LONDON HEALTH IMPROVEMENT BOARD

Alcohol early intervention and prevention:

The London Leadership Summit Event

11th January 2013

The Royal College of Obstetricians and Gynaecology, 27 Sussex Place, London NW1 4RG

Summary

The London Leadership Summit took place on the 11th January 2013, providing an opportunity for London's senior leaders to come together and discuss the importance of prioritising prevention of alcohol harm. The event was designed to offer senior decision makers the opportunity to review the need for alcohol prevention activity and the options for intervention, particularly through the delivery of Identification and Brief Advice (IBA) amongst front line staff.

IBA is a potentially highly effective and cost effective intervention – however to achieve population level gains in London, widespread and sustained implementation across a range of settings will be required. Engagement by senior leaders will be essential in achieving this as the challenges to implementation should not be underestimated.

The summit was organised by the shadow London Health Improvement Board (LHIB) as part of their programme of activity aimed at helping balance London's relationship with alcohol. Delegates received a comprehensive pack including information about IBA, the evidence base supporting this intervention and available resources.

The Summit – event overview

The leadership summit was introduced and chaired by Professor Paul Wallace who welcomed the evident interest by senior leaders in the implementation of IBA across London and expressed the wish that the day's event would strengthen the commitment to raise awareness and promote the use of IBA in their own organisations.

A key theme included the need to harness a multi-disciplinary, multi-sector approach to the delivery of IBA. There are real opportunities presented by the changing public sector landscape. The move in April this year of Public Health into Local Authority arenas could enable better links between different agencies, as could the emergence of the new Clinical Commissioning Groups (CCGs).

The Summit would include contributions from internationally renowned speakers to review the evidence base for IBA in different settings and explore the scale and nature of the issues to be addressed. Crucially, overcoming the barriers to

implementation, supporting staff to deliver IBA and the potential for internet based delivery of IBA were key topics for consideration.

Victoria Borwick, Deputy Mayor for London and Chair of the Health and Public Services committee, Greater London Assembly (GLA), provided background to the LHIB alcohol work strand and reminded the conference about the Mayor's priorities around alcohol including the promotion of IBA.

Geese Theatre Company

Geese Theatre Company were commissioned to provide a number of interactive 'IBA scenario' performances within the programme, designed to provoke reflection and debate amongst the delegates about the barriers to implementation. They energised the audience and injected something different into the event, providing a balance with the formal presentations.

The Geese performances explored the issues likely to be encountered in different settings such as Accident and Emergency departments or Probation services. They involved the audience in scenarios relating to some of the barriers, particularly perceptions about 'whose job IBA is' and concerns about having 'alcohol conversations'.

The activities highlighted the need for training, time, embedding IBA into practice, discussions with colleagues, support from a network and locally relevant resources. Contributions from the floor also identified the need to identify local 'IBA champions' to encourage implementation, the chance to practice using IBA in part of a conversation with service users, and shifting the culture to address alcohol misuse prevention as part of everyday practice.

Setting the scene – Clare Gerada

Dr Clare Gerada, Chair of the Royal College of General Practitioners, spoke to the summit of the key role that GPs have in the NHS. Up to 80% of all activity in the NHS takes place in primary care settings, making GPs the foundation of health care provision.

The frequency of patient GP consultations provides unique opportunities for prevention, but Clare pointed out that there are serious conflicting demands on GPs' time. She asked the audience to understand the need to set frequent statements that GPs '… need more training' against the massive overall burden and current expectations of their other responsibilities. Thus the benefits of preventive approaches must be balanced against the very real challenges of asking over-burdened doctors to do more.

The RCGP already trains GPs with a certificate in substance misuse which includes alcohol misuse, but Clare acknowledged that skills need to be developed more widely and further.

Overview of IBA – Professor Nick Heather

Professor Nick Heather, emeritus professor of alcohol and other drug studies at Northumbria University gave a presentation covering the basis of brief intervention, some of the common misperceptions and a history of its development.

Professor Heather explained that alcohol brief intervention involved the following characteristics:

- Delivered by non-specialists (i.e. not by drug or alcohol workers)
- Is for people ***not*** seeking help for alcohol
- It is 'brief' – typically not more than 5-10 minutes
- Recipients are generally non-dependent drinkers
- The goal is to moderate drinking, not abstain
- The approach normally includes some self-help materials
- It is an 'early intervention', not a 'treatment' approach

The theoretical underpinning for IBA includes cognitive behavioural techniques, motivational interviewing and simple structured advice. However although there is extensive evidence that IBA is efficacious when delivered well, less is known about how is actually works. Even the common delivery principles of FRAMES taught for IBA have a limited evidence base.

Table 1: 'FRAMES' – well known for IBA delivery, but not an exact science

Feedback - clarifying the problem
Responsibility for change - rests with the individual
Advice – information offered on the benefits of cutting down
Menu of Options – possible strategies to help cut down
Empathy – understanding a person's circumstances
Self efficacy – building confidence in their ability to change

Professor Heather emphasised that as a public health measure, IBA could only be effective if implemented widely. A number of "top down" and "bottom up" measures would need to be taken to implement IBA successfully, and these would most likely include appropriate forms of incentivisation. IBA would need to be implemented as one component of a set of overall measures which should include reducing availability of alcohol and increasing price in order to address national level harm.

Although the evidence for IBA is currently strongest in primary care, he pointed out that the 'precautionary principle' is a valid consideration for applying IBA in other settings too. This principle takes the position that we should adopt an approach even though it may not be shown to be effective when there is a significant risk of a negative effect by not doing so.

Application and practice – Colin Drummond SIPS findings

Professor Colin Drummond, Professor of addiction psychiatry at the National Addiction Centre, Kings College London gave a presentation that covered the key findings from the SIPS Primary Care research trial, which were recently published in the BMJ.

The research sample included nearly 2,500 people from three settings in primary care, accident and emergency departments and criminal justice settings. The design of the research was a pragmatic randomised controlled trial (RCT) using three different interventions:

1. Feedback [of screening result] + Patient Information Leaflet (PIL)
2. Feedback + five minutes of structured advice using the SIPS brief advice tool + PIL
3. Feedback + 20 minutes of 'Brief Lifestyle Counselling' (BLC) + PIL

Findings from the research showed that targeted IBA (delivered to selected patients with an increased likelihood of risky drinking) was most cost effective but missed up to 80% of people drinking at risky levels who would have been identified by universal screening.

All intervention approaches in primary care were associated with reductions in risky drinking levels of between 15% and 20% at the 12 month follow up stage – the differences in outcomes between the different groups were not statistically significant. The simplest intervention - feedback+ patient information leaflet - was found to be the most cost effective approach in Primary Care.

Particular difficulties were encountered in recruitment of staff to deliver IBA in A&E settings and therefore specialist staff had to be drafted in to deliver sufficient interventions for the study. Effectiveness was similar to primary care in that simple advice and a leaflet was as effective as other approaches, but with the caveat that specialist staff had to be provided to deliver it.

In probation settings, re-offending rates appeared to be affected by the more intensive intervention, and again, implementation only appeared more feasible with specialist staff. A similar effectiveness in reducing risky drinking levels was demonstrated between each approach as in other settings.

Professor Drummond noted that 'knock-on effects' for treatment services will need to be considered where IBA is implemented; for example, dependent drinkers will be identified in the process and they will need to be referred to specialist treatment services.

IBA and the workplace – Don Shenker

Don Shenker, director of the Alcohol Health Network highlighted in a presentation that the health of the workforce affects bottom line profits and performance of businesses and that although lifestyle issues were addressed in some workplace

settings, very few showed evidence of delivering IBA as part of this. He went on to say that although some workplaces dealt well with issues of dependence, very few adopted any kind of preventive practice. Yet the workforce is an ideal setting in which to deliver IBA with clear potential cost benefits to business in addressing alcohol misuse.

There are currently a small number of studies showing effectiveness of IBA in the workplace from the UK and internationally. UCL has undertaken some research to look at the effectiveness of online IBA which indicates the potential to reach a higher number of people. Don is involved in workforce online IBA pilot studies the North East and in South West London due to start in March 2013.

IBA and the Probation perspective

Heather Munro, Chief Executive of London Probation Trust (LPT) gave a presentation in which she stated that LPT deals with over 70,000 offenders per year. 36% of these offenders report alcohol problems, although other studies and assessment would indicate a significantly greater problem. Alcohol issues predominantly show themselves in violent offending.

Probation clients also have a higher levels of other health and social problems such as mental health problems, drug misuse and homelessness which also tend to have a significant impact on their offending behaviour.

LPT is currently delivering IBA training within its workforce and nearly all staff are now trained. LPT also works closely with treatment providers through the delivery of Alcohol Treatment Requirements (ATRs).

To promote the use of IBA, LPT has operational 'IBA champions' in its teams. Delivery and quality are monitored with incentives for teams delivering the highest level of IBA activity. Data from the monitoring is being used to inform local Joint Strategic Needs Assessments (JSNA) and Health & Wellbeing plans.

IBA and the Local Authority perspective

Councillor Bernice Vanier, Cabinet Member for Health and Adult Services for Haringey Council gave a presentation in which she stated that Haringey has some of the most entrenched health inequalities in the country associated with high levels of deprivation. Haringey has a high level of alcohol-related hospital admissions and high levels of alcohol-related fire deaths and injuries.

Haringey recognises that alcohol affects a number of key cross-cutting issues such as anti-social behaviours, domestic violence, mental health problems and safeguarding - all of which are council priorities. Haringey's Health and Wellbeing Board (HWB) strengthens the focus with a local JSNA and HWB strategy providing political leadership, with input also from the newly formed Clinical Commissioning Groups (CCGs).

Haringey has had a comprehensive local alcohol strategy to tackle the issues for a number of years, with significant local investment in treatment including the Haringey Advisory Group on Alcohol (HAGA). In addition, a number of services have been commissioned, for example:

- IBA in hospital liaison services
- IBA in GP surgeries
- IBA included in health checks in the east of the borough(the most deprived area)
- CQUIN in A&E
- An IBA training programme
- An online screening tool has been developed called 'Don't bottle it up'. It is embedded into the council website and being promoted as part of the wellbeing programme

Significant challenges face local authorities at this time of economic pressure and the council will need to maintain focus within a context of dwindling resources. Pressures include having to compete for resources and funding with other council priorities, embedding IBA within mainstream services such as A&E and primary care, ensuring good practice is delivered and keeping up morale. Despite these challenges there are real opportunities for local authorities to make a difference through the transition of public health teams to the council. In addition there are opportunities to address public health issues within licensing arrangements and addressing the cumulative impact of licensed venues.

Workshops

The afternoon session provided an opportunity to attend one of six workshop sessions. These have been summarised below mainly from the presentation slides.

1. Systematic review of IBA across London

Mark Napier from Centre for Public Innovation and John Currie from Gecko Social Health Outcomes undertook a review of IBA delivery in London across a range of settings. The concise review can be found here.

The research aimed to establish the level of delivery of early interventions for alcohol and identify barriers and facilitators to support LHIB to improve IBA implementation in a variety of settings. It was found that IBA was reportedly being delivered in 91% of boroughs (73% return rate). Primary care, A&E and hospital wards were the most commonly identified settings.

Key themes of the report identified:

Prevention and treatment: different but not separate: IBA is often not recognised as an effective intervention in its own right but rather as a route into treatment.

Understanding of IBA, EBI and other terms: A lack of clarity about key terms – in particular the conflation of IBA and EBI (Extended Brief Intervention). This included those involved in the commissioning of alcohol services.

Data collection and tracking: systems in non-specialist settings do not integrate with mainstream systems and are likely to be of limited use.

The **facilitators** for IBA implementation identified were:

i. **Contextualising the evidence base**: summary of evidence-base aimed at commissioners demonstrating impact on local services. A local evidence-base is not needed

ii. **Individual champions:** IBA delivery can be galvanised by individuals who drive forward the agenda

iii. **Strategic and organisational commitment:** mainstreaming IBA into non-specialist settings relies on organisational commitment and recognition of benefit of this agenda for their own strategic aims

iv. **Incentivisation**: successful delivery is linked to incentives such as CQUIN or DES but requires effective performance monitoring.

2. Alcohol Intervention & prevention in Scotland's criminal justice settings

Dr. Lesley Graham & Andrew McAuley presented the pilot project in Scotland to determine the feasibility and effectiveness of delivering screening and Alcohol Brief Intervention (ABI) in the community justice settings of probation and community service.

Follow-up rates within the study were low and insufficient to tell anything meaningful about the impact of the intervention, however some useful points were highlighted by the qualitative findings in the research:

- The criminal justice setting offers an opportunity to intervene with an otherwise hard to reach population.
- ABIs have potential to be effective in CJ settings in addressing a range of outcomes, both health and justice.
- Although evidence is limited as to their effectiveness, ABIs *can* be accommodated into routine community justice practice.
- Community Justice clients are eligible and willing to consent to ABI if they are drinking at harmful and hazardous levels.
- CJ staff have expressed contrasting staff views on the feasibility of using ABI in practice.

3. Evidence for alcohol intervention and prevention (case studies)

Dr Lars Møller, from the World Health Organisation led a workshop which gave an overview of alcohol health harms globally and across Europe – presentation here. The European Region has the highest alcohol consumption and European alcohol intake is about double the Global average. However there are significant differences in consumption between European countries.

A European Action Plan to reduce the harmful use of alcohol 2012-20 has been published which includes 10 action areas; one of which is **Health services' responses**. These responses are central to tackling health conditions in individuals caused by harmful alcohol use. Evidence-based health services responses include the implementation of early identification and brief advice in primary care, social welfare settings and accident and emergency departments, and also offering brief advice programmes in the workplace and in educational environments.

Just over half of EU countries currently offer Brief Advice programmes but fewer provide training for professionals on IBA approaches.

4. IBA Practitioners Network

James Morris from the Alcohol Academy ran on the new London IBA Network for front line roles – presentation here. The aim of the network is to support tier 1 (i.e non-specialist) staff to do IBA through:

- Improving knowledge and IBA delivery skills
- Increasing the implementation of IBA at London level
- Access to resources and support for IBA delivery
- Assisting the overall objectives of the LHIB alcohol priority to reduce alcohol harm at a London level

The network intends to secure commitment from tier 1 staff to act as local leaders for IBA delivery. However a number of **key challenges** exist including:

- Most front line roles (practitioners) are still unaware of IBA, its benefits and who should do it.
- Practitioners already have a lot to do
- Access to local training & resources is variable
- Practitioner fears about asking about alcohol & potential for resistance
- Lack of organisational support

The network aims to address many of these challenges by allowing members to access:

- Events and seminars focusing on IBA skills, confidence and implementation
- Newsletter and updates

- Online forum (trial phase)
- Informal support to members
- Action Learning Sets
- Access to IBA materials and resources

5. Personal relationships and talking about alcohol

Lauren Booker from Alcohol Concern ran a workshop which addressed how to start the conversation about alcohol – presentation here. Lauren provided practical advice and examples of where and how to start the conversation and using FRAMES model for delivering structured 'brief advice'.

In order to make IBA happen, 5 essential factors were suggested:

- Confidence
- Management support
- Policies and protocols for delivery
- Availability of leaflets/information
- Relationship with local alcohol services

6. E-IBA: Developing an internet based portal to support the delivery of IBA across London

Professor Paul Wallace facilitated a workshop about work planned to develop an internet based IBA tool – presentation here.

The vision is to create ".. *an interactive on-line system or resource for Pan-London use across a range of settings, which would support frontline staff, decision makers as well as members of the public in the delivery of IBA.*"

It would address identified gaps in the delivery of IBA by:

- Developing an online platform providing readily available information, tools and training for delivering IBA.
- Utilising existing resources such the RCGP's e-Learning package as well as the Alcohol Learning Centre.
- Providing an online platform to support the needs of practitioners in delivering IBA in the context of health care, local authority/social services and criminal justice
- Developing an easily accessible platform for any member of the public wishing to assess their own alcohol consumption.
- Drawing input from practitioners to ensure that it will meet their specific needs and requirements.
- Providing decision makers with a robust evidence base for IBA.

Final panel discussion

The final session of the afternoon was facilitated by Will Tuckley, Chief Executive at Bexley borough council and LHIB SRO. Will summed up the issues that had been raised during the day and emphasised the need for 'IBA champions' to drive forward the agenda both at a senior and operational level.

He pointed out the need to work collaboratively and the opportunities inherent within the move of public health teams to local authorities. Will also emphasised that economic pressures meant that a good business case would be needed to secure appropriate resources for IBA delivery.

He noted that awareness of alcohol issues and IBA in particular needs to be raised both with the public and professionals via tailored messages to specific groups.

A panel was drawn from the speakers and audience and two questions put to them:

1. 'What are the biggest barriers to IBA delivery', and:
2. 'Suggest one idea to overcome the barrier'

The panel's responses are summarised below:

- To address barriers of involvement of the voluntary sector; there is a need for dedicated time, resources and incentives
- Many GPs lack awareness of IBA; more engagement in training and the inclusion of IBA markers within the Quality Outcomes Framework (QOF)
- There are significant difficulties in introducing IBA into established hospital routines; 'convincing' staff of value of IBA is key to get them on side
- A key challenge is to ensure recognition of IBA as 'everyone's business'; removing the perception that alcohol is a "specialism"
- Challenges to implementation in A&E departments are not to be under-estimated; having a champion to keep up the 'nagging/nudge' is needed

Twitter discussion

A Twitter discussion took place during the day, using the #LondonIBA hashtag to bookmark tweets. Tweets mainly summarised key information, statements and ideas from the presentations and discussions. Highlights can be found here via Storify.

Conclusion

The London Leadership Summit symbolised the clear commitment to improving alcohol early intervention and prevention at a pan-London level. IBA is effective and simple, but there are many significant barriers to its routine delivery. The level of attendance and the quality of discussion at the Summit indicated the growing recognition at senior levels of the importance of this prevention agenda. But the Summit also illustrated the scale of the challenges facing its translation into routine activity, and the delegates left the meeting in no doubt that both commitment and

imagination will be needed if the strategic approach to London-wide IBA delivery is to achieve a successful outcome.