

Identification and Brief Advice (IBA) in sexual health settings: Briefing for Local Authorities

Rationale

There is growing concern within government, public health departments and the health service about the harmful impacts of increased levels of alcohol consumption in general, and the links with sexually transmitted infections and unintended pregnancies in particular. A recent report by the **Royal College of Physicians (RCP) and British Association for Sexual Health and HIV (BASHH), *Alcohol and Sex: a cocktail for poor sexual health***, presented the evidence linking alcohol use with poor sexual health outcomes, assessed the evidence for interventions designed to reduce the impact of alcohol intake on sexual risk behaviour, and considered the role of sexual health care settings in assessing alcohol intake and providing appropriate interventions.

In response to these developments, sexual health and alcohol misuse are now both priorities for national policy. There is evidence of a strong connection between the two issues:

- People aged 16-24 are among the highest consumers of alcohol (in the UK) and have the highest rates of sexually transmitted infections.
- Alcohol and sexual activity often go together, and although young people associate this with having fun, alcohol is significantly related to poor sexual health outcomes.
- 82% of 16-30 years report drinking alcohol before sexual activity
- Early alcohol use is associated with earlier sexual activity that is more likely to be regretted, and clusters with other risk behaviours, including smoking and drug use.
- 20% of white 14-15 year old girls report going 'further than intended' sexually when drunk
- Young people who are drunk when they first have sex are less likely to use a condom than those who are not drunk.
- There is increasing evidence for a relationship between alcohol use and teenage pregnancy, although more research is needed into causality.
- People who drink hazardously are more likely to have multiple sexual partners.

- Hazardous consumption of alcohol is more common in people attending genitourinary medicine (GUM) departments than the general population.
- Use of alcohol by both victim and perpetrator is common in cases of sexual assault.

Contemporaneous **Public Health Guidance from NICE** (*Alcohol-use disorders: preventing harmful drinking* report (2010 ref), emphasises that alcohol-related harm is a major public health issue and summarises extensive and robust evidence for the effectiveness of Identification and Brief Advice (IBA) in a number of settings, including A&E and primary care. With regard to sexual health services, NICE recommends that adults who have been identified via screening as drinking at hazardous or harmful levels should be offered structured brief advice on alcohol, by relevant trained professionals including those in sexual health.

The evidence for the effectiveness of interventions includes:

- 56 clinical trials which show that five minutes of structured motivational advice is effective in reducing the health risks and reducing drinking to below harmful levels in 1 in 8 recipientsⁱⁱ
- brief interventions in emergency and primary care are effective, and can reduce alcoholic consumption by 4-5 units a week

The firm conclusion from available evidence is that IBA is a simple, cost effective health intervention, which requires minimum staff training and is suitable for delivery in specialist and non-specialist settings. However, the RCP / BASHH *Alcohol and Sex* report concluded that the potential for collaborative working between the sexual health and alcohol intervention agendas had largely gone unexplored. The evidence suggests that there is a strong argument for holistically addressing alcohol and sexual risk simultaneously in sexual health settings.

Metrics (measures to assess implementation at service level)

% of all individuals attending a sexual health service who are screened for alcohol use in one year

Distribution of screening results (scores) including numbers screened (see recommendations)

% of screened attenders invited to receive Brief Intervention (see recommendations)

% of screened attenders who received Brief Intervention within the sexual health service

% of screened attenders referred to alcohol services a) directly or b) following Brief Intervention

Data Quality

Routine inclusion of the alcohol screening questionnaire, e.g. FAST AUDIT and results as part of the patient's electronic case record will enable the metrics above to be obtained easily, and related to individual sexual health data.

Organisations Delivery Setup

1. Directors of Public Health need to work with local Health and Wellbeing Boards to ensure that reducing the harmful effects of alcohol use among sexual health attenders becomes a **strategic priority for the health of the local population.**
2. Commissioners and sexual health leads need to **prioritise the integrated provision of alcohol IBA within mainstream sexual health services.**
3. All sexual health services should **provide information** that highlights the link between alcohol consumption and poor sexual outcomes and signpost sources of useful advice on drinking sensibly.
4. All sexual health services should **appoint a Lead** with responsibility for implementation of IBA and delivery of metrics.

5. Each service needs to **decide how to administer screening** e.g. by patient self-completion, or by specified staff groups (see recommendations).
6. All staff groups involved in identifying individuals at risk of harm through screening and all staff involved in delivering Brief Advice need **appropriate training** (see recommendations).
7. All services need to develop **robust pathways** for referral of patients identified as potentially able to benefit from more intensive intervention.

Evidence of Effective NHS Intervention

The effectiveness of IBA in sexual health settings

The effectiveness of IBA is based on utilising a “teachable moment”, where attendees are given cause to reflect on the behaviour that brought them into contact with any given service provider, be it A&E or the Criminal Justice Service. Clearly, being tested for an STD at a Sexual Health clinic provides an IBA practitioner with an obvious opportunity to capitalise on a “teachable moment”.

IBA is also readily applicable in both specialist and non-specialist settings. The report *Review of Identification and Brief Advice Interventions Across London* (June 2012), which was commissioned by the Department of Health, suggested that no more than half a day be given for IBA training, and cites the SIPS research programme which used a one hour session to train the practitioner cohort in IBA.

In addition, research suggests that integrating IBA within sexual health settings is far more likely to lead to a positive impact on alcohol misuse than engagement with specialist alcohol treatment services. It is reported that whilst 90% of sexual health clinic attendees who drank excessively were prepared to accept written advice, under a third were willing to accept an appointment with an alcohol, health worker, and only one attended for follow up. This suggests that addressing alcohol misuse within the context of an already existing issue – in this case reproductive and sexual-health related – might be a more effective strategy than referral to a specialist alcohol service. It is noted that young people rarely seek help directly related

to alcohol consumption, even when they are consuming alcohol at harmful levels. There are over a million attendances a year at GUM clinics in the UK, which, through embedding IBA, presents an opportunity to tackle harmful levels of alcohol consumption.

The economic case for sexual health and IBA

It is feared that the climate of austerity and government cuts have decreased awareness of safe sex messages and the risks of STDs. The last Chlamydia awareness campaign, called Sex worth talking about, was in 2010, and, under the health reforms, it will now become the responsibility of local authorities to dictate the public health agenda in their own area. Within the current funding context the Public Health preventative approach to health therefore becomes more important.

There is a strong economic argument for investing in measures to reduce teenage pregnancy and rates of STD transmission. Teenage pregnancies place significant burdens on the NHS and wider public services, costing the NHS alone an estimated £63m a year.

IBA within primary care and A&E has been shown to be cost-effective and in some scenarios, cost saving. Economic analysis by the University of Sheffield found that several examples of IBA in GP and A&E settings produce estimated cost savings. The analysis suggested that health and social service savings of £124.3 million may be realised over a 30 year time frame. Assuming that a GP and Practice Nurse deliver IBA to the same clinical standard there is evidence that a Practice Nurse is more cost-effective compared with a GP: £11.50 vs. £23.50 per 5-10 minute brief intervention.ⁱⁱⁱ

Recommendations/Top tips

1. Guidance favours the 'Alcohol-use disorders identification test' (AUDIT) a 10 item questionnaire which is regarded as the 'gold standard' screening questionnaire for detecting hazardous and harmful drinking. However, NICE recognises that the full AUDIT questionnaire has been considered too lengthy for use in routine practice. Thus several shorter versions comprising 1 to 4 questions have been developed, including FAST (AUDIT) which may be more suitable for sexual health services. For under 16 year olds, use clinical judgment as to appropriate screening.
2. Appropriate training in London is readily available, including direct contact training programmes through the Improving Access to Psychological Therapies (IAPT) programme and e-learning courses through the *Alcohol Learning Centre*. The Alcohol Learning Centre has developed three e-learning courses to support IBA in Primary Care, Community Pharmacy and in Hospital Settings. The Primary Care training is accredited by RCN and endorsed by the RCGP and RCP.

For further information and to access the e-learning courses:

<http://www.alcohollearningcentre.org.uk/eLearning/IBA/>

3. Develop guidance to have a collaborative commissioning approach for alcohol and sexual health linked to consequences of risk taking behaviour.
4. Commissioners should ensure service specifications and contracts for sexual health services include alcohol brief interventions and alcohol services undertake sexual health screening. This should include delivery monitoring to ensure effective and correct delivery of alcohol screening and training for practitioners.
5. Staff in both alcohol and sexual health services (statutory and voluntary) to be trained in screening and brief interventions. This will require resources in relation to commitment, training and time.

6. All clinicians providing sexual health services should be trained to refer patients for further support, including local alcohol services.
7. Deliver integrated training and integrated clinics across sexual health and alcohol services.
8. Sexual health services should provide information that highlights the link between alcohol consumption and poor sexual outcomes and signpost sources of useful advice on drinking sensibly.
9. Alcohol information pamphlets being provided to sexual health clinics.
10. DsPH should provide briefing and facilitate the embedding of sexual health and alcohol interventions within HWBB Strategic Priorities and JSNA recommendations.

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ⁱ Royal College of Physicians (RCP) and British Association for Sexual Health and HIV (BASSH)
Alcohol and Sex: a cocktail for poor sexual health. Report of the Alcohol and Sexual Health Working Party.
London: RCP, 2011
http://www.rcplondon.ac.uk/sites/default/files/rcp_and_bashh_-_alcohol_and_sex_a_cocktail_for_poor_sexual_health.pdf

ⁱⁱ Moyer, A., Finney, J., Swearingen, C. and Vergun, P. (2002) *Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment seeking populations*, *Addiction*, 97, p.279-292.

ⁱⁱⁱ North West Public Health Observatory (February 2011) *A review of the cost-effectiveness of individual level behaviour change interventions*, p.17:
<http://www.nwph.info/nwpho/Publications/HEALTH%20%20.pdf>