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

Cheshire and Merseyside Report

EXECUTIVE SUMMARY

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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 were 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. All areas returned a questionnaire.

The analysis is being presented in four separate versions:

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

This is the Executive Summary of the Cheshire and Merseyside report.

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.

Alcohol Identification and Brief Advice

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. [1]

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.[2] 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.[3]

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 Department of Health which include primary care, general hospitals, accident and emergency, mental health, criminal justice services and social services.[4] A Training Needs Analysis

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

6. 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.
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.*[5] 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.
8. Each partnership should identify how training will be provided for each priority group and commission the training.
9. 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.
10. Each partnership should identify how ongoing support will be provided for those who have received training.
11. 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:

12. *Work should be undertaken to ensure that all areas have policies or strategic statements which identify the roll-out of Identification and Brief Advice.*
13. *Further encouragement is given to ensure that Local Enhanced and Directed Enhanced Schemes to tackle alcohol are in operation across all PCT areas.*
14. *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.*
15. *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 in 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.

[1] www.alcohollearningcentre.org.uk
[2] www.alcohollearningcentre.org.uk
[3] Duncan Raistrick, Nick Heather and Christine Godfrey - Review of the effectiveness of treatment for alcohol problems – Department of Health - 2006
[4] Duncan Raistrick, Nick Heather and Christine Godfrey - Review of the effectiveness of treatment for alcohol problems – Department of Health - 2006
[5] http://www.alcohollearningcentre.org.uk/eLearning/Training/CommIBATrain/?parent=5248&child=5250