The role of training in IBA implementation beyond primary health care settings in the UK

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Abstract

There has been a considerable drive to encourage a wide range of professional groups to incorporate alcohol screening (or identification) and brief advice (IBA) into their everyday practice. This article aims to examine the role of training in promoting IBA delivery in contexts outside primary care and other health settings. The data are drawn mainly from a structured online survey supplemented by illustrative material from nine qualitative interviews and insights from an expert workshop. Findings support the results from other research that issues relating to role relevance and role security continue to act as barriers to professional change. Furthermore, issues of organisational commitment and organisational barriers are insufficiently addressed in strategy to promote wider use of IBA. The article concludes that development of appropriate training for alcohol IBA needs to take account of the role of IBA within a complex interactive system of related services and help seeking pathways and consider how training can contribute to changing both professional attitudes and behaviours and organisational approaches to implementing and sustaining IBA in everyday professional practice.

Introduction

There is considerable evidence for promoting identification and brief advice (IBA) as a cost-effective approach to early intervention in harmful drinking patterns, especially when delivered in primary health care contexts (Kaner et al., 2007, 2013). The approach generally consists of using a questionnaire, such as the AUDIT to screen for problem alcohol use, followed by brief advice to motivate the individual to change their drinking behaviour (see Heather, Lavoie, & Morris, 2013 for a full discussion). However, despite the potential, research has highlighted many challenges and barriers to implementing IBA, even in primary health care settings (Thom, Herring, Luger, & Annand, 2014). At the same time, while recognising the difficulties in persuading professionals to adopt IBA into their routine practice, there is, nevertheless, increasing pressure in the UK to widen the reach of IBA delivery to contexts beyond primary care and other health related settings, for instance to criminal justice settings, social care and youth work and social housing contexts (Safe, Sociable London Partnership, 2015; Thom et al., 2014). Evidence for such a broader platform for IBA is mixed at best and studies have found similar professional, structural and context specific barriers to IBA delivery in non-health settings as in health settings. Issues of role legitimacy, role relevance and role support continue to pose difficulties for the delivery of IBA across all contexts (e.g. Nilsen, 2010; Schmidt et al., undated). Importantly, organisational ''climate'' has been suggested as key to strengthening workforce commitment to IBA delivery (Cruvinel, Richter, Bastos, & Ronzani, 2013), but there has been little research examining organisational factors or research looking at the links between organisational factors, professional behaviour and work context.

Training is frequently proposed as an answer to broadening the base of IBA delivery although it is now clearly recognised that training can be only a part of the solution (Babor & Higgins-Biddle, 2000; Coogle & Owens, 2015; Darnell, Dunn, Atkins, Ingraham, & Zatzick, 2015; Schmidt et al., 2015). In a UK study based on interviews with nine practitioners and managers, Fitzgerald, Platt, Heywood, and McCambridge (2014) found that, following a 1-day training course, most practitioners did not use formal screening tools and did not deliver brief interventions. Perceived lack of relevance to the client group and the work context emerged as important reasons for the failure of training to change practice. There is also considerable variation in the content and delivery methods of training so that what is described as IBA training covers awareness, knowledge and skills components to different degrees. The value of education and training to make a contribution to professional practice is not disputed; but there is insufficient evidence on what counts as IBA training, how training impacts on practice, especially in non-

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health settings, and little on the role of training to influence organisational support for the incorporation of IBA delivery into work practices.

This article, part of a larger study on training for IBA delivery in non-health contexts, addresses the role of alcohol IBA training in enhancing professional practice and organisational support from the perspective of a group of trainees. In particular, the article focuses on perceived ''therapeutic commitment'' (Shaw, Cartwright, Spratley, & Harwin, 1978) and on perceptions of organisational factors that influence IBA delivery.

Description of the training and its delivery

The training was delivered in four geographic areas across England. Sessions consisted of core elements with some variations tailored to the more specific needs of professional roles and settings. The core knowledge elements were:

- Information about alcohol units;
- Information about safe limits, i.e. recommended consumption and drink-driver limits; a check on knowledge to see how people calculate unit intake;
- Information about wider alcohol related harm and the physical, psychological and social well-being of drinkers; short and long-term effects of excessive drinking (though not part of a standard IBA course this could provide a useful context for use in brief advice and could be relevant for identification); the meaning of terms such as ''dependence'', ''withdrawal'' and a spectrum of alcohol disorders was discussed;
- Introduction to AUDIT questions, scoring and responses including differences in terminology across screening tools familiar to staff being trained; what constitutes increasing risk and high risk;
- Giving brief advice. One trainer mentioned discussing the evidence base for brief advice, use of the FRAMES model (Miller & Sanchez, 1993) and tailoring advice to individual needs using the Cycle of Change model (Prochaska & DiClemente, 1983);
- Treatment approaches and identifying appropriate treatment options for different levels of alcohol consumption and within different sectors of the treatment system. Differences in patient and community detox outlined. Referrals to local treatment services could be added depending on the course, setting and commissioning agenda. One trainer routinely drew attention to the importance of wider support on offer to family members and carers and their need to understand different signposts and avoid giving vicarious advice to the drinker in question.

Although the sessions were relatively short, trainers employed interactive approaches including a ''warm up'' session and exercises based on addressing delivery challenges and discussion of case studies.

Methods

Mixed methods were used to collect data on the role of training to influence delivery of IBA, an on-line survey, interviews with trainers and with trainees, and discussion at an expert witness seminar. This article draws mainly on the survey findings. Ethical permission for the study was obtained from Middlesex University ethical committee.

Survey

A list of individuals who had attended training sessions between 2012 and 2014 was used to group trainees into two categories: those coming from core health and health related organisations (primary care, hospital, pharmacy) and from specialist alcohol services, who were omitted: and those attached to other organisations (in the main, youth services, housing, probation, police, social services, local authorities), who were included. Since we were interested mainly in experiences of IBA implementation post-training, the time span between training and survey was seen to have advantages although it was recognised that the time lapse would affect response and introduce bias into the sample. A structured survey, including a few open comment questions, was used to gather the views of individuals working within relevant settings. The survey focused on perceptions of the training and of its impact on the trainee and their working practices after training. Questions also explored aspects of ''therapeutic commitment'' drawing on prior studies (Anderson & Clement, 1987; Cartwright & Gorman, 1993; Shaw et al., 1978). The concept of ''therapeutic commitment'' incorporates questions exploring the extent to which respondents feel they have adequate knowledge, training and experience to address alcohol issues with clients, perceptions of role legitimacy (whether workers feel it is appropriate for them to ask about drinking), the extent to which they find it worthwhile to work with such clients and feel they can make a difference, and whether they find the work challenging. Studies, largely from primary care, have indicated that high therapeutic commitment is associated with role security based on experience, support and knowledge of alcohol and alcohol problems (Cartwright & Gorman, 1993). The survey also asked for views on organisational factors and contexts likely to impact on whether IBA was delivered post-training. These questions asked for perceptions of support from the employing agency, the extent to which managers and other staff indicated that it was part of their role to engage with alcohol issues, whether the organisation had sufficient resources and whether respondents felt that the training input would be sustained.

All relevant participants ($n = 462$) who had received IBA training between June 2012 and January 2014 were approached by email and asked to complete the questionnaire by using Bristol Online Survey (BOS). An explanatory letter provided full details about the study, the funding source and the link with the training agency. The survey was anonymous. Trainees were assured of anonymity, that only the research team had access to responses and that responses would not be given to employers or to the training agency. They were asked to supply an email (for researcher use only) if they were willing to participate in an interview following the survey. In total, 89 individuals responded to the survey (a response rate of 19.2%); one questionnaire was unusable leaving 88 usable survey returns. It was assumed that people attending the earlier training sessions might be less likely to respond and

this proved to be the case; 39.8% of respondents had attended training before March 2013 and 60.2% attended after March 2013. The survey was used to generate the descriptive data reported below.

Interviews

Interviews with the two trainers provided a description of the content and methods of the training sessions and reflections on IBA training in general. Taped, open discussion interviews were also held with five trainees, identified from survey respondents who had agreed to a follow up interview, and two managers of services whom we approached through the trainees. The interviewees worked in varied contexts: police, general counselling/psychotherapy, social work, midwifery, parenting in a youth offending team, family organisation support, supported living (people with learning difficulties). The open discussion interview schedules were adapted depending on whether the respondent was a service manager or a practitioner but the following domains were explored: the extent to which alcohol problems are a factor in the respondent's work context; whether the individual worker feels it is appropriate to identify and respond to clients' alcohol issues, knowledge of IBA and perceptions of it use/ appropriateness in the respondent's work context, perceptions of the role of employer organisations/agencies in responding to alcohol problems among clients, the degree of support/ commitment for addressing alcohol issues from respondents' organisations/agencies, the role of training in addressing individual commitment and organisational adequacy to respond. These interviews sought to expand on themes emerging from the survey and respondents' comments are used here for illustrative purposes only.

The expert workshop

A report from the one-day workshop is available (Thom, Herring, & Bayley, 2015). The 18 workshop participants included trainers, researchers, policy makers and practitioners from a range of disciplines and work setting. Discussion covered a range of issues regarding the implementation of IBA in non-health contexts. The role of training was one of the topics covered, the question posed being ''What is the role of training in broadening the base of IBA implementation''? The workshop findings were useful in augmenting understanding from the point of view of a wider group of trainers, practitioners and academics but they are not used substantially in this article.

Analyses

The survey was used to generate descriptive statistics and to identify themes for further exploration. Answers to open questions were extracted, listed into categories and ordered into main themes that were explored further in the interviews. The role of training in IBA delivery in non-health contexts was one main theme explored in the literature review, the survey, the interviews and the expert workshop. Content analysis was used to examine qualitative data from open survey questions, the interviews and the expert workshop. Within the training theme, the main categories emerging

were: respondents' perceptions and evaluation of the content and delivery of training; perceptions of the relevance and usefulness of IBA (the focus of the training) to work contexts; the extent to which training had resulted in delivery of IBA; the challenges in delivering IBA and the role of training in relation to other factors such as organisational support and therapeutic commitment in addressing challenges. These thematic strands are discussed below. The data reported are from the survey or follow up interviews unless noted specifically as coming from the expert workshop.

Findings

Respondents' training and work contexts

The majority of survey respondents who gave a response ($n = 86$) were based in Hampshire (50.0%), followed by Birmingham (45%), Dudley (4%) and Hereford (1%). Most respondents (85%) received their training in mixed professional groups from different organisations. Others were trained as part of a mixed professional group within their own organisations (8%); or as part of a single professional group just from their organisation (5%); or as part of a single professional group from different organisations (2%). Just over half (55%) received full day training and the remainder received half day training.

Survey respondents were drawn from a wide range of work contexts: social care was the most frequently reported area ($n = 21$), followed by community worker and housing worker ($n = 11$ each), family support worker ($n = 9$), education, youth work and criminal justice ($n = 6$ each), older people, sexual/ domestic violence ($n = 2$ each) and armed forces ($n = 1$). Although the survey aimed to exclude people from health and specialist alcohol services, a few were included due to lack of clarity on the lists used to identify relevant organisations. There were three people from substance misuse services and eight people from health related areas – most working in the community as, e.g. midwives or community nurses.

Almost half (49%) of participants said that alcohol related issues were common in their work with clients and 48% found that alcohol issues came up sometimes. A minority (3%) said they never came across alcohol related issues in their work with clients. The issues mentioned by respondents who commented related predominantly to addiction, binge drinking, heavy drinking (mentioned by 32 people), followed by antisocial behaviour, including domestic abuse and crime ($n = 12$), alcohol related mental health issues ($n = 8$), loss of accommodation and homelessness ($n = 8$), financial problems ($n = 7$), parental alcohol issues ($n = 6$). This could be seen to reflect a view of the problem as one of dependency and heavy, problematic drinking rather than an awareness of the signs relevant to early intervention and most suited to the use of IBA.

Perceptions of training delivery and content

Overall, survey respondents and interviewees were positive about the training; as one interviewee commented:

So we had 25 staff on the training that we had just recently and everybody has said that the training was fantastic; it really helped them because now they know where to

signpost the people who have got alcohol issues. (Manager, supported living services).

Most survey respondents (85%) said they preferred face-to-face alcohol training rather than online training; most (98%) said they found the trainer well qualified and most (94%) found that the methods were effective. The length of training was thought to be about right (85%) although eight people disagreed and it was suggested that more time was needed to absorb what was learnt. Six people did not comment on length of training.

Similarly, there was high satisfaction with the content of the training and the relevance of the content to respondents' work contexts. With the exception of one person, everyone ($n = 87$) found the content of the training sessions interesting; most (90%) said nothing was missing that should have been included. The 10% who identified gaps suggested including:

- more information on the health impacts of drinking, on dual diagnosis and on alcohol issues with regards to older people, and recovering alcoholics;
- more on sources of help within the community;
- information on how to deal with the problems specific to their own fields.

Most survey respondents (87%) found the training relevant to their work; two people (2%) rated the training as not relevant and 10 people (11%) neither agreed nor disagreed with the statement on relevance.

Data from the interviews indicated that issues around working in multi-professional or single professional groups or work contexts warranted further exploration.

I was in with a group from the prison service and some had very strong views about how to put things across (to clients) and so there was a lot of discussion about that and ours is a softly, softly approach and we observe for quite a while before we go in unless it is really in your face and there are bottles piling up in the sink. (Senior social worker working with families).

While this trainee found the mix of professional experiences helpful, others felt that they needed more time with professionals who shared the same work settings or client group. As one person from a local counselling service said:

At many levels it was really useful that there was a mix of professions there, but on the other level it would have been good to have a review day and come back and work together with professionals who work in the same remit. (Counsellor, local services)

Yet others saw both the advantages and disadvantages:

There was a mix of professionals on the course, which was interesting, but also limiting. If it was more specific, say health visitors and maternity, psychiatric nurses, we would have been more likely to get more out of it with respect to the damage it does to the baby and the Mum as well psychologically. However, having said that, I also learnt a lot from other people as well as from different professions. Maybe a bit more around pregnancy and after pregnancy. (Midwife)

Application of training to the workplace

Most survey respondents (79%) said the training helped them to apply IBA to their working practice. Two participants (2%) strongly disagreed with the statement that the training had been helpful and 19% neither agreed nor disagreed. However, of the 82 people who answered the question, only 43% said they had delivered IBA post-training; 57% had not used their IBA training. Furthermore, frequency of use was low with only one person reporting ''more than once or twice a day'' and only nine reporting at least once or twice a month. Reasons given for not delivering IBA were: lack of opportunities for IBA application in their work ($n = 14$), workload issues ($n = 13$), lack of time ($n = 9$), lack of confidence ($n = 7$), not relevant to their area of work ($n = 7$), change of role ($n = 5$).

Asked whether they had encountered any challenges in trying to implement IBA into their work, 61% did not answer; 16 people said they had not faced any challenges, and 19 said they had encountered some challenges: the clients were not interested ($n = 13$); not enough time ($n = 6$); workload issues, lack of resources and lack of interest among colleagues and others in the workplace ($n = 2$ each). It is interesting that few survey respondents answered the question on challenges, especially given the low delivery rate and the fact that interviews elicited many comments about challenges and difficulties. Possibly the survey format was a disincentive.

Therapeutic commitment

Research on changing professional behaviour to encourage – largely general practitioners – to become more engaged with responding to patient's alcohol problems suggests that it is possible to enhance ''therapeutic commitment'' to identifying and responding to alcohol problems among patients and clients (Cartwright & Gorman, 1993). The provision of training and support within professionals' organisations and local service structures are key elements to securing change. We examined the extent to which these trainees displayed therapeutic commitment along the dimensions described in earlier studies.

As Table 1 shows, although survey respondents felt it was a legitimate role and many felt they could make a difference to clients' lives, and despite favourable responses regarding the training and its relevance to their work, respondents still did not feel that they had adequate experience or enough training and they did not particularly like working with clients with alcohol problems, perhaps because the majority found the work challenging.

Evidence from the expert workshop and from the interviews also indicates that delivering IBA in settings outside health care services frequently raises issues of role relevance and the need to adapt standard IBA approaches to suit working contexts.

The reason for not using IBA was explained by a trainee from a police force who told us that a considerable number of his colleagues have been trained, but none of them had delivered any IBA afterwards. They did not have the

Table 1. Therapeutic commitment.

	Number answering the question	% Answering ''yes''	% Answering ''no''	% Answering ''not sure''
Have skills/knowledge to deal with clients' alcohol-related issues	84	71.5	3.5	25
Have sufficient training to deliver IBA	88	49	23	28
Have sufficient experience to carry out IBA	86	49	29	22
Appropriate to ask clients about drinking	88	82	4.5	13.5
Can make a difference to client's life	88	77	7	16
Like working with clients with alcohol problems	88	42	10	48
Find it challenging to work with clients with drinking problems	88	62	7	31

Table 2. Perceptions of organisational commitment.

	Number Answering the question	% Answering ''yes''	% Answering ''no''	% Answering ''not sure''
Support from management for organisational intervention in alcohol	80	63	8	29
Support from staff for organisational intervention in alcohol	87	59	32	9
Organisation's resources adequate to respond to client's alcohol issues	87	52	30	18

opportunity to do so as they usually met people at a stage where they are drunk, disorderly or violent, when IBA was not possible. He said that he and his colleagues are very frustrated as they no longer have arrest referral schemes (an approach which diverted arrestees into the treatment system), as this scheme along with the community alcohol team had been cut – so there was nowhere to refer people to, and no ''teachable moment'' for IBA. In his view, there was a lack of organisational commitment including from police headquarters. Other interviewees from the police supported this view. The exception was one policeman who worked in the community and encountered homeless people. He found the training very relevant to his work and said that he made use of some of it; with homeless people he now understands why they drink and gives them advice on how to reduce their drinking. There was, however, no time to do AUDIT screening.

Some aspects of IBA were considered as more acceptable and more useful (especially if adapted) than other aspects. In general, trainees were less likely to carry out screening than to provide advice. One family social worker commented that she used an IBA approach approximately once or twice a month, assisted by leaflets but without screening:

> The leaflets are really handy as they have got everything you need to open up the discussion with the family about the effects of alcohol, without being in their face and without it being finger pointing, wagging kind of approach, it is more let's explore this and see where you are at and see what we can do to help, because that is our approach. (Family social worker)

The work context, the position of the trainees' agency in relation to other helping agencies, and the existing assessment tools used by practitioners also influenced readiness and ability to implement IBA as the following examples illustrate:

> To be honest probably 1 or 2 do screen but as a general rule no and partly because if you have got a family come through and there is a child protection concern. . .there will

already be some other agency involved so it is about working together . . . . . . I think we don't use it often, maybe we don't use screening enough; but I think often that would not be something people would be doing initially, because often we are working with families that are quite reticent about working with us anyway. (Family services manager).

> For the young people, part of the question and assessment tool is to ask them about their alcohol and drug use and with the parents we don't necessarily ask that question but it doesn't mean we couldn't do it. You know we do look at vulnerability within it. (Member, youth offender team).

Organisational commitment

Most survey respondents (81%) agreed that their organisation should be involved in helping clients with alcohol problems; 13% were not sure and 7% did not find it appropriate for the organisation to be involved in a client's alcohol issues. How well the organisation is linked into a local network of services is also important in providing referral pathways when alcohol problems are detected or when more specialist care is deemed necessary. Most survey respondents were aware of local services for people with alcohol problems (90%), but fewer had experience of using or contacting these services for their clients (62%).

But, as Table 2 shows, perceptions of support from management and staff and assessment of adequacy of organisational resources were not particularly high, especially given that this is a sample that had been released by their agencies to undertake IBA training.

However, interviewees gave examples that illustrated the kinds of support trainees had experienced:

> I think as an organisation (XXX) is really good at encouraging the workers to train and to develop skills. So my manager is really, really supportive with any training that I show an interest in and want to do, . . .and we have an

internal training department as well . . .. they do prioritise it for the workers. (Senior social worker/families).

They do a questionnaire after all training and also then through supervision and things like that; you know, the managers find out how, whether you'll use the training, how you see using it. So yes, there is a good impact on using training. (Member, youth offender team).

Workforce development is an important aspect in addressing alcohol issues among wider client groups; but staff turnover and mobility mean that organisational commitment is a necessary element if training and other efforts to broaden the delivery of IBA are to be sustainable. While 68% of survey respondents stated that they did pass on their knowledge of IBA to other colleagues, 32% did not; only 54% stated that their colleagues had expressed an interested in IBA and just over a third of respondents (37%) said that if they left the agency, a trained worker would be able to carry out IBA. However, 69% said that colleagues were interested in receiving ''some generic alcohol training''. The managers we interviewed reported that efforts were made to identify appropriate training and share learning, typically, noting feedback at team meetings and occasionally, completion of a post-training questionnaire:

Each manager has to do a training needs analysis for all the training that you feel that your staff will require for the following year. So I list everything from mental health training, risk assessment, risk management and that, to drug and alcohol training. (Supported services manager).

Researcher: Do you talk to people to see if they have actually been able to put things into place what they have learnt? Manager:- We do. One of the things we do when a member of staff has been on training is to ask them to feedback to team meetings as well as about what they found useful and skills they could use from the training, and indeed whether or not they have actually been able to put it into practice or not, because as I said, one of the difficulties is that you don't know really whether alcohol is going to be an issue or not. (Manager, family services organisation).

However, given the complex organisational structures within which many trainees were employed, line managers were only one link in the organisational chain and also subject to pressures. This became particularly stressful at a time when resources were being cut. As one interviewee recognised:

Their workload is tough and they have goals to achieve, coming from top down. Sometimes managers are being told this is what you have to do and there is no negotiation. Managers are in the position that they have to tell their staff: That's how it is, you have to manage. It will get worse; some colleagues are starting to go off with stress. (Counsellor, local services).

Discussion

The training described in this article is not necessarily typical. In the UK, there is a large number of IBA and alcohol awareness training programmes being delivered at local level by different providers and in variable formats (e.g. see http://www.alcohollearningcentre.org.uk/). Delivery models include face-to-face and, increasingly, on-line, self-directed learning and are variable in length of training, training materials and methods. This raises questions – supported by some of our data – regarding the possible need for some standardization and for further examination of how to fit or adapt IBA training to suit specific professional and work contexts. It is not that existing training is inappropriate; rather that we have too little information about what is being delivered and whether it is adequate to meet the training needs of professional groups outside traditional health settings and working in agencies which are frequently part of complex networks of service provision. It may be that IBA is not suited (in its intended form) for use in all work contexts. As illustrated in this account, very few people actually delivered IBA after training, screening was considered as inappropriate in many circumstances and it is likely that what was delivered by some trainees was an adapted version of IBA (These results are similar to the findings in other studies, e.g. Fitzgerald et al., 2014). The question arises, then, – should IBA be delivered as intended or can it be adapted to suit different work contexts and how far can it be adapted and still be IBA? (This is addressed more fully in the expert workshop: Thom et al., 2015). The findings highlight the need to consider who is best placed to receive IBA training and which contexts are more likely to prove appropriate for the incorporation of IBA into routine practice.

Our findings support the results from other studies (Fitzgerald et al., 2014; Parkes et al., 2011; Stead et al., 2014) that ''therapeutic commitment'' continues to be relevant and of particular importance in efforts to expand IBA delivery beyond primary care and hospital settings. Even where, as in this study, respondents feel it is a legitimate part of their role to ask about alcohol consumption, perceptions and experiences of the relevance of IBA to actual working practices are major factors determining whether IBA is applied as a standard tool, or partly applied – generally ''advice'' rather than screening – or not applied at all. Training might fruitfully address aspects of role security and role relevance which may need strengthening within training programmes. Whether training based on multi-disciplinary and multi-work contexts is preferable to single professional or in-house training emerged as an issue which warrants further exploration; but it is important in considering how to make IBA a relevant part of current working practices. However, securing professional behaviour change is, as noted above, only one element in expanding the reach of IBA beyond traditional health care settings. What we have called ''organisational commitment'' is also key to the spread of IBA to contexts such as social care, housing, criminal justice or education and youth services.

In the course of the study, it became apparent that the term ''organisation'' needed more thought. The data draw attention to the problem of defining and examining the role of the organisation in facilitating or hindering use of IBA. ''Organisation'' may mean one agency or it may be a composite of several agencies, sometimes placed in different geographic locations and sometimes engaging in

different aspects of practice, e.g. a group of agencies providing a variety of family services. Furthermore, organisations and agencies may be linked to, or part of, local prevention, treatment, care or other helping services. Thus, understanding the structure of an organisation and its position within complex local systems is relevant both to identifying the potential uses of IBA and to developing appropriate training. For instance, as our findings showed, in many work contexts, screening using a standard tool such as AUDIT is not seen as appropriate or practical. Within organisations (or agencies), our data and the experience of participants at the expert workshop suggest that training may have short-term impact at best if the organisational infrastructure is not in place to provide support for IBA delivery and to ensure that training and learning is not restricted to individuals and lost when they move on (Thom et al., 2015).

Rhydderch, Elwyn, Marshall, and Gral (2004) posit that organisations are complex adaptive systems, continually evolving and changing through the interactions between actors within the organisation and the wider environment. Issues of complexity and flexibility to adapt to changing circumstances are important factors in the health and social welfare area where there is likely to be constant re-structuring and workforce turnover. Viewing organisations as complex adaptive systems encourages examination of the links between IBA training, workforce development, possible shifts in an organisation's culture and in collective learning within the context of changes in the wider environment. It also emphasises that, although training is a valuable element in broadening delivery of IBA to diverse contexts, as in clinical practice, education of individuals alone is unlikely to change behaviour (Babor & Higgins-Biddle, 2000).

We recognise that our sample is small and unlikely to represent those who have received training of one kind or another throughout the UK. Response rates to the survey were low and our follow up interviews were dependent on survey respondents providing email contacts (very few did and some did not reply when contacted). We also recognise that time from training was likely to affect delivery of IBA, either by giving more time for trainees to put their knowledge into practice or for a drop in the level of delivery stimulated by training. Despite the limitations, it could be argued that those who answered the survey and the request for interview present a ''best scenario'' picture in that they were motivated enough to engage with the topic. Furthermore, the picture of IBA delivery post-training and the challenges of implementation that emerge from the survey and from the qualitative data reflect the findings from other research and from the experience of participants at the expert workshop (Fitzgerald et al., 2014; Parkes et al., 2011; Stead et al., 2014; Thom et al., 2015). In particular, the study reported here indicates the need to examine the role of IBA within a complex, interactive system of related services and help seeking pathways and to consider how training can contribute to changing both professional attitudes and behaviours and organisational approaches to implementing and sustaining IBA into professional practices.

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