North London Alcohol Hub Identification and Brief Advice (IBA) workplace pilot research

A feasibility study into delivering IBA within workplace settings

Final evaluation report

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Contents Page

1. Introduction 3
The North London Alcohol Hub IBA workplace project 3
Aims 4
Methods 4

2. Literature Review 7
Introduction 7
Recognising the need to address alcohol in the workplace and recommended actions 9
Hangovers and performance 10
Alcohol problems, predictors and norms in the workplace 10
The responsibility of the employer to promote health and wellbeing 11
Studies that show what works and gaps in the research 11
Uptake of IBA by employers 13
Student/college drinking and interventions 14
Economics and cost benefits 14
Summary 15

3. Research findings 18
Introduction 18
Awareness of current workplace alcohol policies 19
Overall impressions of IBA (Full) training / Lite sessions 20
Expectations and concerns before and after training 23
Materials / information handed out 25
Giving alcohol advice 27
Exploring the barriers to implementing IBA 28
Integrating IBA within the workplace 31

4. Conclusions and recommendations 33

5. References 35

Appendix: Ratings on PRE and POST IBA training perceptions 38

1. Introduction

The effects of alcohol use on the workforce are increasingly found to be detrimental to workplace activity and productivity (FASE, 2010). Despite this, the effects of risky or harmful drinking above government guidelines remain largely unrecognised although they contribute significantly to absenteeism and poorer performance at work. Currently, most workplace policies relating to alcohol use tend to focus on high risk or dependent drinkers and are linked to disciplinary action, and some also provide support in the form of treatment and/or counselling.

Brief Interventions (IBA) is a validated strategy providing early intervention before or shortly after the onset of alcohol related problems, its aim being to reduce drinking at risky levels (Babor *et al*, 2007); it is not designed to address alcohol dependence. Significant reductions in drinking have been found across a diversity of health care settings where IBA has been applied, such as primary care, pharmacies etc and evidence is beginning to accrue that it offers potential for reducing alcohol-related harms in the workplace. The practicalities of delivering IBA and the effectiveness of IBA training in the workplace have yet to be explored, as far as we are aware.

The North London Alcohol Hub IBA workplace project

The North London Alcohol Hub IBA workplace project was designed to deliver IBA training in the workplace to a range of roles across a variety of settings. The training was initially delivered to staff employed by the statutory partners within the North London Alcohol Hub boroughs, but was also extended to other private and voluntary sector organisations. In the main, organisations included health and local authorities, but sessions were also extended to environmental services, commercial organisations and other local authorities. The project was not developed to test the effectiveness of IBA per se, which has already been extensively assessed, but it aimed to explore the practical aspects of delivering IBA in the workplace and the factors which would enhance or hinder effective implementation.

In the main, those in managerial or supervisory roles received Full IBA training involving a half-day session. However, for those employees with limited time or without staff to manage , 'Simple Brief Advice' sessions lasting about 2 hours, referred to as 'Lite' sessions in this report, were offered as an alternative. A summary of each follows in Box 1 and further details of IBA variations can be found in the Alcohol Academy briefing paper, 'Clarifying brief interventions' at: http://www.alcoholacademy.net/news/19/65/Clarifying-brief-interventions-Academy-briefing-paper.html

Box 1: Summary of Full IBA and Lite sessions

Full IBA training provides the skills for identifying alcohol misusers and responding with brief advice or referral for dependent drinkers.. It covers the theory, evidence base and practical application of IBA- including key delivery skills in line with Motivational Interviewing principles. In the training sessions participants carry out optional self –screening or 'identification', semi-role plays and discussions among other activities.

Box 1 continued
A LITE (Simple brief advice) session aims to equip attendees with simple skills to help them understand alcohol awareness and misuse issues. It introduces key concepts for responding to alcohol misuse in the workplace. Participants are not trained to carry out IBA, but are introduced to the screening tool and simple options for at-risk Vs dependent drinkers.

An essential difference between the two types of session is that Full training covers alcohol awareness *and* equips them with skills to deliver IBA to others. In the Lite sessions the focus is on alcohol awareness, and informally sharing information and resources as opposed to delivering IBA.

Aims

Middlesex University was commissioned to carry out an evaluation of the IBA workplace project via The Drug and Alcohol Research Centre (DARC). The research was designed as a pilot study to evaluate the feasibility and effectiveness of IBA in a range of workplace settings and among roles encountering employees drinking at increasing / higher risk levels. Findings from the evaluation would be used to support policy makers and local commissioners or alcohol leads by exploring the practical implications and possible outcomes of developing IBA in the workplace.

The specific objectives focussed on:

- assessing the acceptability and effectiveness of the IBA training delivered through the NLAH IBA workplace project;
- establishing which roles are most suited to delivering IBA;
- examining response to the AUDIT screening tool, materials, giving advice and possible barriers;
- exploring previous experiences of dealing with alcohol issues in the workplace and the impact on different roles;
- investigating the extent to which workplace alcohol policies are important and could be developed to facilitate successful implementation and sustainability of IBA.

Methods

Literature review

Whilst a considerable body of evidence demonstrating the effectiveness of IBA in healthcare settings is currently available, relatively few studies can be found examining the effects of IBA in the workplace, although the number is growing. It was therefore decided to carry out a brief narrative review of the literature available, focussing on relevant international and UK studies.

We searched for relevant articles and reviews up to and including April, 2011, using 'Summon™ ', a search facility providing access across a wide range of electronic health and science related databases. The search terms used were: alcohol & workplace/employers; alcohol & workplace/employers & SBI; identification, brief advice & workplace/employers; identification, brief advice & workplace/employers.

Data collection

This report draws on the responses of employees attending 25 IBA Alcohol Academy training sessions delivered to various workplace roles across a variety of settings. Training took place between August 2010 and June 2011. We used a combination of quantitative and qualitative research methods to collect data. Pre and post training surveys were used to gather quantitative measures while in-depth follow-up interviews provided qualitative accounts of attendees' experiences, attitudes and issues arising from the training.

Pre and post training surveys

Prior to training participants were invited to respond to an online survey to provide baseline information about their attitudes, beliefs and experiences. A total of 204 respondents completed the pre training online questionnaire. To facilitate data collection for the pilot we decided to include only those participants with email accounts and access to the online survey; we recognise the limitation this presents for the evaluation in excluding employment sectors without this resource.

Participants were asked to complete a post training survey approximately one to three months after training, with a reminder sent to them a week later. Response rates to the post training survey are encouraging with about half of those completing the pre survey (101) filling it in. 78 of the 101 responses are from those receiving Full training while 23 are from employees attending Lite sessions. Such a response rate is above that usually obtained without telephone follow-up in the researchers' experience.

Follow-up in-depth interviews

In the post survey 26 individuals provided contact details for further discussions about their experiences and respondents' details were also obtained from other sources e.g. researcher

attending training session, trainer contacts. All potential contacts were followed up by email and a total of eight agreed to be interviewed in greater depth. The following range of roles was captured in the follow-up interviews: health leads, managers in public services, occupational health roles and counselling/mediating roles. Seven of the eight interviewees had attended Full IBA training and one had taken part in a Lite session. Semi-structured interviews lasting approximately half an hour were carried out with these respondents by telephone and all interviews were recorded and transcribed verbatim.

2. Literature review

Introduction

This review examines alcohol use in the workplace, with a particular focus on the need for and effectiveness of Identification and Brief Advice (IBA) in tackling hazardous drinking. Some employers now have alcohol or substance misuse policies (e.g. Barnet NHS Alcohol and substance misuse policy, 2009) which encourage managers to address alcohol misuse at an early stage, provide help, support and advice and support the rehabilitation of employees who are identified as having a problem. Most policies do not necessarily promote particular evidence based, effective approaches such as IBA. Baggot and Powell (1994) carried out a comparative study of workplace alcohol policies in Leeds and Leicestershire and some of the key findings of the study suggested that most policies were of the disciplinary type, were highly inconsistently implemented and there was an absence of staff training in the application of the policies. More recently, in 2007, the Chartered Institute for Personnel and Development (CIPD) found that fewer than six in ten employers have a policy that covers drug and/or alcohol misuse at work and only a minority of organisations proactively communicate these policies to all employees or train line managers to handle the issue appropriately.

There is no legal obligation for UK employers to have or implement alcohol policies (IAS 2009); however health and safety legislation requires employers and employees to maintain a safe environment and if an alcohol related incident were to occur both employee and employer could be deemed liable. Furthermore, employment protection law requires employers to deal with alcohol dependence as a form of sickness, allowing employees the opportunity to overcome the issue.

Identification and Brief Advice has been promoted by NICE (2010) as a key effective, evidence based intervention in health settings for preventing harmful and hazardous drinking and reducing alcohol consumption. NICE was founded in 1999 to ensure equal access to medical treatments and high quality care from the NHS in England and Wales; it provides guidance, sets quality standards and manages a national database on health improvement, prevention and treatment of ill health.

The Alcohol Academy (2010) has produced a briefing paper which provides a clear explanation of IBA (also commonly known as (SBI) Screening and Brief Interventions within research literature), what it is, where it might fit into care pathways and who delivers it. An excerpt from it is shown below.

IBA commonly refers to the delivery of 'simple brief advice' following identification, which is supported by an extensive literature. It is noteworthy that:

- *'Simple brief advice' entails structured advice lasting 5-10 minutes, commonly delivered by non-alcohol specialists (i.e. as a tier 1 intervention)*
- *'Simple brief advice' is known to be effective for increasing and higher-risk drinkers, but not dependent drinkers*
- *Generic (tier 1) practitioners should be offered short training or make use of available e-learning modules to deliver 'simple brief advice', which should include the provision of self-help literature and information on further support*
- *Routine, opportunistic 'simple brief advice' in general settings is essentially a public health approach that will bring benefits at population level over time, as well as individual benefits*
- *'Simple brief advice' is not treatment. If it is falsely perceived to be treatment or counselling it can deter risky drinkers from accepting 'simple brief advice'*
- *Commissioners must ensure that 'simple brief advice' is not presented as a treatment approach, but ensure it takes place within the context of integrated alcohol care pathways*

Alcohol Academy (2010)

There is an extensive International evidence base for IBA in healthcare settings. The findings from a review of 32 controlled trials are compelling: one in every eight individuals screened and receiving brief advice reduced their drinking to lower risk levels (Moyer et al, 2002). A comprehensive analysis of screening and brief advice by GPs in the US was carried out by Solberg et al (2008). The analysis showed the intervention was one of the highest ranking in terms of effectiveness and cost benefits of all the preventative services evaluated (n=25) and as such recommended that IBA should be prioritised by practices and its coverage extended.

The cost effectiveness of screening and brief intervention in primary care was tested in a randomised controlled trial 'Project Treat' in Wisconsin (Fleming et al 2002). The results of the study showed that significant costs were saved at 12 and 48 months follow up in terms of alcohol related hospital and emergency department costs, motor vehicle outcomes and legal outcomes and therefore the data supports the cost effectiveness of the intervention (Mundt 2006).

The evidence base for using IBA in workplace settings is not as well established as in health settings however some useful studies have shown benefits in terms of reducing alcohol consumption, improving health outcomes and reducing costs.

Recognising the need to address alcohol in the workplace and recommended actions

It is 25 years since Jenkins (1986) showed a strong correlation between drinking and absence from work in a study of young civil service staff in Britain. More recently Aviva (2008), a major insurance and financial services provider, reported 'Booze is 'number one threat' to worker wellbeing on its website. It was reporting on a UK survey carried out by Yougov and Norwich Union which showed :

> *'....that almost a third of employees (32%) had been to work with a hangover and 15% had been drunk at work. One in 10 said this happened at least once a month, while one in 20 said it was once a week.*
>
> *Of those who had gone to work with a hangover or had been drunk at work, 85% said it affected their performance or mood. More than a third (36%) found it hard to concentrate, while 35% admitted to being less productive and 42% felt tired to the point of being sleepy.*
>
> *A quarter of workers (25%) said their drinking meant they did the minimum amount of work and went home as soon as possible and almost one in 10 "made lots of mistakes".'*

(Source : http://www.aviva.co.uk/risksolutions/news/2008/05/08/booze-is-number-one-threat-to-worker-well-being/)

While a number of studies have investigated the general effects of alcohol use on the workforce, they are rarely concerned with alcohol use actually in the workplace itself. A recent Australian study carried out by Pidd et al (2011) focussed on this particular aspect. It revealed that more than one in twenty workers admitted having worked under the influence of alcohol and that those most at risk (of attending work under the influence of alcohol) were young, never married, male workers with no dependent children who were frequent drinkers. Some industries and employment sectors were also found to be more at risk than others for employees' use of alcohol at work, in particular the hospitality industry, but also construction and financial services. Managers and professionals were found to be higher risk groups for drinking at work, a finding corroborating similar patterns observed in a US study (Matano et al, 2002). The authors bring to our attention the likelihood of managers acting as poor role models and the cultural norms around alcohol use within different industries which may inhibit unsafe or risky drinking practices in the workplace (Pidd et al, 2011). Implications for policy and practice highlight employees' failure to associate the negative effects of alcohol use at work on their work performance and the authors suggest that further research is needed into cultural and contextual factors, such as work place controls, stress and alienation.

Addressing the negative effects of alcohol consumption at work, the Institute of alcohol studies (IAS 2009) factsheet on alcohol and the workplace point out that alcohol affects work performance in three main ways:

1. Raised alcohol levels at work affect efficiency and safety
2. Hangovers affect attendance and performance

3. Persistent heavy drinking can lead to serious social, psychological and medical problems which are associated with work attendance and performance.

In discussing mental health in the workplace, Seymour (2010) states that mental health and alcohol and drug problems are relatively common (one in six UK workers). One of the key messages from the report was that line managers need skills and training on effective ways of addressing mental health in the workplace which could help minimise or avert associated problems with absenteeism and presenteeism.

The (HSE) Health and Safety Executive (1996) provide a guide for employers on alcohol at work. It suggests that 17% of personnel directors consider alcohol consumption a major problem in their organisations. Their concerns are specifically: poor performance/productivity, lateness and absenteeism, safety, morale and employee relations, poor behaviour/discipline and company image. The HSE suggest that all companies would benefit from development of an alcohol policy and describe what should be included in it. They suggest managers need to be trained specifically to address alcohol in the workplace. However, the Chartered Institute for Personnel and Development (CIPD 2007) carried out a survey of 505 Human Resource professionals in the UK who worked for organisations employing over a million people. They found that only 33% of employers trained their managers on alcohol and drug policy and management issues.

Hangovers and performance

Ames et al (1997) reported a negative effect of hangovers on job performance from their study in the US. More recently in the UK, Ashby and Mahdon (2010) carried out a qualitative study in 2010 which sought to understand why employees come to work when they are ill. Although this study did not specifically focus on alcohol use, it highlighted that presenteeism (coming to work when feeling unwell) is significantly related to low performance at work, and that it is more prevalent than sickness absence. Those workers who came to work when feeling unwell had higher levels of anxiety and lower levels of psychological wellbeing than other workers. They found that presenteeism had a greater deleterious effect on performance of a company than absenteeism and suggested that employers should therefore address the underlying causes. Among the recommendations from the study were ensure that policies are applied consistently across the workforce, ensure that managers have adequate training to encourage and optimise health and wellbeing and ensure employees feel their organisation and their manager values this.

Alcohol problems, predictors and norms in the workplace

Hodgins et al (2009) acknowledged the negative effects of alcohol in the workplace in considering the prevalence of alcohol problems in different occupations and the different individual or job characteristics which might predict alcohol problems. Hodgins' (2009) study results were based on a telephone survey in Alberta, Canada where participants were asked about alcohol use and employment. A standard tool (AUDIT) was used to assess alcohol consumption and risk level. Their results showed a high correlation between smoking and alcohol related problems; therefore they

suggest it may be feasible and efficient to address alcohol alongside more general health concerns in work settings. Norms supporting after-work drinking in or near workplaces and the degree of job responsibility (specifically for men) were found to be predictors of alcohol problems. Some studies focussing on the correlation between job stress and alcohol misuse have provided mixed or inconsistent results, possibly due to inconsistent measurements (Hodgins et al 2009). Stress in itself was not found to be linked to alcohol problems. Their findings support interventions to alter workplace drinking norms including IBA.

Hodgins et al (2009) feel that the workplace is an ideal setting for prevention and interventions as most adults are employed, they spend a lot of time there and employers have good reasons to motivate participation (Roman & Blum 2002). Randomised Controlled Trials (RCTs) are rarely carried out on interventions in the workplace, however a few studies have shown positive results for workplace interventions on alcohol (Anderson & Larrimer 2002, Richmond et al 2000). Some of these studies have interestingly shown better results for women than for men. This may be partly explained by the differing social norms that exist around alcohol for men and women in Canada. Norms are beliefs which can evolve over time based on availability, approval and use of alcohol in the workplace, and are specific to certain work-types. Drinking norms have a strong effect on workers' drinking behaviour, for men more so than women it seems, from Hodgins' findings. As norms differ from one setting to another it is not necessarily the case that this finding can be transferred to other settings or to the UK.

The responsibility of the employer to promote health and wellbeing

Dame Carol Black published a review (Black 2008) of the health of Britain's working population in 2008. She had consulted widely with a range of stakeholders via discussion events and written submissions and found that there was strong support for workplace initiatives to improve health and wellbeing. It was felt that a business case needs to be made to employers to quantify the benefits and costs associated with workplace interventions if progress is to be made. One of the aims of the review was to change attitudes, behaviours and practices that stand in the way of good health. Along the same lines, the objectives of the report include a vision of health and work in Britain, prevention of illness and promoting health and wellbeing. Recommendations from her report suggest that there needs to be an expanded role for Occupational Health Teams and a shift in attitude to ensure employers and employees realise the importance and economic benefits of improved health and wellbeing.

Studies that show what works and gaps in the research

There is a good evidence base for the effectiveness of Screening and Brief Interventions (IBA) in Primary care (Kaner 2007, Fleming 2002) but less attention has been paid to evidencing its effectiveness in the workplace.

A Scandinavian study (Hermansson et al 1998) set out to discover if screening and brief interventions used in health services could also be useful in the workplace. Employees were offered a check on

their alcohol habits (n=333 employees) at routine Occupational Health appointments. 98% participated and of these 21% showed excessive alcohol use and consequently were contacted by the Occupational Health service. A higher percentage of those contacted by phone (80%) attended for further Occupational Health input, compared with those contacted by letter (17%),. They concluded that alcohol screening and secondary prevention is feasible in the workplace.

Hermansson and colleagues in a more recent RCT study (Hermansson et al 2010) in Sweden investigated the results of SBI in a large transport company. The study was of 990 employees, mainly men, who used Occupational Health services for routine lifestyle check-ups. The study found that 20% of those screened were drinking hazardously. Three groups were studied; a brief intervention group, more intensive intervention and control group. The results at 12 months showed reductions in drinking but no real difference were apparent between the three groups; they concluded the interventions were effective but screening itself acted positively in terms of reducing drinking.

Whilst it is now fairly routine practice for Occupational Health Teams to provide screening and interventions on a number of health issues, Watson et al (2009) found only two that included alcohol in the screening process. Watson et al's study looked at the feasibility and cost of conducting a Randomised Controlled Trial of SBI delivered by Occupational Health nurses and its acceptability by the workforce. The work setting was in a local authority in Scotland and evidence based techniques were used in the interventions, such as motivational enhancement techniques. Participants were sent a general lifestyle survey, which included an AUDIT screening, through the post. This enabled 'hazardous' drinkers to be identified and offered a brief intervention. The study showed baseline scores and follow up after 6 months. The results showed a greater reduction in alcohol use in the intervention group than the control group in relation to units consumed per day, drinking days per week, and mean number of units per week. It also showed that the intervention group had fewer hospital and primary care visits than at baseline, whereas for the control group visits increased over the period. The costs were £3.60 per screening and £12.48 per intervention. Savings of resources as a result of the intervention were worked out illustratively as £332 per intervention. Watson and colleagues calculated that 6606 people would need to be screened initially to achieve a statistically appropriate sample. 92% of those who received a survey with AUDIT screening were happy to receive it and most preferred to get it at home rather than at work. 70% felt it was appropriate for Occupational Health nurses to provide advice and information about alcohol and their health and positive comments were received from all but one of the participants who received an intervention.

The implications of Watson et al's study suggest that delivery of SBI in the workplace has the potential to reduce alcohol related harm and save public sector resources. Caution is advised as the results for the feasibility study were not statistically significant due to sample size, however the trend data suggests that it is worth conducting a larger scale study, possibly with a longer follow up period. Potential obstacles flagged up regarding the implementation of wholesale SBI throughout the workforce were concerns about confidentiality and information being passed back to employers, which would need to be addressed in any further roll-out. A further potential obstacle of 'fitting it into the day job' both for Occupational Health Teams and employees might be an issue. One consideration emerging from Watson et al's study(2009) is that periodic health screening which includes alcohol screening and offers opportunities for brief Interventions is feasible and potentially

beneficial. The authors suggest that the rate of take-up of the intervention could be increased by one-to-one phone calls or face-to-face follow-up after screening.

Webb, Shakeshaft, Sanson-Fisher and Havard (2009) carried out a systematic review of workplace interventions for alcohol related problems. They suggest that workplaces are ideal places for alcohol interventions because they provide access to difficult-to-reach populations e.g. young men and high risk drinkers. Workplaces provide venues where employees can receive interventions; as considerable time is spent there, it is in the interest of employees in terms of health and in the interests of employers in terms of reducing sickness absence and fewer injuries. Despite this, employers raise concerns about whether it is their responsibility to address alcohol use and the potential costs to their businesses of intervening.

Of the studies Webb et al (2009) considered, eight were in the US, one in Sweden and one in Australia. They suggest that there is a pressing need for a better standardised approach to the methodology and measurements used, in order to improve any future evaluations of workplace interventions. They also note that many of the studies did not deal with gender differences sufficiently. They found relatively few (four) studies which employed RCTs and all were felt to be methodologically flawed, however, all except one study reported statistically significant improvements in reduced alcohol consumption, binge drinking and alcohol problems. They concluded that brief interventions, interventions within lifestyle checks, psychosocial skills training and peer referral all have potential to result in benefits. They also noted a number of obstacles to delivery of interventions and evaluation projects. These obstacles included obvious factors such as demands of the workplace taking precedence, which could have adverse effects on recruitment and consistency. They noted that lack of management and workforce commitment also resulted in even greater difficulties. A further potential problem was considered to be turnover of staff over time, i.e. some staff dropped out of the evaluation and hence reduced the follow up rate. Structural changes in the organisation were also flagged up as potentially problematic which could result in changes in study design during the research.

The ‘Ensuring Solutions to Alcohol Problems’ website (Ensuring Solutions to Alcohol Problems 2008) at the George Washington University medical centre reports that in the US an annual survey (eValue8) of health plan providers (n=150 providers) showed that 58% of them would pay for substance use screening and brief intervention as part of their health plans. This suggests that the technique has sufficient evidence of effectiveness in reducing risky use of alcohol and other drugs. All US federal employees are therefore now covered for the intervention by their health plan. The website itself even provides a ‘workplace SBI toolkit’ online.

Uptake of IBA by employers

Research was undertaken in the US to investigate how Screening, Brief Intervention and Referral to Treatment (SBIRT) was being implemented by employers (McPherson et al 2009). The study showed that whilst employers were open to and interested in SBIRT, significantly few had actually delivered it in their workplaces. The authors suggested ways to improve the take up of the intervention which included: Educating and informing employers of the cost benefits of the impact of SBIRT; marketing it via employee assistance programmes and health insurance companies; training Occupational

Health Teams and practitioners; and marketing the approach using outreach to business leader forums.

Student/college drinking and interventions

Although colleges and universities are first and foremost regarded as educational institutions, they are at the same time work environments for both students and staff. There is little evidence of either research or evaluation investigating the targeting of student drinking patterns in the UK (John & Alwyn 2010); however some international studies have addressed this particular population.

A study was undertaken in New Zealand (Kypri et al 2003) of a random sample of University students to establish the acceptability of practitioner-based versus web-based Screening and brief interventions. The study found that most students (81%) as well as most hazardous drinkers (82%) preferred the web-based version. This finding may be relevant to young people in general, rather than just students.

In 2006 (Saitz et al 2006) carried out a study exploring the effectiveness of online SBI for a cohort of 4008 students in the US. Students were invited to take part in either an alcohol specific screening or screening as part of an overall health assessment. Those with an AUDIT score of 8 or more received a minimal or more extensive online brief intervention. A month later they completed another assessment which showed that 33% of women and 15 % of men who had an unhealthy score at baseline, no longer drank excessively. There were no significant differences between the minimal or more intensive intervention groups.

John and Alwyn (2010) are not confident that the US trend for social normative approaches to student drinking behaviour, has much relevance, transferability or as consistent an evidence base as in the UK. They feel the social norms approach has been somewhat 'oversold' and UK testing of the approach is needed. Changing norms does not, on its own, change behaviour and, if used, then it should be part of a multi-component, evidence based strategy which includes SBI and targets different levels of alcohol consumption. The authors suggest University-wide alcohol policy development should be prioritised which has commitment and support from directors through to students themselves. They also suggest training for managers and key stakeholders to challenge the norms and improve skills to address alcohol concerns, including IBA.

Economics and cost benefits

Anderson (2010) reported on the economic harm caused by alcohol in Europe and the impact of workplace policies on this based on a systematic review. He noted that alcohol is a risk factor in absenteeism and presenteeism and estimated that half of all social costs of alcohol are due to lost productivity. He describes two studies which found a link between individuals' levels of alcohol consumption and sickness absence. In the current economic downturn it is unclear what the impact will be on levels of alcohol related harm, as in previous slumps alcohol consumption levels have reduced but alcohol deaths increased dramatically. This was probably as a result of an increase in

harmful patterns of drinking rather than actual overall consumption levels. He emphasises that national alcohol policies could considerably reduce lost productivity via policies which increase the price of alcohol. Recognised that there are very few studies evaluating alcohol workplace policies, he suggests that Identification and Brief Advice within the context of lifestyle checks and other interventions can produce what he refers to as 'small' beneficial results and iterates that these results have only a limited impact on the national economy even if widely implemented. In his conclusions, his answer as to whether workplace policies can contribute to reducing the economic harm caused by alcohol to the European Union is 'not much', however policies should be implemented because of the benefit of resulting health gains.

Quanbeck et al (2010) developed a US cost benefit model that considered the costs of alcohol related absenteeism and presenteeism against the costs of providing SBIRT (Screening, Brief Intervention and Referral to Treatment) from an employer's perspective. A previous US study (Fleming et al 2002) had considered benefits from a societal perspective which had shown benefits outweighing costs by 39 to 1.6 and significant reductions in problem drinking were observed in both the intervention and control group which had not received the brief intervention. This anomaly was speculatively explained by the screening itself having the effect of prompting the participant to reassess their drinking independently of any intervention. According to Quanbeck, SBIRT is the fourth most cost-effective clinical preventative service nationally in the US. The authors point out some gaps in knowledge around empirical estimates for costings due to presenteeism, although they suggest the costs of presenteeism outweigh those of absenteeism because of the greater number of days when people come to work feeling unwell due to alcohol, than when they do not. A simulation model was used to provide a cost analysis. The results were worked out over a four year period. They calculated a cost benefit of $771 (~ £480 March 2011 rates) per employee over the four year period of providing the service. Represented another way the ratio of benefits to costs was 4.4 to 1 and therefore investing in these approaches appears worthwhile from an employer's perspective.

Summary

This section provides the key points from the literature reviewed.

- To-date very few studies have been conducted examining IBA in the workplace despite its promotion by NICE (2010) as a key effective evidence-based intervention in health settings (for prevention of harmful/hazardous drinking and reducing alcohol consumption.)

- Drinking and its effects can have negative impacts on the workplace. Both absenteeism and presenteeism (coming to work unwell) are found to significantly affect work performance; there are also more serious risks to health and safety associated with heavy drinking (Institute of Alcohol Studies, 2009. Ashby & Mahdon (2010) and Quanbeck (2010) suggest that employers need to address the underlying causes.

- The workplace is an ideal setting for alcohol and other health prevention and interventions as most adults are employed and spend a lot of time there and employers have good reasons to motivate participation (Roman & Blum, 2002; Hodgins et al, 2009; Webb et al, 2009).

- Patterns of drinking, attitudes and responses to employees' alcohol use at work differ between and within different employment sectors; in particular the hospitality industry, financial services and construction industries are at greater risk for alcohol consumption at work; so too are managerial and professional staff (Pidd et al, 2011). The culture and context of drinking within different work environments need to be considered together with the attitudes and abilities of managers to respond to alcohol related issues.
- Not all employers have workplace alcohol policies; only a low proportion of employers train managers on alcohol and drug policy management issues (Baggott, 1994; CIPD, 2007)
- The evidence base for using IBA in workplace settings is not as well established as in health settings but is growing. Studies show similar benefits in terms of reducing alcohol consumption, improving health outcomes and reducing costs (Hermansson et al, 1998 and 2010; Watson et al, 2009; Webb, 2009).
- Some studies have shown that screening alone (without brief intervention) results in positive outcomes in terms of reducing alcohol consumption (Fleming, 2002; Hermansson, 2010) and other studies show that minimal intervention is as effective as more intensive brief intervention (Saitz 2006).
- A business case can be made based on evidence showing the cost effectiveness of IBA in the workplace with reductions in health and social costs (Watson et al, 2009; Ensuring Solutions to Alcohol Problems, 2008). A US study showed that a saving to the employer of $771 (approximately £480 at March 2011 rate) per employee receiving IBA could be made over the four year study period (Quanbeck, 2010). Screening, Brief Intervention and Referral to Treatment (SBIRT) is considered the fourth most cost-effective clinical preventative service nationally in the US (Quanbeck 2010).
- Most employees find IBA acceptable and feel it is appropriate for employers/Occupational Teams to address alcohol (Watson 2009).
- Ways of increasing workplace take-up of IBA include: educating / informing employers of the cost benefits of the impact of SBIRT and training Occupational Health Teams and practitioners as well as targeted marketing approaches (McPherson et al, 2009).
- Potential obstacles to implementing IBA in the workplace include: employers' concerns about whether it is their responsibility to address alcohol and the cost implications; concerns about confidentiality / information being passed to employers; fitting it in to the 'day job' for both workers and Occupational health teams; lack of management or workforce commitment; turnover of staff and structural changes (Watson et al, 2009; Webb, 2009)
- Managers and Occupational Health staff need skills and training on effective ways of addressing alcohol in the workplace via IBA (Seymour, 2010; HSE, 1996; Ashby & Mahdon, 2010; John and Alwyn, 2010).
- Alcohol is only included in few Occupational Health Service screenings (Watson et al, 2009). There needs to be an expanded role for Occupational Health Teams and a shift in attitude to

ensure employers and employees realise the importance and economic benefits of improved health and wellbeing (Black 2008).

Training employees in effective ways of addressing alcohol in the workplace is mentioned in the literature as a recommendation but appears not to have been researched or evaluated. Since a strong case for IBA is evident from the literature, it is timely to try to assess the possibility of using training as a stimulus to implementing IBA in the workplace.

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3. Research findings

Introduction

The following findings are based on the responses of employees attending 25 Alcohol Academy training sessions who completed the pre and post surveys and the eight individuals who participated in the follow-up interviews.

It should be noted that throughout the findings percentages are based on the numbers of people responding to the particular question asked. Caution needs to be exercised when interpreting the findings of the Lite post training sample as the numbers involved are relatively small. In view of this, when we consider post training responses the focus in the report is on findings from employees attending Full IBA training.

The distribution of responses to the pre and post surveys across the range of roles can be seen in Table 1 below.

Table1: Sample profile of roles

Role	**PRE** (n = 202)	**POST**	
		Full IBA (n = 76)	**Lite** (n = 20)
Employee assistance/support role	20%	7%	35%
Health and Safety role	4%	5%	0%
Health lead/practitioner	18%	9%	5%
Human Resources	17%	25%	10%
Management position in public sector	24%	29%	15%
Occupational health	11%	14%	0%
Police/fire brigade service	0%	0%	0%
Safety critical role	1%	0%	0%
Strategy lead/commissioner (e.g. DAAT or PCT)	2%	1%	5%
Union representative	4%	1%	5%
Other	11%*	8%	25%

* These respondents provided descriptions in addition to those listed

Highest responders to the pre survey are those in management positions within the public sector, representing about a quarter of all respondents, followed by employee assistance roles, health leads and human resource employees (HR). Attendees from occupational health (OH) represent about one in ten of those responding to the pre training survey. Following Full training responses are highest among managers and HR and both show increases, while employee assistance role responses tail off from 20% to 7% and health lead responses also drop from 18% to 9%. Speculating on possible reasons for this, the decrease could be a result of the increased time needed to complete the lengthier Post training survey. Encouragingly a slight increase in responses is found among OH staff. Those attending Lite sessions and responding to the post survey are mainly staff in employee assistance roles, managers and HR staff.

Recommendations from the literature suggest that there needs to be an expanded role for occupational health teams (Black, 2008) and that managers and occupational health staff need skills and training on how to effectively address alcohol and related problems in the work place using IBA (Seymour, 2010; HSE, 1996; Ashby and Mahdon, 2010; John and Alwyn, 2010). In view of these recommendations it is encouraging that response rates in completing the post training questionnaire are highest among managerial staff, HR and OH staff i.e. sectors highly likely to encounter alcohol related issues, either directly or through referrals. These findings may be indicative of levels of interest but may also reflect other factors affecting response rates such as time pressures or staff turnover for example.

Awareness of current workplace alcohol policies

The literature suggests that many employers do not have workplace alcohol policies and only few employers train managers on alcohol and drug policy management issues (Baggott, 1994; CIPD, 2007) and these findings are reflected in this study. Most interviewees are not aware of specific alcohol policies within their workplace but believe that they are mostly embedded within other more general health and safety or human resource policies and professional conduct or staff manuals, for example. The policy statements are thought to broadly indicate that coming to work under the influence of alcohol (and/or drugs) constitutes gross misconduct. Although interviewees discuss the disciplinary and supportive pathways contained within alcohol policies, on the whole it appears that guidance is sought on an ad hoc basis when alcohol issues surface, either through people self-identifying a problem or a problem being detected by managers or other staff. Providing guidance on alcohol policy issues for the managers and health leads we spoke to does not appear to be routine practice; nevertheless, they do seek advice from HR and/or support from occupational health staff for dealing with alcohol related problems when they arise.

*"I think in most places what they have is they think they have a drugs and alcohol policy......
And what they don't, is they don't actually and do they ever test – no and even when there have been grounds where somebody has been under suspicion of alcohol in the workplace, they don't even test them then. So it's actually realising that there are legalities and they have either got a policy that... it has to be an active policy."*

(Occupational health)

We found that only one counsellor of the eight interviewees we spoke to, including OH and other counselling roles, had previously undertaken any formal alcohol related training, which closely corresponds with findings from the literature; and yet one OH role and a counsellor were involved in educating managers about drugs and alcohol policy implementation, for example, how to identify substance misuse and referral procedures/pathways. Our findings confirm that, prior to IBA training, interviewees in managerial roles/health leads do not receive guidance on how to tackle alcohol issues in the workplace. Given their lack of training, they approach alcohol issues more from an entrenched problem-solving focus and less from a preventative, awareness-raising perspective; and this mindset has important implications for their emotional and behavioural responses to training in terms of screening and giving advice. Their perspectives differ from those of some OH and counsellor roles, who deal routinely with alcohol related problems, especially when they are working more

generically and providing services across a range of employment sectors; these roles tend to be more conscious both of the need for broader preventative measures and for addressing the issues underlying alcohol problems.

Overall impressions of IBA (Full) training / Lite sessions

In this section we first of all explore general responses to the training and Lite sessions from the more discursive qualitative data i.e. the follow-up interviews and this provides a context for then looking at the more structured responses to training from respondents in the surveys.

Follow-up interviewees' perceptions

Feedback on the delivery of training from open-ended responses to the survey and interviewees is extremely positive overall. Without exception all interviewees comment on the professional, knowledgeable and personable way in which the sessions are delivered and how information is conveyed in an accessible manner. Participants find the Full training and Lite sessions useful in encouraging people to think about safe levels of drinking, as well as expanding their knowledge of alcohol and related issues in the workplace. Attendees in a variety of roles speak of the training being practical in that they learn important useable skills and different approaches to address the broad spectrum of alcohol related issues at work.

"The guy was very good... personable and the pace was good for all levels to follow and it was full of good, practical stuff. I'd recommend it"

(Manager, London Borough)

"He was teaching us better phrases to use and more socially acceptable terms."

(Occupational health)

"We found it a very interactive session, very educational session and we felt again it really helped us in moving forward with one, 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)

Locating drinking within people's lives as an acceptable and enjoyable thing to do is an important strength of both training and Lite sessions and this, coupled with an educational framework and the use of non-judgemental language, helps to moderate both personal feelings about the potential criticism involved in evaluating one's own drinking and concerns about judging the habits of others. Rather than directing behaviour, the sessions are seen as creating opportunities for people to reflect on their own and others' drinking and attitudes. Prominent in some interviewees' recollections of training, particularly non health management roles, is their surprise at the recommended guidelines on alcohol consumption and the strengths of different drinks. Discovering that their own and others' drinking is above government recommendations encourages them to reflect on their personal behaviour and habits as a result. Training does therefore appear to create an impact on personal awareness and attitudes to alcohol consumption in general and to alcohol related issues in the workplace context.

"Most of the feedback from my guys is that they were surprised at how low the level of alcohol was before it was a problem - 'I do not have a drink problem but then looking at this, maybe I do'."

(Manager, London Borough)

"I was totting up my scores and I was like 'My word!' you know, whereas you may have thought, I mean we could all go out for a night out but you'd think more now about, okay should I be driving , should I be doing this, that, so I really do think it's had a big impact.!"

(Manager, London Borough)

Providing people with practical examples examining alcohol units in various strength drinks and role play creates variety and keeps up interest, making for an enjoyable as well as informative session. Most interviewees comment on the role play as being a useful tool in encouraging them to reflect on the calm and matter-of-fact manner in which they might approach different situations and in triggering further discussion. Some managers, though, would like to have seen more role plays enacted, in the hope that they would help them to address their own particular workplace problems, and an OH role suggested expanding the role play into a full interview between trainer and actor again to help managers learn more about how they might address different problems. An interviewee's suggestion of creating a DVD to illustrate a range of role play scenarios might be worth considering in future training development. Another OH role could foresee a more generic use for the role play approach in other health related training sessions.

"Probably what we found the best was the interactive bit, doing the units, the Velcro units (alcohol units in drinks exercise)*, we loved that"....... and later "we felt as a team, that when ...we had a difficult patient/client and one who was very open to listening to suggestions, we said we could use the scenario he gave us, not just for alcohol but lots of things that people are referred for, because he was very good at giving us a way of trying to remain sort of cool and calm and then recognising somebody doesn't want to know you know"*

(Occupational health)

While there was broad support for the manner and methods used to deliver training, some interviewees raised suggestions about how training groups might be structured differently to facilitate discussions, for example, by trying to include minimum numbers of similar roles that would enhance the sharing of experiences and approaches. This appeared particularly relevant among OH roles. Given the organisational and administrative challenges involved, the structures of particular training groups may nevertheless be worth considering in future training programme planning. Notwithstanding these suggestions there was clearly value in having a mixed group to create awareness of and discussions around the challenges faced by different roles.

"We didn't have a lot of people to draw from to see if other people had the same situations and what they'd done in those situations"

(Occupational health)

"They could have maybe encouraged some of the clinical people to attend, because I think when you are looking at it from an HR perspective and then looking at it from a manager's perspective, it is slightly different than the two come together"

(Health lead/manager)

Survey respondents' perceptions

Training and Lite sessions have had a number of positive effects on knowledge of and attitudes towards alcohol and its effects in the workplace and these can be seen in Table 2 below which compares the mean scores achieved before and after training across a series of statements. A more detailed analysis of respondents' perceptions is appended.

Understanding of alcohol and its effects is at a high level both before and after training; some of the highest mean scores can be seen across this measure and levels of agreement increase accordingly. Before training 80% agree that they have a good understanding and this rises to 88% for Full training attendees and 85% for Lite session attendees.

After training employees feel they have greater awareness of procedures for referral and resources available once they have identified a problem and better understanding of the support and treatment services available for people with alcohol problems. The increase in means for the latter is among the most significant shifts obtained after Full training with 35% agreeing beforehand rising to 88% after.

Table 2: Pre and post training perceptions of alcohol and related issues in the workplace.

Statements	**PRE** (n=195)	**POST**	
		Full (n=74)	**Lite** (n=20)
Alcohol and its effects:			
I feel I have a good understanding about alcohol and its effects	5.18	5.42	5.45
Treatment/support/resources:			
I have a good understanding of treatment services and support for people with alcohol problems	4.01	5.16	4.75
If I identify a problem there are appropriate referral procedures and resources I can use	4.54	5.00	5.35
Delivering alcohol interventions:			
I feel I can improve workplace factors and employee wellbeing by delivering alcohol interventions	4.35	4.61	4.85
I have a good understanding about how to deliver effective alcohol interventions	3.48	4.78	4.65
Within my job role, I feel confident to talk to and advise colleagues about alcohol use	4.20	5.15	5.05
Impact of alcohol in the workplace:			
I feel the impact of alcohol is an important issue for workplace health & wellbeing	5.73	5.30	5.85
I feel alcohol plays a significant role in many workplace problems	4.31	4.27	5.00

Mean score range 1: strongly disagree and 7: strongly agree

Looking at employees' perceptions of their own understanding and beliefs in delivering alcohol interventions highlights some of the greatest impacts training has had on their confidence, understanding and beliefs. In particular, respondents feel better able to understand how to deliver

effective interventions themselves after training and greater confidence within their job roles to offer advice on drinking. The greatest increase in means can be seen for this last dimension concerning the effect of training on confidence within role, where agreement to the statement rises from 38% pre training to 81% after. Interestingly, the lowest rate of agreement (20%) can be seen before training in respondents' understanding of how to deliver training effectively, and it is encouraging to note the increase to 70% agreement after attending Full training from this relatively low baseline response.

Respondents, on the whole, feel that alcohol has a significant impact on workplace health and wellbeing with extremely high levels of agreement to this statement (93% agree before and 84% after Full training). While they are therefore very clear in their general view of the impact of alcohol in the workplace, their responses are more diluted to the suggestion that alcohol plays a significant role in problems and the belief that delivering alcohol interventions in the workplace can help to resolve them. Mean scores across these dimensions remain fairly stable after training. Their responses may be largely dependent on their role and particular experiences in their own work environment and how alcohol problems have arisen and been addressed. In the interviews, respondents' previous experiences were found to vary considerably; some roles e.g. occupational health managed alcohol related issues as a matter of routine, in contrast others had never previously encountered problems with alcohol at work. In the pre training survey just over half (54%) of employees said they had not given alcohol advice or information to any colleague at work before. This may account for the higher scores among the Lite sample across statements assessing the impact of alcohol in the workplace, a third of who were in employee support roles and who are more likely to have experience in dealing with alcohol issues among staff.

Expectations and concerns before and after training

All prospective attendees were asked to rank their hopes and expectations together with their fears and concerns about the training.

Table 3: Ranking of hopes and expectations prior to training

Hopes / expectations:	**Ist choice**	*** Mean % age ranking**
Increasing knowledge around alcohol use/misuse	47%	32%
Knowing how and where to refer dependent drinkers	10%	20%
Supporting the development of a healthier workforce	16%	16%
Understanding the relevance of alcohol within the workplace	11%	15%
Learning how to deliver IBA for risky drinkers	13%	13%
Networking with and learning from other colleagues	2%	4%

* Mean % age of respondents ranking each statement as 1st, 2nd or 3rd choice

N.B. Different numbers of respondents ranked each statement

Table 3 shows that, by far, respondents' main hope for the training focuses on increasing their knowledge around alcohol use and misuse; it is the first choice among nearly half the sample (47%)

and almost a third on average vote for this above other expectations (32%). This is also given as a main reason for attending training sessions by many follow up interviewees. Some managers are responsible for operational staff using equipment or machinery and stress the need for clear information on how to deal sensitively with alcohol issues that may arise. Aligned to this, in the same interviews many managers and health leads relate their need for better awareness of alcohol and issues to specific problems they have previously encountered in the workplace; occupational health and counsellor roles in contrast focus on refreshing and updating their training around alcohol. Looking at responses to the Post training survey, it is likely that different roles' experience of alcohol issues in the workplace is through being aware of and needing to respond to problematic drinking and this would help to explain why there is also a strong emphasis on gaining further knowledge of referral procedures for dependent drinkers as an outcome of training.

"HR were looking at it as something that could be used in the organisation and as a manager I was interested in that whole thing, to see how you could implement it if you did have a thing with a staff member"

(Health lead/manager)

"I see a lot of people who misuse alcohol, even though a lot of them are very small. For me it was almost a refresher training, but also because I knew managers were going to be there I wanted to help them or empower them to deal with the growing issue"

(Counsellor)

Respondents also hope to find out more about supporting the development of a healthier workforce and to understand the relevance of alcohol in the work environment. It is not surprising to find that learning how to deliver IBA to risky drinkers is rather less of a priority for potential attendees given the other choices, but this is also likely to reflect familiarity with and knowledge of IBA found among roles already delivering support, such as OH , counsellors and employee support roles, for example. A general readiness to accept the idea of training as a useful professional resource is evident across findings from the surveys and interviews, while knowledge of issues can be seen to support the professionalism of managers as decision makers.

Table 4: Ranking of concerns and fears prior to training

Concerns / fears	**Ist choice**	*** Mean % age ranking**
Feeling confident enough to talk about other people's alcohol use	31%	21%
Addressing related issues such as stress, depression, anxiety	19%	22%
The level of further support available for dependent drinkers	14%	21%
The appropriateness of my role in addressing alcohol issues	18%	19%
Finding time to integrate IBA within my practice	10%	13%
Thinking about my own alcohol use	8%	5%

* Mean %age of respondents ranking each statement as 1st, 2nd or 3rd choice

N.B. Different numbers of respondents ranked each statement

Staff attending training were asked to rank their concerns beforehand and Table 4 above summarises their responses. Having enough confidence to discuss other people's drinking is a major worry with nearly a third of attendees ranking it as their primary concern (31%) and about a fifth on average opting for it as a concern over and above others. Other important reservations cluster together with about a fifth of respondents on average expressing each of them as concerns. They are: addressing issues such as stress, depression and anxiety often associated with drinking; finding out more about the support available for dependent drinkers; and worries about the suitability of their role in dealing with alcohol issues in the workplace.

Table 5: If training met hopes and expectations for course

If hopes and expectations met	POST	
	Full (n = 71)	**Lite (n = 20)**
Not met	1%	0%
Slightly met	21%	20%
Met well	68%	75%
Entirely met	10%	5%

After training attendees were invited to rate the extent to which Full training and Lite sessions had addressed their hopes and expectations (see Table 5). The great majority of respondents attending either Full IBA training or Lite sessions are of the view that their hopes and expectations have been well met (78% for Full attendees; 80% for Lite) and that the full training in particular has been responsive to their concerns (78%) (see Table 6). Among those involved in the Lite sessions most (61%) feel their concerns have been well addressed though there appear to be some (39%) who still express concerns. It must be remembered, as stated earlier in this report, that the actual numbers responding are low and that 39% represents only seven employees.

Table: 6 If training addressed concerns and fears

If concerns and fears addressed	POST	
	Full (n = 71)	**Lite (n = 19)**
Not at all	1%	0%
Partially addressed	21%	39%
Addressed well	72%	61%
Entirely addressed	6%	0%

Materials / information handed out

After training many respondents have internalised the value of communicating alcohol related messages and are forthcoming in giving out the NHS booklet 'Your Drinking and You' and the alcohol

unit information wheel to colleagues and others, as can be seen in Table 7 below; after training, about half of those responding to the question have handed out at least one item.

Table 7: Materials and information handed out since training

Materials/Information handed out	POST	
	Full (n = 60)	**Lite (n = 19)**
A screening tool (e.g. AUDIT) for colleagues to self-complete	13%	11%
The NHS 'Your Drinking and You' booklet without screening	35%	26%
Alcohol unit information	30%	26%
A link to an online web resource	5%	5%
I have not given out any of these materials/information	52%	68%
Other	8%	5%

N.B. Multiple responses possible

Of those who have given out information and attended training, the NHS booklet has been handed out by about a third and the alcohol unit by similar numbers. Among individuals attending Lite sessions about one in four give the booklet and the unit information to others. Some of the interviewees handed out materials such as the NHS booklet to colleagues and friends and family, while others left them in prominent places for staff to pick up. Positive responses to the materials are reported and they create interest: interviewees comment on the surprise some colleagues express in working out the unit values of their alcohol consumption.

"People have been shocked actually at how many units one glass of wine is, for example, and they've said they really didn't realise, they thought they were only having two or three glasses of wine.... and I'd say 'do you know how many units that is?' and they're like 'bloody hell!'"

(Counsellor)

"Just talking with my close work colleague, we said, 'this is an eye-opener'. Truthfully I don't think we've ever sat down before and looked at the amounts we drink and this was the first and only time we would have done this"

(Manager / Lite session)

As well as handing out NHS booklets and unit information, 13% have handed out the AUDIT self-completion screening tool to colleagues and a few have provided links to an online web resource. Interviewees comment on the similarity of the screening tool's format to other existing tools and its ease of use, but most importantly, it provides a platform for subsequent discussions around drinking.

"One of the most useful things out of this is to have a tool that you can use, it makes it a little bit more consistent with the message you are getting across as well".

(Occupational health)

"The tool – it's something that we use, sort of tools like that, clinically, so it fitted my models, fitted with me nicely"

(Health lead/manager)

Giving alcohol advice

Before training just under half of employees (44%) responding to this particular question in the pre survey (n=194) had given verbal alcohol related advice or information to colleagues, in the main on just a couple of occasions (See Table 8). In the one to three month period since training just under a third have given verbal advice to other staff, irrespective of whether they attended Full training or Lite sessions.

Table 8: If alcohol advice ever given / given since training

If alcohol advice given:	PRE training (Ever given advice) (n = 194)	POST (Advice given since training)	
		Full (n = 75)	Lite (n = 20)
Yes	44%	31%	30%
No	54%	69%	70%
Unsure	2%	0%	0%

Table 9 below highlights the variation in experience of giving advice about alcohol before training/Lite sessions; about a third of staff have only given advice on one occasion, just under a third have done so more frequently - up to five times, while the remaining third have given advice on five occasions or more. Employees' experiences, as already noted, are likely to differ by job role responsibilities and also by length of time in their current role and would help to explain the variation found in frequency of offering advice. Overall, there is little variation in the number of times respondents give advice after training or attending Lite sessions – just under twice on average. It is possible that some may have considered handing out booklets and materials as advice which could explain the high number of occasions stated by a few individuals.

Table 9: How often alcohol advice or information given

How often alcohol advice given	PRE* (n = 88)	POST*	
		Full (n = 23)	Lite (n = 6)
Only once	34%	30%	50%
Up to 5 times)	38%	61%	33%
5-19 times	15%	4%	0%
20 times or more	14%	4%	17%
Mean	2.08	1.83	1.83

N.B. PRE refers to lifetime total advice given prior to training, POST refers to total number of times advice given in 1-3 month period since training

Most often advice given to colleagues and employees after Full training has been in the form of a general discussion about alcohol use, as can be seen in Table 10 below. More than two thirds (68%) of those giving advice have taken part in discussions and almost a quarter of respondents have given brief advice but without using the screening tool (23%). Well over a third (37%) though have given

the screening tool to colleagues as a self completion exercise and then offered brief advice. A few staff have referred people on to occupational health but not to specialist services.

Table 10: Alcohol-related advice or information given to colleague/employee

Alcohol-related advice/information given	POST	
	FULL (n = 22)	LITE (n = 5)
Brief alcohol advice following the use of a screening tool (e.g. AUDIT) identifying risky drinking	37%	0%
Brief alcohol advice without the use of a screening tool	23%	60%
A more general discussion about alcohol use	68%	40%
Made a referral to Occupational Health	14%	0%
Made a referral to Alcohol Treatment Services	0%	0%

N.B. Multiple responses are possible

When they do give advice, and bearing in mind the low numbers involved in the Lite sessions, staff show increased confidence after training both in the kind of advice they give and how they are able to convey it. This can be seen in Table 11 below where every person who gave advice after training is confident in their approach.

Table 11: Perceptions of confidence in giving advice and manner of delivery

Perceptions of confidence	PRE (n = 87)	POST	
		FULL (n = 23)	LITE (n = 6)
Alcohol advice/information given was:			
Appropriate	89%	100%	100%
Neither appropriate or not	8%	0%	0%
Not appropriate	3%	0%	0%
Mean score	4.08	4.48	4.33
Overall manner of delivery was:			
Appropriate	75%	100%	100%
Neither appropriate or not	20%	0%	0%
Not appropriate	6%	0%	0%
Mean score	3.87	4.30	4.17

Mean score range: 5: Very appropriate 1: Completely inappropriate

Exploring the barriers to implementing IBA

About two thirds (66%) of respondents to the post survey have not given alcohol advice since Full training and they suggest three main reasons for this. Time pressures and concerns over the

appropriateness of their job role are given by 15% and 17% respectively, while almost two thirds (62%) say they are not encountering staff with alcohol problems and not handing out the screening tool as a result (See Table 12 below).

Table 12: Reasons for not giving alcohol advice

Reasons	**Full (n=52)**
I haven't had enough time to use the screening tool	15%
My working relationships make it difficult for me to introduce the screening tool	4%
I haven't felt confident enough to raise the subject of alcohol use	2%
I feel my job role isn't appropriate for me to introduce the screening tool	17%
Need has not arisen/not identified anyone	62%
Other reasons	8%

From the follow-up interviews, the ways in which interviewees have experienced, responded to and managed alcohol problems at work can be seen to underpin their reasons for not giving advice. But, more generally, they are not attuned to the idea of raising awareness about alcohol issues and perceiving IBA as a preventative measure and this has important implications for IBA take-up. The barriers to implementing IBA are now addressed more fully.

Crossing the boundary between work and private life

Broaching the subject of alcohol related issues with employees raises concerns among managers and some OH staff about intruding into employees' personal and private lives and possible breaches of confidence. Managers were hesitant to talk about alcohol related issues with staff and a strong desire to get foreclosure when they did was often noted. The following comment from a health lead /manager shows the difficulties faced both in introducing the subject and setting limits on the boundaries of probing into an employee's drinking habits.

"Basically, I sat her down privately, because I'd never mention this in public, and just explained that sometimes I had smelt alcohol on her breath in the morning and you just need to be aware of that. I didn't actually ask her about her drinking habits or anything. It didn't affect her work but what I did make sure she noticed was, you know, that if it's going too far, we are becoming aware of this."

(Health lead/manager)

"That is the difficulty I think is knowing what forum to use to do a general chat about alcohol"

(Occupational health)

Assessing effects of alcohol on work performance

Discussing behaviour of a personal nature, especially when it is not visibly detrimental to an employee's performance at work presents difficulties. The following comments are illustrative of the kind of dilemma a manager might face:

"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)

"It's a very fine line you see because I think that there's been occasions where members of staff have come in after quite a heavy night's drinking and smell of alcohol and I think it's a real balance of okay what do you say to people .... I mean clearly if someone looks inebriated and is very dishevelled, but there is kind of that fine line between are they or aren't they. You can have drunk into the night and come into work and still smell slightly of alcohol but does that mean that you can't do your work?"

(Health lead/manager)

The taboo surrounding the discussion of alcohol problems at work can be seen in the secrecy and protection offered by colleagues to a member of staff they suspect may have alcohol problems. Problems with an employee are sometimes only brought to the attention of managers when external factors directly affect the employee's ability to work, for example, disqualification from driving. The need for visible 'evidence' of an employee's alcohol problems is again indicative of a general lack of awareness of how alcohol might impair an employee's work performance in ways not immediately apparent to them, e.g. poorer reaction times and judgements.

Potential for disciplinary action

Although IBA training emphasises and reinforces the preventative role that screening provides, many respondents' perception of using the screening tool is primarily to diagnose and validate problematic drinking of which they already have some awareness, rather than using the tool opportunistically and preventatively to raise awareness of drinking at risky levels. An interviewee's comment below vividly encapsulates this common misperception:

"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)

Use of the metaphor, 'looking for fires' is indicative of more deep-seated motives underlying some managers' reluctance to administer the screening tool, for example, they may be fearful of the repercussions of misdiagnosing problematic drinking, which could lead to disciplinary action and the possibility of the person being stigmatised. Until the role of the screening tool is more fully internalised among managerial staff, then competing work demands are likely to prevail over opportunistic screening at work. So, when asked to consider handing out the screening tool more generally, one respondent suggested:

"I might do as an exercise to people, say to them 'do you know how much you, let's have a look at drinking and stuff'. But then again you must say as a manager I've got other things on my mind that I must deal with"

(Health lead – manager)

Appropriateness of work role

As already noted, the main concern after training for approximately one in six managers is about the appropriateness of their job role for introducing the screening tool and this is endorsed by comments from interviewees. Managers, counsellors and OH roles see OH as having a key role within an organisation in terms of screening and responding to alcohol issues by advising and supporting managers and HR, together with offering support to employees. OH therefore takes on not just an educative and mediating role but, importantly, one that facilitates discussion of alcohol in a neutral forum rather than within the department where the employee works. Notwithstanding this, some managers and health leads have found novel ways of introducing the screening tool into their workplace which overcome some of the barriers discussed.

Integrating IBA within the workplace

Findings from the literature suggest that the workplace is an ideal site for alcohol interventions (Roman & Blum, 2002; Hodgins et al, 2009; Webb et al, 2009) and our interviewees are found to be very receptive to integrating IBA into their workplace settings. One interviewee makes the following observation:

"The work place is an ideal forum for education ... particularly for the men, the men will not go to the GPs ... the men are very open to coming to us so either attending our sort of 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. "

(Occupational health)

Occupational health roles and some counsellors believe IBA can be incorporated into the advice and support they offer to managers directly, while some managerial roles, who might be resistant to screen and give brief advice themselves, recognise that to prevent issues arising in future, alcohol could be addressed as part of more general lifestyle assessments, for example, by incorporating it into policies concerning sickness and absence e.g. in return-to-work interviews or as part of new employees health assessments. It can be seen that IBA would provide a useful framework for thinking about and discussing alcohol in the workplace. Some interviewees, including OH roles and managers have incorporated IBA within return-to-work interviews and one public services manager had already noticed an improvement in attendance for two employees; a number intend to use it as part of their practice in future.

"I give people the right tools and the right information and then they have a choice about what to do and what we want is better health outcomes. Alcohol training fits in nicely there."

(Occupational health)

"I think as an organisation if you implemented it, or incorporated it into a policy around sickness, absence and say 'look this is a tool that you can use' and you educate people about it, it would be very, and if it becomes sort of part of the organisation, or the norm, that we sort of look at it in this way, that that would be terribly useful".

(Health lead/manager)

The prevailing way of thinking about and addressing alcohol issues in the workplace is one of problem-solving and the inherent barriers this attitude entails, therefore incorporating IBA within routine practices could help to shift existing attitudes from a problem-solving focus to awareness-raising and prevention. This would dovetail with the widespread view that alcohol awareness-raising is needed, in particular changing cultural, organisational norms around drinking. One suggestion with this aim in mind is to hold alcohol awareness-raising days in the workplace.

From an organisational perspective, interviewees feel that there is often a lack of guidance and procedures for dealing with alcohol problems at work, and problems are therefore approached on an ad hoc basis, as already noted earlier. This suggests that, at organisational level, policies need to be developed and to be actively implemented with clear consistent guidelines and pathways for support outlined.

"Sometimes in OH it can be quite hard to get sort of evidence, factual evidence to build your approach on, and I think these tools sort of help....to add that little bit of weight. But also I think it tends to mean that we are all singing from the same hymn sheet and assessing for the same criteria and so that's where I think it will help and that's where I think we will have changed in our approach."

(Occupational health)

4. Conclusions and recommendations

- Responses suggest that IBA half-day training successfully equips a range of workplace roles with greater knowledge of alcohol and its effects and provides practical, useable skills. Attendance at Lite sessions similarly enhances awareness of and reflection on both personal drinking habits and those of colleagues and others.
- Following training, people feel considerably more confident about giving advice about alcohol use with respect to the content and manner in which to deliver it. Training also creates greater awareness and knowledge of the support and treatment services available for alcohol problems. A general readiness to accept training as a useful professional resource is evident across the findings.
- Materials have been handed out by some respondents since training and a small number of them have given advice, most often in the form of a general discussion.
- There is currently some misapprehension about delivering IBA/using the screening tool opportunistically. This may reflect a wider IBA delivery issue in recognising that screening should not be targeted at those who are suspected of alcohol misuse, but routinely offered to all contacts, regardless of the practitioner's perceptions. Overcoming fears in asking about alcohol use may also be regarded as a key barrier for training to address.
- Among non-health roles, a problem-solving focus is evident which has implications for the ways in which they respond to screening and giving advice. Some failure among these roles to clearly distinguish IBA as an early intervention as separate from established problems needing disciplinary actions may be imperative. Incorporating IBA within routine health and well-being interventions could help shift attitudes around alcohol issues from problem-solving to awareness-raising and prevention.
- Role appropriateness for delivering IBA is a key factor. Genuine or appropriate opportunities to deliver routine IBA may be lacking for many workplace roles and managers; however ideas of delivery through 'Return to work' interviews or other health interventions were suggested. Nevertheless, real barriers exist for more general roles and managers to deliver IBA , largely that managers and staff question the suitability for delivering formal health interventions.
- There is general consensus that Occupational Health and counselling roles appear to be well placed to integrate IBA within their practice and the literature supports the idea of an expanded role for OH. Some have already incorporated IBA into routine practice, such as 'Return to work' interviews or 'lifestyle' checks, and the intention to use IBA among OH and counselling roles is high. OH must be supported to deliver IBA by ensuring they have the appropriate knowledge and skills – many were unaware of the appropriate tools and resources but keen to use them after training.

- A key role for OH can be seen in delivering IBA by advising and supporting managers and HR, and offering support to employees. Delivering IBA within OH services facilitates discussion of alcohol in a neutral forum.

- The literature suggests that a shift is required among employers and employees for them to realise the benefits of having a staff with improved health and well being. It suggests that IBA needs to be part of alcohol workplace policies within the context of a broader 'health & wellbeing' agenda.

- High-level organisational buy-in is needed to support managers and other workplace roles in the delivery of IBA. Alcohol workplace policies may be key to facilitating the delivery of IBA in the context of a 'health & wellbeing' agenda.

- Ways of addressing and trying to shift organisational and cultural norms around alcohol need to be found, together with raising the profile of alcohol more generally in the workplace. The literature suggests that social and behavioural norms around alcohol vary according to occupational roles and employment sectors; managers and professional staff are among those most likely to be drinking at risky levels. This further supports the idea that IBA should be included in alcohol workplace policies within the broader framework of health and wellbeing.

- Managers are currently seeking guidance from OH and HR on an ad hoc basis when responding to existing problems in the workplace; at organisational level, there is a general need for the development and active implementation of alcohol policies with clear guidelines and pathways for support that can be consistently applied.

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Appendix: Ratings on PRE and POST IBA training perceptions

Statements:	PRE Training (n = 195)			POST training					
				Full (n = 74)			Lite (n = 20)		
	Agree	Dis-agree	Mean	Agree	Dis-agree	Mean	Agree	Dis-agree	Mean
I feel the impact of alcohol is an important issue for workplace health and wellbeing	93%	5%	5.73	84%	14%	5.30	95%	0%	5.85
I feel I have a good understanding about alcohol and its effects	80%	8%	5.18	88%	10%	5.42	85%	5%	5.45
I have a good understanding of treatment services and support for people with alcohol problems	35%	41%	4.01	82%	14%	5.16	70%	15%	4.75
Within my job role, I feel confident to talk to and advise colleagues about alcohol use	38%	36%	4.20	81%	11%	5.15	65%	10%	5.05
I feel alcohol plays a significant role in many workplace problems	41%	17%	4.31	39%	27%	4.27	70%	10%	5.0
I have a good understanding about how to deliver effective alcohol interventions	20%	54%	3.48	70%	16%	4.78	60%	15%	4.65
I feel I can improve workplace factors and employee wellbeing by delivering alcohol interventions	49%	23%	4.35	65%	15%	4.61	60%	5%	4.85
If I identify a problem there are appropriate referral procedures and resources I can use	47%	18%	4.54	84%	12%	5.00	85%	5%	5.35