ChaMPs public health network

Alcohol Concern
Consultancy and Training

Report of an Alcohol Identification and Brief Advice Training Needs Analysis across the North West Region

Cheshire and Merseyside Report

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Contents

Introduction

The aim of this report is:

- To provide the Public Health Networks of Greater Manchester, Cumbria and Lancashire, and Cheshire and Merseyside with a training needs analysis to assist the planning of systematic alcohol identification and brief advice training in 2009/10 and beyond.

The objectives of this work are to:

- Undertake a Training Needs Analysis
- Develop a Training Tool
- Develop a Training Plan

The training needs analysis is based on a questionnaire which was sent to 21 local authority areas. It should be noted that after discussion it was agreed to treat St Helens and Halton as one partnership, because all their work was joint. The form was completed by a range of different officers within the partnerships (see appendix 1). All areas returned a questionnaire.

The professional groups focused on in this report were chosen partly on the basis of the advice in the Department of Health's *Review of the effectiveness of treatment for alcohol problems*[1] and in part as a result of discussions with the commissioners of the research.

The analysis is being presented in four separate versions:

- A regional overview report
- Greater Manchester report
- Cumbria and Lancashire report
- Cheshire and Merseyside report

Each report is presented in exactly the same way but records and reviews a different dataset.

Each report covers the following themes:

- Overview for the area covered
- The data for the area covered
- Barriers
- Comments from other agencies
- Developing a training tool / plan
- Appendix

Following a first review of the information gathered, the ChaMPs commissioners asked for further insight to be gathered from key stakeholders in Cheshire and Merseyside. The additional information is included in appendix 4.

Methodology

The contents of this research report are based mainly on a series of questions specified and agreed by the lead commissioner. These questions were put to a

series of identified local contacts (see appendix 1). The questions could be answered in the form of written responses to a questionnaire (see appendix 2) or answered in a telephone or in a face to face interview. The majority were completed as written returns. This data was then analysed by Alcohol Concern and turned into a draft report. This was sent out for comment to regional leads and the report was adjusted in a number of ways as a result. Desk research was undertaken to produce the latter sections of the report on ideal models for Identification and Brief Advice training.

The data used in this study covers the period 2007-9. It is recognised that while significant efforts have been made to capture all local IBA activity, the information may not be reflective of all activity currently taking place.

Partnerships

It was agreed by the lead commissioner that the basis for this research would be the Drug and Alcohol Action Team partnership boundaries. These are coterminous with the local authority areas. This was chosen in preference to the PCT boundaries because it was felt that more work related to alcohol would be commissioned on this basis.

However, it is recognised that the DAAT partnership itself may not be the strategic driver for future change. The lead may come from the PCT, the Local Strategic Partnership or the Local Authority. In talking about future action this report still uses the term “partnership” but recognises that other bodies may take the lead.

Acknowledgements

We would like to thank all the respondents and interviewees for their help with the project. We would also like to thank Paul Keeling, Lifeline and all the commissioners – Mike Jones (lead commissioner), Alison Farrar, Carol Johnson-Eyre, Paula Hawley-Evans and Alison Wheeler.

Section 1

Executive Summary – Cheshire and Merseyside

Introduction

Alcohol is a major cause of health, social and criminal justice problems in the North West. The region has the highest rates of alcohol specific mortality for both men and women. Liverpool and Halton are among the top ten areas for alcohol related harm in the country according to the North West Public Health Observatory. It is recognised at national, regional and local level that action is required to tackle alcohol related harm.

A national indicator (NI39 / Vital Signs 26) to measure change in the rate of hospital admissions for alcohol related conditions has given further impetus to tackling this problem. An essential factor in the achievement of these aims will be the widespread identification of those who are drinking at harmful levels and the delivery of brief advice by a range of professionals in a number of different settings. This is one of seven "High Impact Changes" set out by the Department of Health. [2]

A large body of research evidence supports the effectiveness of Identification and Brief Advice (IBA) in primary care including at least 56 controlled trials. For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels. Patients who received IBA in Accident and Emergency made 0.5 fewer visits to the unit during the following 12 months.[3] However, these changes should not be limited to primary health care and hospitals, the Department of Health also flags up the importance of targeting mental health, criminal justice and social care.[4]

Alcohol Concern was commissioned to provide the Public Health Networks of Greater Manchester, Cumbria and Lancashire, and Cheshire and Merseyside with a training needs analysis to assist the planning of systematic alcohol identification and brief advice training in 2009/10 and beyond. This research has looked at the extent to which IBA training is happening across North West England and made appropriate recommendations.

Recommendations

This report sets out its recommendations in the form of a training plan based on the findings of this research. This plan is generic and sets out the steps that need to be taken by an area which is starting from scratch. It is impossible to develop a single specific training plan for the region or the three areas because each partnership is at a different stage of development. The following sets out 11 stepped recommendations which can be followed to develop a robust approach to Identification and brief advice.

1. Each partnership should identify the provision of identification and brief advice as a strategic priority and that training local Tier 1 staff is a local objective
2. Each partnership should consider whether to establish a LES
3. Each partnership should be encouraging the use of the DES
4. Each partnership should agree which screening tools are to be used
5. Each partnership should consider the priority groups of Tier 1 staff for which IBA training will be provided. These should take into account the priority groups identified by the D
6. Department of Health which include primary care, general hospitals, accident and emergency, mental health, criminal justice services and social services.[5]

A Training Needs Analysis tool is included in Appendix 2 and could be developed for use with particular staff groups. Other Training Needs Analysis tools may also be available.

7. Each partnership should identify how training will be provided for each priority group. A range of methods of delivering training should be considered to maximise the staff reached. This should include one day training, half day training and elearning due to issues in releasing /covering staff.
8. Each partnership should identify the resources to provide the training. This should be done in the light of the Department of Health's *Guidelines for the commissioning of Identification and Brief Advice (IBA) training.*[6] Partnerships should also look at the NW focused commissioning guidance, 'Commissioning training for behaviour change interventions: evidence and best practice in delivery, Powell & Thurston 2008'. http://www.nwph.net/champs/Publications/Behaviour%20change/Commissioning%20training%20for%20behaviour%20change%20-%20full%20report%20-%20autumn%202008.pdf
   Interagency collaboration on commissioning and resources will also support this recommendation.
9. Each partnership should identify how training will be provided for each priority group and commission the training.
10. Each partnership should establish monitoring and evaluation systems for the training and ensure that a consistent record of people and professions trained is kept. Measurable outcomes should be developed to ensure that IBA work is undertaken.
11. Each partnership should identify how ongoing support will be provided for those who have received training
12. Each partnership should identify what refresher training will be provided for those who have received training

In Cheshire and Merseyside it is particularly recommended that:

13. *Work should be undertaken to ensure that all areas have policies or strategic statements which identify the roll-out of Identification and Brief Advice.*
14. *Further encouragement is given to ensure that Local Enhanced and Directed Enhanced Schemes to tackle alcohol are in operation across all PCT areas.*
15. *IBA training needs to be rolled out generally but in particular, prison, social care, secondary health care and job centre staff have all been insufficiently targeted in the area.*
16. *Partnerships need to develop monitoring, evaluation systems and ongoing support systems for IBA and IBA training.*

Summary of the results of the TNA

The majority of partnerships had a strategic aim to provide alcohol identification and brief advice (IBA) training.

A majority of the partnerships have commissioned IBA training, but 2 of the 7 had not commissioned training. 4 partnerships said they did not have any contracts in place to

provide IBA training after 2009/10. The other partnerships demonstrated a range of plans for further training.

3 of the 7 partnerships had a complete record of participants and their roles. In total the partnerships identified 2339 people who had been trained Since April 2007. This included the following professionals:

- 394 GPs and other primary care staff.
- 150 Accident and Emergency.
- 133 secondary care staff.
- 54 probation staff.
- 124 pharmacy staff.
- 51 police staff (and 26 magistrates in one partnership).
- 92 drug workers.
- 40 voluntary sector staff.
- 4 Job Centre staff although very few partnerships had addressed this area.
- 50 social care staff.
- 262 housing staff.

No partnerships identified any training of prison staff, although one partnership had plans to target this group. 2 partnerships had targeted employers for training: 1 said that it was considering such training for next year.

Given the varying size of the areas and the lack of data on the actual number of staff in each group, it is hard to draw specific conclusions about these numbers, however, the numbers of social care staff appears low and the lack of training in prisons is obvious. At the very least these numbers suggest much training is still required.

A variety of trainers were identified by the partnerships, of whom the most commonly used provider was HIT who were providing training for 2 partnerships. The other partnerships were using a variety of local services and 1 had a full time trainer. The research asked about the costs of training per one day session, however, the information was too varied to provide an average figure.

Almost no other training was identified by partnerships. Only 1 partnership identified other pieces of training. In the same way very little other related activity was identified by partnerships.

The majority of partnerships reported having some method of monitoring the impact of the IBA training. However, the methods varied immensely and no standard approach to monitoring exists. The majority of partnerships also identified some kind of ongoing support. However, again no standard approach to follow up was identified. Plans to refresh training were also variable.

6 (out of 7) partnerships either said they did not have a Local Enhanced Scheme (LES) or did not know about a LES. More partnerships provided a positive response about the

implementation of the Directed Enhanced Scheme (DES). 4 had DES schemes in operation. All the partnerships that provided information identified AUDIT or one of the shortened versions of AUDIT as the local screening tool.

Alongside the main review a selection of nine partnerships across the whole region were asked for their views on the barriers to implementing IBA training. In addition the review itself identified a number of barriers. The message from both these sets of comments was very clear. There are two key problems to implementing IBA training.

- A lack of financial resources for some partnerships, particularly those who were not selected as Early Implementer sites.
- Problems in releasing staff from work to attend training. A&E staff and GPs were specifically identified.

Section 2

The Responses to the Training Needs Analysis

2.1 Is there a local policy or strategic aim to provide IBA training?

The majority of partnerships had a strategic aim to provide IBA training. 1 partnership did not answer the question.[7] A number of partnerships identified the location of the strategic aim. In general these were the local alcohol strategy.

Alcohol Service Plan agreed with the PCT[8]
Draft strategy[9]
Alcohol strategy.[10]
Alcohol strategy[11]
Part of our Programme Plan – Mandate Progress Report [12]
Yes[13]

2.2 Do you have a LES operating in your partnership area?

Partnerships were asked whether they had a LES operating in their area. Answers were more negative then positive: only 1 had a current scheme. 2 said they did not have a scheme or did not respond. 1 partnership said its scheme was under development and another had a scheme for part of its area but was developing one for the other half. Another referred to the DES instead of the LES. These negatives included one where the scheme had been suspended.

Have DES - if a GP practice conducts mini audit they receive a small fee £2.33[14]
Under development[15]
No response[16]
One is currently operating in Western Cheshire PCT and one is in the planning stage in Eastern Cheshire PCT [17]
No – was but currently suspended[18]
No[19]
No[20]

2.3 How is the DES being rolled out in your area?

3 out of the 7 partnerships either did not have a scheme (1), did not respond (1) or did not know (1).

Done directly with practices through a consortia. Primary care practices over 4 PBC areas[21]
56 practices – monitoring done by PCT T&D dept[22]
Rolled out January 2009 no data as yet, being recorded on quarterly basis, built into GP systems[23]
Information was not available from Western Cheshire PCT. Within Eastern Cheshire, 30 out of 52 practices have signed up to the DES and approximately 25 of these have actually screened people. This has not been monitored as of yet as it is in its infancy.[24]
No response[25]
No scheme in place[26]
No response[27]

2.4 What tool or tools are being used for IBA in this area?

All the partnerships who provided information identified AUDIT or one of the shortened versions of AUDIT as the local screening tool. 1 partnership did not provide information.

AUDIT used within primary care[28]
AUDIT main one AUDIT C can be used[29]
AUDIT C[30]
AUDIT[31]
FAST and AUDIT[32]
No information[33]
AUDIT and AUDIT C[34]

2.5 Has the partnership directly commissioned any alcohol IBA training?

The majority of partnerships have commissioned IBA training.

To be commissioned[35]
Indirectly as part of ADS contract and A&E liaison project[36]
A full time trainer has been employed[37]
We have commissioned a GP to deliver a number of sessions[38]

2.6 Do you have any contracts in place to provide IBA training after 2009/10?

4 partnerships said they did not have any contracts in place to provide IBA training after 2009/10.[39] The other partnerships demonstrated a range of plans.

No – St Helens have used tier 4 provider Merseycare NHS Foundation Trust to provide training as when and they don't pay. [40]
No[41]
No[42]
Yes SATINS (Sefton Alcohol Treatment Intervention Nursing Service) [43]
Post will 18 month post, finishes March 2011[44]
From April 2009, 15 training sessions have been booked[45]
No[46]

2.7 Do you have a complete record of the participants and their profession / role?

3 of the partnerships had a complete record of participants and their roles, 4 answered no. [47] [48] [49] [50]

2.8 How many people have received training in each year?

In total the partnerships identified 2339 people who had been trained over the last two and a half years.

2007/8?	**2008/9**	**2009 to date**
112[51]	787[52]	38[53]
Unknown[54] see note 2	Unknown[55]	Unknown[56]
0[57] see note 1	58[58]	0[59]
0[60] see note 1	166[61]	0[62]
April – April 424[63]	April – April 536[64]	April – present 98[65]
0[66]	0[67]	0[68]
40[69]	80[70]	0[71]

Note 1: These two partnerships responded negatively to this question but in later questions identified groups trained. The total identified in other questions has been attributed to them.
Note 2: This partnership provided no figures for numbers trained but indicated that training had occurred but had no data.

2.9 How many GPs have received IBA training since 2007/8?
In total the partnerships identified 138 GPs and other primary care staff who had been trained over the last two and a half years.

16[72]
58[73]
N/A[74]
6[75]
3 surgeries 18 staff[76]
0[77]
Training will be starting in July officially, DAAT training delivered to approximately 40 GPs in Western Cheshire [78]

2.10 How many Other Primary Care Staff have received IBA training since 2007/8?
In total the partnerships identified 256 other primary care staff who had been trained over the last two and a half years.

187[79]
No response[80]
N/A[81]
N/A[82]
39 = 9%[83]
0[84]
30[85]

2.11 How many Accident and Emergency Staff have received IBA training since 2007/8?
In total the partnerships identified 150 staff who had been trained over the last two and a half years.

36[86]
0[87]
50% - difficulty getting access to time off for training. Some of this has been ad-hoc on the job training. This is being reviewed and a training policy being worked on by the Acute Trust[88]
34 = 8%[89]
0[90]
Training has begun but no numbers held in Western Cheshire, similar in Central and Eastern Cheshire [91]
80[92]

2.12 How many Secondary Healthcare staff have received IBA training since 2007/8?

In total the partnerships identified 133 secondary care staff who had been trained over the last two and a half years.

93[93]
0[94]
0[95]
Ad hoc training of acute trust staff by alcohol liaison nurse [96]
N/A[97]
40[98]
Training has begun, but no numbers held[99]

2.13 How many Probation staff have received IBA training since 2007/8?

In total the partnerships identified 54 probation staff who had been trained over the last two and a half years.

15[100]
4[101]
0[102]
Working with probation. Alcohol treatment requirements work is in progress but numbers probably small: 6-8. 20 in total in last three years, trainers were both from the Windsor Clinic, the local Tier 4 provision.[103]
N/A[104]
28 staff 100%[105]
All probation officers have been trained in IBA but numbers are not available[106]

2.14 How many Pharmacy staff have received IBA training since 2007/8?

In total the partnerships identified 124 pharmacy staff who had been trained over the last two and a half years.

16[107]
0[108]
No – working with colleagues in pharmacy at the moment to see if this is the appropriate way to go – pharmacists needing payments maybe an issue to take this forward [109]
3[110]
None but will be part of new project [111]
105 = 25%[112]
Not known, possibly 0[113]

2.15 How many Police staff have received IBA training since 2007/8?

In total the partnerships identified 51 police staff and 26 magistrates who had been trained over the last two and a half years.

51[114]
0[115]
0[116]
N/A[117]

Magistrates 26 PCSO's[118]
N/A[119]
Not known, possibly 0[120]

2.16 How many Drug Service staff have received IBA training since 2007/8?
In total the partnerships identified 92 drug service staff who had been trained over the last two and a half years.

12[121]
0[122]
N/A[123]
0[124]
80 people trained in conjunction with the DAAT[125]
N/A[126]
Not known[127]

2.17 How many Prison Service staff have received IBA training since 2007/8?
None of the partnerships identified any training of prison staff. One partnership had plans to target this group.

0[128]
N/A[129]
0[130]
0[131]
Planned[132]
N/A[133]
Not known[134]

2.18 How many Arrest Referral Service staff have received IBA training since 2007/8?
Only one partnership identified specific training for (15) arrest referral workers, but in some cases this is because they either did not have any or were already trained.

0[135]
N/A[136]
0[137]
0[138]
We don't have any[139]
15 = 4%[140]
Not known[141]

2.19 How many Voluntary Sector staff have received IBA training since 2007/8?
In total the partnerships identified 40 voluntary sector staff who had been trained over the last two and a half years.

32[142]
0[143]
0[144]
N/A[145]

Some voluntary services joint trained with the DAAT – more alcohol awareness[146]
8 = 2%[147]
Not known[148]

2.20 How many Job Centre staff have received IBA training since 2007/8?

Only 1 partnership identified any training for Job Centre staff (4) over the last two and a half years.

0[149]
N/A[150]
N/A[151]
4[152]
N/A[153]
Not known[154]
0[155]

2.21 How many Social Care staff have received IBA training since 2007/8?

In total the partnerships identified 50 social care staff who had been trained over the last two and a half years.

36[156]
N/A[157]
0[158]
0[159]
14 mix of mental health teams more planned[160]
N/A[161]
Not known[162]

2.22 How many Housing staff have received IBA training since 2007/8?

In total the partnerships identified 262 housing staff who had been trained over the last two and a half years.

179[163]
N/A[164]
0[165]
Not known, most probably 0[166]
0[167]
Community training some were housing - 25 people[168]
58 = 14%[169]

2.23 Which other groups have been trained not covered by above list?

1 partnership identified other agencies that had received training. 6 partnerships indicated no other agencies. A variety of other agencies were identified as having received training. These are simply listed below for information:

Citizen Advice Bureau[170]
Community Wardens[171]
Social Partnership[172]
Arch Initiatives[173]

Sure Start[174]
Social Partnership[175]
Progress to work[176]
Phoenix Futures[177]
One stop Shop[178]
TNG training group[179]
Elderly Care Agencies[180]
College[181]

2.24 Have employers been targeted as a group?

2 partnerships had targeted employers for training.[182] [183]

Managers are contacted and told about the training and what we are trying to achieve. If the training is relevant then their team is trained as a group. If they only have a small group of staff then if possible arrangements are made for them to join another group.[184]

2.25 Which agencies or training providers provided the training?

A variety of trainers were identified by the partnerships, of whom the most commonly used provider was HIT who were providing training for 2 partnerships. 3 partnerships were using local services and 1 had a full time trainer.

HIT[185]
Lifestyle service Uni Hosp Aintree[186]
ADS and alcohol community service post currently under recruitment in Health Improvement PCT [187]
Full time trainer[188]
HIT[189]
In-house[190]

The research asked about the costs of training per one day session (excluding accommodation / refreshment costs). The information was too varied to provide an average figure

£15k[191]
£66K - Number of days not specified, it's a block contact, but they would expect to reach all 56 GP's – over £100 per GP[192]
None – part of service contract[193]
N/A[194]
Unknown[195]

2.26 Training Materials

Alcohol Concern sought copies of any training materials used in courses. However, only one set of materials was received.[196] One of the local providers was contacted directly but refused to share details of their course.

2.27 What other IBA training has taken place in your partnership area since 2007/8 but which was not commissioned by you?

Only 2 partnerships identified other pieces of training

Probation commissioned our community alcohol service, social services commissioned training for some members of mental health team.[197]
IM staff have undergone Alcohol training sessions. [198]

In the same way very little other related activity was identified by partnerships.

2.28 What arrangements are in place to monitor the ongoing use and impact of IBA?

5 partnerships reported having some method of monitoring the impact of the IBA training. However, the methods varied immensely. No standard approach to monitoring exists.

Evaluation on the day of training and evaluation three months from date of training[199]
Information comes back via PCT[200]
Quarterly[201]
The trainer role is also to quality assure following the training. This is done by follow up support and quarterly forums for various groups to attend [202]
There is no current dataset with Central and Eastern Cheshire[203]
No training[204]
Laptus, service database, hospital episode data[205]

2.29 Are there arrangements in place for ongoing support / back-up for those trained and undertaking interventions?

4 partnerships identified some kind of ongoing support, another said it was limited. 2 said no. However, the follow up identified is of variable quality.

Further training needs are identified in the evaluation, top up training is provided together with Train the Trainer Courses for organisations who wish to cascade training to other members of staff. [206]
This is central to their strategy which is why STATIN is used and therefore are able to find out why GPs not taking up training if that is the case [207]
No[208]
Yes clinical practice review sessions, regular team meetings and feedback sessions and further training [209]
Not currently but the new post will be involved in this. A&E Nurse undertakes this role in hospital [210]
Yes as above, also refresher training can be provided, and ongoing support by the training as and when required [211]
Currently this is limited[212]

2.30 What plans are in place to refresh IBA training for those who have received it?

Plans to refresh training were also variable. 2 partnerships either did not answer or gave a negative response. The plans for the other 5 partnerships varied greatly.

Further training needs are identified in the evaluation, top up training is provided together with Train the Trainer Courses for organisations who wish to cascade training to other members of staff. [213]
3 individual programmes will be provided [214]
No[215]
Motivational interviewing training Sept 09[216]

New position will undertake a needs assessment and refresh training including developing training strategy, monitoring and assessment and evaluation of training programme [217]
A new course has recently been designed to ensure all issues highlighted in “evidence and best practice in delivery” are covered.
Refresher train can be provided [218]
No plans as yet[219]

Section 3

Other Services

Alcohol Concern contacted representatives of specific professional groups to provide another perspective on IBA training and to determine if other courses or programmes are being undertaken in addition to those already identified from the partnerships. The response to this research was overwhelmingly negative. Little other training was identified. This section contains information from the whole region.

3.1Supporting People

Alcohol Concern spoke to service managers in various areas. Supporting People staff are not directly responsible for the delivery of front line services: all work with service users is contracted out. No overall strategic plan for the delivery of IBA exists, although it may form the remit of some of the contracted organisations. No records of IBA are kept by Supporting People and each local council has a strategic team that commissions providers who work with vulnerable adults and is more or less autonomous, so no region wide information is available.

3.2 Chambers of Commerce

There is no training directly carried out or commissioned by the Chambers of Commerce. Each area works independently so there is no national or regional policy regarding alcohol. Members have access to a HR company if they have any queries, where they will receive advice on, say, how to support a staff member who has alcohol problems, but this is the extent of their contribution.

3.3 CARAT Workers

No CARAT workers have been trained on a regional basis. Some training may have occurred at individual prisons but it is unlikely as there is no funding for alcohol work of any kind and it is not in the remit of CARAT workers to work with inmates who solely use alcohol. The interviewee was concerned about the lack of funding and feels that IBA may help to cut the re-offending rate in young adult offenders – this has been identified as a major problem.

3.4 Job Centres

No strategic or local initiatives are in place for IBA training. It is possible that the psychologists who work with staff may come across excessive alcohol use among staff or staff may mention clients for whom this is a problem but referral would be made to local alcohol services if deemed necessary as it is outside the remit of Job Centre Plus staff.

3.5 Probation Service

The probation service has a full time trainer who delivers brief interventions training to staff via the North West Training Consortium. However, this is not part of an overall training plan and different probation services have differing training requirements for their staff.

Section 4

Identified Barriers

Alongside the main review a selection of nine partnerships from across the whole region were asked for their views on the barriers to implementing IBA training.

- **Respondent 1** - It is difficult to get staff to attend, as they cannot be released from work. Originally, training was a full day but this has been gradually shortened to just a couple of hours and is often delivered during practice meetings. On occasions it has been possible to provide cover for the time that staff will be out of the workplace but this is not financially viable for all who need the training.[220]
- **Respondent 2** – Same problem as respondent 1. They are now delivering half days. They have found that delivery by a local GP, alongside a DAAT trainer has helped. Often hard to get a response from potential trainees – claim current workload already excessive and could not commit to further involvement. Funding always a problem.[221]
- **Respondent 3** – Same problem as respondents 1 & 2. They have overcome barriers by trying to match IBA to the type of work already carried out. For example the fire service deliver IBA specifically about the fire risks involved when drinking.[222]
- **Respondent 4** - No problem with commissioning training, however, it is difficult for people to commit to a whole day training: they are currently re-commissioning to offer 2 x ½ day sessions instead. They have commissioned research on outcomes of training and found people offering (more) help than they may be qualified to deliver and not referring clients on.[223]
- **Respondent 5** - They have not delivered any due to lack of funding so the barrier is funding and nothing else. They feel that they have won the "hearts and minds battle" already so that is not a real barrier.[224]
- **Respondent 6** – GP attendance was a problem but the provision of a financial incentive via the DES has increased uptake.[225]
- **Respondent 7** – There are no barriers to delivering the IBA training but there is a barrier in staff delivering the brief intervention.[226]

Respondent 8 identified a number of barriers to the roll out of brief interventions.

- Pharmacies will not release staff even for 2-3 hours to attend training
- GPs attend training but do not go on to conduct brief interventions.
- Staff cite the cost of locum cover as the reason for not attending
- Evidence of screening but only a small minority are identified as requiring brief interventions
- There is no funding to provide cover or external training.[227]

Respondent 9 answered at greater length than any other: "Regarding IBA, training has been provided for GPs and primary care staff. In theory, the appropriate services now have the capability to deliver IBA when and where appropriate and should be actively screening to do so. There is no mechanism currently in place to record and monitor whether or not this is happening. More IBA training is planned for any frontline agencies where it might benefit, but as yet this has not taken place. I am currently deeply sceptical (but hoping I am wrong) about the

capability of this model to deliver effective and reliable brief advice that can be monitored as necessary. There seems to be a fairly unproductive relationship between the DAAT and the PCT and I am rarely made aware of what the PCT are up to. There is no effective system in place to record whether or not GPs are delivering IBA and no viable point of access for me to start addressing this. The only sensible way seems to be to contact GPs on a monthly basis for progress updates. There are around 40 practices in the area and this amounts to a considerable work implication. Any ideas or examples of good practice to address this would be incredibly well received as it is fast turning into one of my biggest headaches! I have tried a couple of times to get into this but it has proved very difficult to get anywhere and to find the appropriate people I need to talk with."[228]

The review itself identified a number of barriers:

• Uncertainty over funding, although external funding is in the process of being sought for a service which will be tendered.[229]
• The partnership has started to develop an initiative to ensure that GP's and Pharmacists are trained in IBA, unfortunately due to a freeze on PCT funding this initiative is having to be adapted.[230]
• It is in this year's training plan. Last year saw a freeze on training other than healthcare infections[231]
• A&E service: difficulty getting access to time off for training some of this has been ad-hoc on the job training this is being reviewed and training policy being worked on by acute trust[232]

The message from both these sets of comments is very clear. There are two key problems to implementing IBA training.

- A lack of resources, especially financial, for some partnerships, particularly those who were not selected as Early Implementer sites.
- Problems in releasing staff from work to attend training. A&E staff and GPs were both specifically identified.

Section 5

A Model Training Programme

5.1 Introduction

The term 'identification and brief advice' covers a range of advice giving interactions, generally lasting for 5 – 10 minutes, and containing a number of active ingredients which, when delivered appropriately, may encourage the individual to make changes in drinking behaviour. Opportunistic brief interventions as defined here are not to be confused with specialist brief interventions delivered over several sessions in treatment settings.[233]

Outcome studies show differing levels of change in drinking behaviour after brief interventions and many efficacy studies have found them to be as effective in reducing alcohol consumption as extended interventions.[234] The aim of these interventions is to effect behaviour change in hazardous and harmful, but not necessarily dependent, drinkers. Brief interventions are not a treatment and are most effective in those who are not showing signs of dependence. However, if during the course of conversations between practitioner and patient, it becomes apparent that a patient is drinking problematically, motivational techniques can be used to encourage referral to specialist agencies.

5.2 Course Structure

The content of any IBA course will be dictated by the structure and content of the intervention being promoted. Thus the first question in designing a course is to clarify what outcomes are expected.

A number of frameworks exist to structure these outcomes. For example the US Substance Abuse and Mental Health Service Administration states that interventions typically use three components:

"a. Information or feedback about screening results, BAC upon admission, the link between drinking and injury, guidelines for low-risk alcohol consumption, methods for reducing or stopping drinking, etc.

b. Understanding the patient's view of drinking and enhancing motivation.

c. Clear and respectful professional advice about the need to reduce risk by cutting down or quitting drinking and to avoid high-risk alcohol-related situations."[235]

Therefore any course would have to focus on enabling people to undertake these three elements.

The literature identifies a number of active ingredients for practitioner training. To effect change in practitioner attitudes and practices, the training needs to focus on:

- the evidence for the effectiveness of brief interventions and the benefits of skilful implementation;
- content and brevity of interventions;
- skills development and skills practice in delivery and increasing motivation and self-efficacy.[236] [237]

Although GPs are not the only professional group a training tool would need to be developed for, there is more research evidence about their perceptions around talking about alcohol issues. This is likely to be similar for other professional groups. Research suggests that if GPs are unconvinced of the potential benefits of tackling alcohol issues, or at least if a cost benefit analysis suggests that time could be better spent on other patient problems, there is little incentive to commit to

a programme of brief interventions (Rollnick *et al*, 1997). This, therefore, has to be a key component of any course.

Research also suggests that GPs may differ about what is considered to be an appropriate consumption level at which to instigate a brief intervention.[238] Therefore, staff need to be clear about what constitutes hazardous and harmful levels of alcohol use.

Research by the Department of Health suggested that GPs do not routinely discuss alcohol with patients as they perceive a lack of specialist services to refer patients on to.[239] Therefore, available services need to be part of the training.

5.3 Brief Intervention Course Models

Since 2000, a variety of materials have been produced such as the World Health Organisation manual for delivery of brief interventions in primary care.[240] These provide comprehensive guidelines and materials for effective evidence based brief interventions to guide the practitioner through interventions without any specialist prior knowledge. They suggest session content and give practical examples of delivery.

The World Health Organisation outlines a framework for delivery of brief interventions, based on a study by Bien *et al*, (1993).[241] This uses the FRAMES model to guide the content of an intervention. FRAMES is the acronym for six elements of an intervention, which, ideally, should be structured and tailored to the patient's current position in the cycle of change. This is a client centred, non-confrontational approach, using a mixture of motivational and educational statements to bring about change in drinking behaviour. It may be supplemented by literature or worksheets for the patient to study at home. A key feature of brief interventions is that they can be delivered by non-alcohol specialists, such as GPs.

The Drug and Alcohol National Occupational Standards have developed a unit: AH10 - Carry out brief interventions with alcohol users. To perform competently in this unit a worker needs to have:

1. a working knowledge of how alcohol, as a drug, affects the body and mind, how this can affect behaviour
2. a working knowledge of the characteristics of dependence
3. a working knowledge of legal implications of alcohol use in specific circumstances, including road traffic legislation and issues around consent while intoxicated
4. a working knowledge of the risks alcohol can present to an individual's health and wellbeing, including:
a) the immediate risks that can arise from being drunk
b) the potential health and social risks associated with longer term risky drinking
5. a working knowledge of the unit system of measuring alcohol content and what constitutes safe, hazardous, harmful and dependent drinking as defined by the World Health Organisation
6. a working knowledge of the changes which can be made to drinking behaviour to improve health, wellbeing and personal safety
9. a working knowledge of how to administer and interpret results from an

appropriate screening tool (AUDIT or AUDIT derivative)
10. a working knowledge of the principles of active listening, and how to apply them
11. a working knowledge of how to present and explore options with different individuals
12. a working knowledge of how to present information and advice fully, accurately, concisely and in ways appropriate to people's needs
13. a working knowledge of how the cultural background of the individual can affect the working relationship
14. a working knowledge of the cycle of change model and how to help individuals make and review decisions and establish priorities
15. a working knowledge of how to identify how alcohol might contribute to current risk situations
16. a working knowledge of the importance of brief interventions to enable individuals who do not need specialised treatment to change their drinking behaviour
17. a working knowledge of the services available to treat individuals with alcohol problems

This project sought details on the courses used within the region. Very few were received, in some cases because of concerns about confidentiality. [242] [243]

The Cheshire and Wirral Partnership NHS Foundation Trust's course material was provided by their commissioners. Its objectives are to:

- Identify the difference between hazardous, harmful and dependent drinking levels
- Recognise the reasons why people drink
- Undertake the delivery of brief interventions
- Identify situations when they will be able to conduct alcohol screening (AUDIT)
- Calculate units of alcohol
- Use the correct pathways to refer individuals to the harm reduction team and the dependant team.

It covers:

• The impact of alcohol
• Information on alcohol, e.g. units, physical effects
• AUDIT
• The types of drinker
• Targeting interventions at the different types of drinker
• Brief interventions

Alcohol Concern's own course aims to enable participants to:
1. Apply knowledge of the alcohol unit system in the calculation of overall individual consumption.
2. Use and interpret the AUDIT alcohol screening tool in order to assess hazardous, harmful and dependent drinking.

3. Communicate effectively and confidently with service users about their alcohol use based on a respectful and non-judgmental approach.
4. Impart alcohol related knowledge such as long-term health implications and short-term biological/psychological/behavioural effects of alcohol in an effective and non-judgmental way that supports change.
5. Provide information about the various treatment and support options available for alcohol users.
6. Identify and make appropriate referrals to local support mechanisms for those experiencing problems with alcohol.

The training covers:

• Units and limits
• Drink-driving
• Harms related to alcohol
• National drinking trends, types of problem drinking and the importance of brief interventions.
• Screening with AUDIT tools.
• Referral and support options.
• Brief Intervention procedures and tools.
• The language of intervention for alcohol misuse.
• Structured dialogue practice.
• Extended Brief Interventions
• Referral pathways

The Department of Health has developed an elearning tool which is available on the Alcohol Learning Centre website.[244] This provides a two hour interactive course aimed at GPs and primary care staff, albeit the course is also relevant to other frontline staff. This covers a number of elements:

• Session Introduction
• Alcohol Facts
Covering units, Recommended limits, Modern drinking habits including home drinking, the risks, clarifying terminology, alcohol dependence
• Alcohol as a Drug
Covering alcohol's effects, alcohol and physical and mental health and social well-being, drink-driving, antisocial behaviour.
• Looking at Brief Advice
Covering simple identification, attitudes, cost to NHS, evidence for brief intervention, characteristics of brief advice, the IBA pathway
• Using Identification Tools
Covering AUDIT-C, FAST, SASQ, AUDIT-PC
• Full AUDIT Tool
Covering Introduction, scoring, analysing results and practice
• Brief Advice in Practice
Covering attitudes among the professional and the patient, the stages of change, benefits of alcohol reduction
• Structuring Brief Advice
Covering information for lower risk drinkers, brief advice using information leaflets, providing encouragement.

• Conducting Brief Advice
Covering practitioner attitude and approach and clinical approach, video examples
• After Brief Advice
Covering the principles of extended intervention, knowing when to refer patients and treatment pathways

5.4 A Model Course

All of the courses outlined above appear to offer an adequate framework for providing identification and brief advice training. Drawing on these models and research evidence it is possible to develop a synthesised model for a one day course.

Aim: To enable Tier 1 workers to identify, offer brief advice and appropriately refer people with alcohol-related problems.

Learning outcomes: By the end of the course participants will:

- Understand the unit system for measuring alcohol consumption
- Understand the safe/sensible drinking limits
- Understand the law around drink driving
- Understand the physical, psychological and social effects of alcohol
- Understand the definitions / characteristics of hazardous (increasing risk), harmful (high risk) and dependent drinkers.
- Be able to use screening tools including AUDIT
- Be aware of the evidence on the effectiveness of brief interventions
- Be able to offer brief advice to hazardous and harmful drinkers
- Be aware of extended brief interventions
- Be able to make appropriate referrals into treatment services.

Associated Drug and Alcohol National Occupational Standards Competencies

The course will provide participants with knowledge and understanding specified in the following DANOS units:

- AH10 - Carry out brief interventions with alcohol users.
- AA1 - Recognize indications of substance misuse and refer individuals to specialists.
- AA3 - Enable individuals to find out about and use services and facilities.
- AD1 - Raise awareness about substances, their use and effects.

Sample Programme

9.15am **Arrival / coffee**

9.30am **Session 1.1 - Welcome**
Introductions
Practical issues e.g. fire exits, toilets, lunch.
Warm Up Exercise

9.45am **Session 1.2 – Alcohol: the facts**
Knowledge about alcohol: units, limits, drink driving, physical, social and psychological effects

11.15 am **Coffee**

11.30am **Session 1.3 – Identifying Hazardous, Harmful and Dependent Drinkers**
The categories of drinkers
Using the AUDIT tool and other screening tools
12.30pm **Lunch**
1.30pm **Session 1.4 – Making An Appropriate Simple Intervention**
How to talk to hazardous, harmful and dependent drinkers about change
Understanding and applying the stages of change
Using the FRAMES model
Video examples of brief interventions in practice
Information on extended interventions
3.15pm **Tea**
3.30pm **Session 1.5 - Understanding Substance Misuse Services**
Understanding substance misuse services
Making appropriate referrals to substance misuse services
4.15pm **Session 1.6 – Summary, Final Questions and Evaluation**
4.30pm **Close**

5.5 Adjusting the Course for Different Requirements

This report cannot provide a tailored course for every eventuality. It is likely that the model course will need to be adjusted to meet the myriad variations that real circumstances will require. For example some groups will require a briefer training course to accommodate time pressures, GPs may be an example of this. Police or Accident and Emergency staff may require a course which is split over a number of shorter sessions to accommodate shift patterns. A half-day course programme is attached below as a model of a shorter session.

9.15am **Arrival / coffee**
9.30am **Session 1.1 - Welcome**
Introductions
Practical issues e.g. fire exits, toilets, lunch.
Warm Up Exercise
9.40am **Session 1.2 - Identifying Increasing Risk, High Risk and Dependent Drinkers**
Knowledge about alcohol: units, limits, drink driving
Knowledge about the physical, psychological and social effects
Knowledge about Increasing Risk, High Risk and Dependent Drinkers
Group work and Feedback
11.00 am **Coffee**
11.15am **Session 1.3 – Screening Tools to Identify Increasing Risk, High Risk and Dependent Drinkers**
Using the AUDIT Tool; presenting the FAST and AUDIT-C tools
Group work and Feedback
11.45am **Session 1.4 – Providing Appropriate Brief Advice**
Brief Advice: How to talk to Increasing Risk, High Risk and Dependent Drinkers about change
Making Appropriate Referrals to Substance Misuse Services
Group work and Feedback
12.50pm **Session 1.5 – Summary, Final Questions and Evaluation**

1.00pm **Close**

Section 6

Strategic Steps to Planning / Recommendations

This report sets out its recommendations in the form of a training plan based on the findings of this research. This plan is generic and sets out the steps that need to be taken by an area which is starting from scratch. It is impossible to develop a single specific training plan for the region or the three areas because each partnership is at a different stage of development. The following table sets out an 11 step process which can be followed to develop a robust approach to Identification and brief advice. At each step it identifies some specific activity at the area level.

It is recognised that the DAAT partnership itself may not be the strategic driver for future change. The lead may come from the PCT, the Local Strategic Partnership or the Local Authority. Individual agencies, such as the Probation Service, may also choose to take action themselves.

Step 1
Ensure that each partnership has identified the provision of identification and brief advice as a strategic priority and that training local Tier 1 staff is a local objective
Cheshire & Merseyside: *The two areas identified that did not have policies or strategic statements should be supported to develop such policies.*
Step 2
Each partnership will have considered whether to establish a LES
Cheshire & Merseyside: *Consideration should be given to whether the 5 areas which did not identify a LES should be encouraged to have one and how to respond to the scheme which has been suspended.*
Step 3
Each partnership will be encouraging the use of the DES
Cheshire & Merseyside: *The 4 partnerships which did not identify a scheme should develop schemes.*
Step 4
Each partnership has agreed which screening tools are to be used
Cheshire & Merseyside: *One of the partnerships needs to identify which screening tool is being used and ideally this should be AUDIT or one of the shortened versions.*
Step 5
Each partnership will consider the priority groups of Tier 1 staff for which IBA training will be provided. These should take into account the priority groups identified by the Department of Health which include primary care, general hospitals, accident and emergency, mental health, criminal justice services and social services.[245]
Each partnership will consider the priority groups of Tier 1 staff for which IBA training will be provided
Cheshire & Merseyside: *Prison, social care, secondary health care and job centre*
Step 6
Each partnership will identify how training will be provided for each priority group
Step 7
Each partnership should identify the resources to provide the training. This should be done in the light of the Department of Health's *Guidelines for the commissioning of Identification and Brief Advice (IBA) training.*[246] Partnerships should also look at the NW focused commissioning guidance, 'Commissioning training for behaviour change interventions: evidence and best practice in delivery, Powell & Thurston

2008'. http://www.nwph.net/champs/Publications/Behaviour%20change/Commissioning%20training%20for%20behaviour%20change%20-%20full%20report%20-%20autumn%202008.pdf Interagency collaboration on commissioning and resources will also support this recommendation.
Step 8
Each partnership will identify how training will be provided for each priority group and commission the training.
Step 9
Each partnership will establish monitoring and evaluation systems for the training and ensure that a consistent record of people and professions trained is kept. Measurable outcomes should be developed to ensure that IBA work is undertaken.
Cheshire & Merseyside: *3 partnerships need to develop monitoring and evaluation systems*
Step 10
Each partnership will identify how ongoing support will be provided for those who have received training
Cheshire & Merseyside: *4 partnerships need to develop an ongoing support system*
Step 11
Each partnership will identify what refresher training will be provided for those who have received training
Cheshire & Merseyside: *2 partnerships need to develop plans to refresh training*

Appendix 1 – People Completing the Form

Partnership	Contact	Position
Salford	Andrew MacDonald	DAAT Coordinator
Stockport	Simon Armour	Senior Public Health Advisor
Cumbria	Paul Musgrave	Joint Commissioning Manager
Blackpool	Steve Morton	Alcohol Harm Reduction Policy Officer
Wirral	Theresa Whittingham	Trainer
Sefton	Ian Canning	Health Promotion Specialist
Rochdale	Jenny Lovett	DAAT Coordinator
Warrington	Jane Knight	Alcohol Coordinator
Halton and St Helens	John Holden	Commissioning Manager, Substance Misuse
Bolton	Joanne Higham	Alcohol Joint Commissioning Manager
Bolton	Phil Ramsell	Senior Health Promotion Specialist
Safer Trafford	Andrew Clark	Data Analyst
Oldham	Perry Gunn	DAAT Joint Commissioning Manager
Manchester	Janet Mantle	Consultant in Public Health
East Lancashire	Ian Treasure	Alcohol Harm and Reduction Commissioning Manager
Cheshire	Jane Stairmand	Alcohol Commissioning Manager
Tameside	Sabrina Fuller	Public Health Consultant
Blackburn & Darwen	Karen Cassidy	DAAT Coordinator
Liverpool	Phil Sadler	Alcohol Coordinator
Wigan	Paul Keeling	Alcohol Coordinator
Bury	Elma Ikin	DAAT Manager
Knowsley	Stuart Dodd	Alcohol Coordinator

Appendix 2 – The Training Needs Analysis Tool

North West Alcohol Identification and Brief Advice Training Needs Analysis

Please note that this questionnaire uses the term "Identification and Brief Advice" to cover what was formerly called screening and brief interventions training.

Name of partnership:
e.g. Wigan
Contact name:
Partnership lead
Contact details:
Email, phones, address
Is there a local policy or strategic aim to provide IBA training?
(Secure a copy)
Has the partnership directly commissioned any alcohol IBA training?:
How many days / sessions in 2007/8? *Number*
How many days / sessions in 2008/9? *Number*
How many days / sessions are planned in 2009/10? *Number*
Do you have any contracts in place to provide IBA training after 2009/10?
Yes/no plus details
Do you have a complete record of the participants and their profession / role?
Yes/no
How many people have received training in each year:
2007/8? *Number*
2008/9? *Number*
2009 to date? *Number*
How many people in each of the following groups have received IBA training since 2007/8
GPs
Other Primary Care Staff *Number and estimated % of total of that staff group in the area.*
Accident and Emergency Staff *Number and estimated % of total of that staff group in the area.*
Other Secondary healthcare staff *Number and estimated % of total of that staff group in the area.*
Probation staff *Number and estimated % of total of that staff group in the area.*
Pharmacists *Number and estimated % of total of that staff group in the area.*
Police officers *Number and estimated % of total of that staff group in the area.*
Drug service staff *Number and estimated % of total of that staff group in the area.*
Prison service staff *Number and estimated % of total of that staff group in the*

area.
Arrest referral workers *Number and estimated % of total of that staff group in the area.*
Voluntary sector staff *Number and estimated % of total of that staff group in the area.*
Job centre staff *Number and estimated % of total of that staff group in the area.*
Social care *Number and estimated % of total of that staff group in the area.*
Housing *Number and estimated % of total of that staff group in the area.*
Which other groups have been trained not covered by above list?
List other agencies
Have employers been targeted as a group? Yes / No
If yes please describe:
Which agencies or training providers provided the training?
Names and contact details for each provider
How much have you paid on average for trainers per one day session (excluding accommodation / refreshment costs)?
£xxx
What other IBA training has taken place in your partnership area since 2007/8 but which was not commissioned by you?
Training – *details*
Target groups – *details*
Training Providers – *details*
Number and professions/roles if known? – *details*
Contact details for agencies commissioning training
Details
Details
Details
Other activity.
List any other relevant activity
Could you provide us with a lead contact for your:
PCT – regarding primary care
Name, agency, email, phones, address
Trust providing A&E /secondary care services
Name, agency, email, phones, address
Probation service
Name, agency, email, phones, address
Police
Name, agency, email, phones, address

Do you have a LES operating in your partnership area?
Please provide details of investment, number of practices, monitoring arrangements and outputs / outcomes identified to date.
How is the DES being rolled out in your area?
Please provide details of investment, number of practices, monitoring arrangements and outputs / outcomes identified to date.
What tool or tools are being used for IBA in this area?
e.g. AUDIT / FAST / Audit C and if more than one who is using which?
What arrangements are in place to monitor the ongoing use and impact of IBA?
Please describe
Are there arrangements in place for ongoing support / back-up for those trained and undertaking interventions?
Please describe
What plans are in place to refresh IBA training for those who have received it?
Please describe
Could you please send us a copy of training materials used and a copy of your local alcohol strategy and any other strategic statement relevant to IBA training.
Note what and when secured

Appendix 3 – Glossary of Terms

AUDIT - Alcohol Use Disorders Identification Test, a World Health Organisation alcohol screening tool
AUDIT-C – A briefer version of the AUDIT tool
BAC – Blood alcohol count
CARAT workers – Prison drug workers
DAAT – Drug and Alcohol Action Team
DANOS – Drug and Alcohol National Occupational Standards
DES – Directed Enhanced Service, a national health service scheme which can pay primary care to screen for problem drinkers
FAST– A briefer version of the AUDIT tool
IBA – Identification and Brief Advice, the term used to cover what was formerly called screening and brief interventions.
LES – Local Enhanced Service, a local health service scheme which can pay primary care to screen and offer other help to problem drinkers
PAT – Paddington Alcohol Test, a screening tool for A&E units
Supporting People – Commissioner of housing services

Appendix 4 – Summary of Additional Information Gathered on Cheshire and Merseyside

Interview responses

Cindy Freeman, Head of Service Improvement Unit.
Cindy coordinates training for community nurses and health visitors. There is no specific brief intervention training delivered because they have researched Motivational Interviewing and Brief Interventions and concluded that the same questions are asked and the same results achieved so they stick with their current programme as follows.

All 90 Health Visitors and 5 Staff Nurses receive compulsory 4 day training in Motivational Interviewing techniques (training bought in). Health visitors also receive one day training in delivering the AUDIT screening tool.

All other staff i.e. the Community Nursing Team (community matrons and practice nurses), work with palliative care and long term conditions and receive a mandatory day's training: Choosing Health Study Day, which covers the basics of health promotion including alcohol, smoking, obesity and nutrition. This covers broaching the subject, advice on cutting down, motivational work etc. Alcohol use in their patients is identified on admittance documentation.

There are no formal evaluations of the effectiveness of this work but anecdotally the health visitors are happy to deliver and report responsive patients. Cindy was recently called to an incident and was able to witness a health visitor delivering motivational interviewing to a mother and found her work effective.

From 2010 she will be organising training for the Falls Prevention Team. This will be a modified Alcohol Study Day, probably delivered in a half day as it is difficult to get community nurses off task for a whole day. There is a drug and alcohol team in the building and referrals are made internally where necessary.

The Service Improvement Unit is about to take over responsibility for training for the whole of provider services, such as physiotherapy, podiatry etc and, when this happens she will develop further training to meet any needs identified.

Cindy feels that her staff would benefit from access to e-learning materials to back up their courses. She also mentioned that Liverpool and Sefton have developed laminated health promotion cards, about the size of a postcard, with information on alcohol units and a picture of the body showing alcohol related harm, which staff carry around and use to show patients. She would like to know if she could access such cards – she does not have the budget to develop these herself but if they could be rolled out through the trusts her staff would use them.

There have been no barriers to dissemination, implementation or delivery identified. Cindy is planning an audit and evaluations but has other priorities at present.

Julie Chadwick, Five Boroughs Head of Learning and Development
All of their clients have a mental health or learning disability diagnosis. Alcohol is not discussed. Julie said that there is no training for staff as they are secondary care so it had not been identified as a priority. There are no plans to implement brief interventions or to deliver training. I was then given the details of the Substance Misuse Nurse, Bronagh Williams. Bronagh confirmed that there is no training for staff in place but, as part of their recovery planning and assessment, patients are asked about their alcohol use. This information is not used to identify whether brief interventions may be appropriate.

Paula Furmedge, Training and Development Manager at The Walton Centre
No alcohol related training is delivered at the centre. Paula was not aware of brief interventions. She is responsible for a team of nurses and health care assistants who deal with patients with neurological problems. She suggested contacting Sue Jago. She said that a question about alcohol consumption is used during admission and is documented. If problematic use is identified the patient will be passed on to the alcohol centre at Aintree. Graham Mitchell, a ward matron, who is also the rehab nurse specialist reiterated that there is not training for staff on screening or brief interventions for alcohol use but suggested that it would be possible for nurses to deliver such interventions.

Another ward matron, Phil Cane said that they do not deliver any interventions to patients and has had no indication that this is likely to change. Julie Elwill of PALS said that this is not something she has come across, but felt it was a good idea.

Jan Naybour, Cardiac Rehabilitation Nurse, Cardiothoracic Centre
(Original contact – Liz Cooney)
Jan has completed train the trainer training for brief interventions. She has delivered three sessions to nurses so far, each lasting half a day. She has many more planned but identified that getting ward managers to release staff was sometimes problematic. She feels that her team is in an ideal position to impact on the health of patients as, having just had a health scare, they are often keen to receive information and contemplate changes. On the other hand she was wary that staff may find it difficult to broach the subject of alcohol when patients are vulnerable, having just received a diagnosis. Jan was genuinely enthusiastic about brief interventions and explained to me how she has adapted her training to include information about the calories in alcohol, which is often relevant to patients who have been told to lose weight in relation to their illness.

She has an evaluation for attendees, commenting on the venue trainer, meeting of objectives etc and has received positive feedback. She is not yet in a position to provide follow up training or support but it is her intention to offer one to one feedback to each participant once she has some help and can free

up some time. Jan is hoping to train a colleague to deliver training to nurses (there are 1000 – 1200 potential participants) as she believes that being able to offer a variety of dates will encourage more people to participate, rather than offering just one at a time. She pointed out that alcohol consumption is recorded already by all staff, but then not acted upon, which she feels is a wasted opportunity. She gave the example of low blood pressure – a nurse would not record this and then not take action to rectify it, so why should it happen with alcohol? Jan is hoping to find a "health promotion champion" to further the cause.

Formal alcohol screening is not used but the Drink Aware drink wheel is used with patients to help them to establish their unit consumption. Jan identified that her staff use the "alcohol cards" so that they always have a resource to hand and can encourage patients by showing them the harms caused by alcohol as well as units. These were supplied by Liverpool PCT.

Jan went on to talk about referral pathways – CHAMPS are in the process of setting up a single point of contact for alcohol referrals as her team may have to refer to a wide variety of organisations if they come across alcohol dependence: patients come from Merseyside, Manchester, North Wales and beyond. She hopes that this will make referral easier.

Jan feels that her training would also benefit from wider publicity, rather than just the standard flyer in the corporate communications email. Cardiac patients automatically get a standard health promotion pack but thoracic patients do not and Jan suggested that alcohol and advice and information should be provided in the pack and to thoracic patients.

Liz Grady, Health Promotion Practitioner, Alderhay Children's Foundation Trust (Original contact - Tina Fiddies)
I was originally told by Tina Fiddies that there is no brief intervention work conducted at the hospital, it had not been identified as a training need and there were no plans to begin training. However, she then gave me contact details for Liz Grady, suggesting that health promotion may know something about it.

Liz delivers health promotion training to staff, of which there are about 2,600, mostly nurses. This includes brief intervention training and this year she has trained 150 staff so far. She holds weekly half day sessions to cover different aspects of health promotion. As they are a WHO health promotion hospital, the nurses see the delivery of health promotion as an integral part of their role and are willing to implement any new initiatives. She has not done any follow up training or formal monitoring / evaluation but has had positive feedback from participants. There is no screening, just the use of the "alcohol cards" to work out units. Staff do use the FRAMES model for delivering brief interventions.

One difficulty identified is releasing nurses to attend training. Liz has overcome this by visiting wards at shift handover (am/pm), where she has about 40 minutes with staff to introduce and deliver training activities. At this

time there are always staff on the wards so it is convenient for the ward staff. During these meetings she also delivers alcohol awareness training.

Liz informed me that brief interventions are also carried out in A& E and gave me contact details for one of the nurse practitioners there (Sarah Jackson).

Linda Chesters, Alcohol Liaison Nurse, Wirral University Teaching Hospital (Original contact – Cathy Thompson)
Linda is responsible for training all of the link nurses on the wards, who then cascade training down to their nurses. She holds regular meetings with them to identify training needs and solutions. She identified that a current problem is that patient assessment documentation has recently been changed and the questions about alcohol have been missed off. Thy do not use a screening tool as the nurses find AUDIT too long, AUDIT C is also not used; however, they do ask patients the following:

- Do you drink alcohol?
- If yes, how much?

If more then 6-8 units on more than 3-4 days a week patients are put on the "alcohol pathway", referred to the Windsor clinic or are given leaflets and verbal information. If less than the amount above, they are given the leaflets and information. This is not based on FRAMES but all staff are competence tested annually. Engagement workers are also in place and it is their role to encourage patients to access services: signpost, remind them of appointments, accompany them, offer advice etc. They are not trained in brief interventions. Community detoxification is available for alcohol dependent patients.

Lindsey Howard, Harm Reduction Nurse Practitioner, Wirral University Teaching Hospital (original contact – Cathy Thompson)
They have one full time trainer, Theresa, who delivers alcohol brief Intervention training to staff and outside agencies. The training is mapped to DANOS, takes one full day and participants receive a certificate when completed. It is delivered to all staff who have client contact. And referrals are made to Tier 2 services if necessary (where clients will be assessed and receive 4 – 6 sessions of extended brief interventions or be referred to the alcohol dependence team for group sessions and then one to one work).

Brief interventions training comprises use of AUDIT, background information on brief interventions, how to give advice on safer drinking, working out units etc. The programme has been in place for four years and training is also delivered to local GPs (no DES) and pharmacies (LES in place) and other partner agencies. No exact idea of how many but hundreds of staff trained in that time. They will be promoting the training during alcohol awareness week and focusing on workers. They promote the training as part of a general health promotion agenda and it is part of their SLA.

Dr Faisal, Clinical Lead in Addictions for the Mersey Care NHS Trust.
(Original contact – Helena McCourt)
Dr Faisal stated that drug keyworkers have received no alcohol training whatsoever and would benefit from, and welcome brief interventions training. They have no SLAs for alcohol and refer all alcohol use to CIC or inpatient services at the Windsor Clinic. Consequently, they do not conduct alcohol screening or offer information or advice for alcohol users.

Vicky Stirling, Learning and Development manager, CCO, (original contact Chris Lloyd)
There is no mandatory training for staff on any alcohol related topic and she has not come across brief interventions. Suggested that it's possible that the cancer rehabilitation department may be in a position to deliver interventions to clients abut is not aware of any training received or planned. Department is relatively new so there may be training commissioned independently elsewhere that she is not aware of.

Carmel Fraser, T&D manager, Sefton PCT (Original contact Liz Carr)
Carmel is responsible for developing brief interventions training for staff. They have been delivering brief interventions in other lifestyle areas for a while and have just begun to roll out alcohol. 4 sessions delivered so far, each lasting for half a day. There have been no problems with getting participants to attend. They have prioritised GPs because it slots in with the DES but they are urging GPs to screen all patients regardless. GPs have welcomed the initiative and feedback from evaluations has been positive, stating that it has increased confidence in communicating with patients about alcohol and knowing where to refer to. They have developed three levels of training for staff:
Level 1 – alcohol awareness, looking at raising the issue and what constitutes safer drinking for all front line staff
Level 2 – screening using AUDIT and delivery of brief advice as well as using the identified referral pathway for those in need of treatment. This will go out to as many PCT staff as possible. They are also hoping to roll it out to other parts of the borough and to voluntary organisations and local authority staff.
Level 3 – more intensive, GPs are the target audience

The programme has also been delivered to Children's Centre managers and Health Visitors. Carmel has developed a number of initiatives to support this including a flow chart of how to respond to patient needs and a list of local alcohol support agencies and a resources order form, which has been sent to all GPs so that they can fax through their orders for more materials. They are currently using Department of Health leaflets and Drinkaware drink wheels for handouts to patients and displays in surgeries. Monitoring is being carried out by identifying changes in GP referral numbers/activity. Surgeries that are not referring will be contacted and offered support and asked why.

Dr Lynn Owens is delivering the training alongside clinical staff who go over case studies and Carmel who does the operational side (referrals etc). Carmel would very much like Train the Trainer training so that her team can deliver the training and it will be sustainable. She feels that this is important

for the professional development of the staff as well as being more efficient than commissioning from outside.

Leonard Hughes, Head Learning & Development at St. Helens ad Knowsley Trust (Original contact - Pauline Whitfield)
Leonard is not delivering brief interventions and is not aware of any that are being delivered. He would be interested in staff receiving training, however, and believes that staff would deliver brief interventions. He identified elearning as an ideal way forward for his staff. They have a new Learning Management System whereby staff can log on to learning opportunities at will and these will be logged automatically on staff records as part of their professional development. I pointed out that monitoring of delivery would also be necessary and he said that it would be good as part of a whole package so that staff could access at will, to overcome barriers of not being available at training times, but also access face to face training and support. Leonard mentioned that patients who identify alcohol problems are referred to local services.

Sue Bland, Lifelong Learning Coordinator, Southport and Ormskirk
Does not deliver brief intervention training. Nothing has been commissioned and they have nothing in the pipeline.

Karen Hancocks Baringer, Training and Development manager, Warrington PCT (original contact – Debbie Massey)
Do not deliver alcohol brief interventions, either as part of induction or as CPD. They have no policy covering this but suggested that it did need to be developed

Kate Kenwright, Learning and Development manager, Liverpool PCT
(Original contact – Angela Delea)
Kate began a programme of brief intervention delivery in May. So far 96 staff have been trained within the PCT and 29 within the council. They will begin a new training cycle in October. The uptake has been good and there is even a waiting list. Promotion is via a general email bulletin that comes out weekly and an email branded “Health Works and Wellbeing”, which is individually sent to staff. The training is half a day and is aimed at lifestyle issues in general, of which the alcohol information forms part. They do not use screening tools but do use FRAMES for the delivery of brief advice. They have also trained trainers at The Royal and the Heart and Chest Hospital. Kate attended a five day course with two trainers who they commissioned from Sefton PCTt– Val Andrews and Barbara Harris.

So far a blanket approach has been taken, training anyone who signs up but they plan to target specific workers in future, in particular staff on the Child Measurement Programme, as they will be working closely with parents. They have found feedback very good and participants have enjoyed the training. No barriers to accessing training have been identified but getting commitment from the trainers has been tricky. 17 have been trained but, of these, only 11 have delivered sessions and ideally she would like each trainer to deliver 5 sessions each year. Kate thinks that their managers and other senior should

be encouraging them to lead sessions and monitoring the response from participants in terms of attendance and delivery of Brief Interventions, especially as many of them are supposed to be professional development mentors. Kate would like to see more trainers in place to ensure continuity.

April Morris, Training and Development department, Royal Liverpool and Broadgreen University Hospitals (Original contact – Jackie Green)
April does not deliver brief interventions to staff in her training packages, nor has she come across anyone else who does

Carole Jordan, Staff Development Manager, Countess of Chester Hospital (original contact - Leonie Kenney)
They do not deliver brief interventions training, or indeed anything to do with alcohol, to staff.

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