need to realise importance / benefits of improved health and wellbeing (Black, 2008)