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To cite this article: Rachel Herring, Betsy Thom, Mariana Bayley & Jordan Tchilingirian (2016): Delivering alcohol Identification and Brief Advice (IBA) in housing settings: A step too far or opening doors?, *Drugs: Education, Prevention and Policy*, DOI: [10.1080/09687637.2016.1176992](https://doi.org/10.1080/09687637.2016.1176992)

To link to this article: <http://dx.doi.org/10.1080/09687637.2016.1176992>



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Published online: 16 May 2016.



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REVIEW ARTICLE

Delivering alcohol Identification and Brief Advice (IBA) in housing settings: A step too far or opening doors?

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Abstract

Within the UK, there is a drive to encourage the delivery of alcohol screening (or identification) and brief advice (IBA) in a range of contexts beyond primary care and hospitals where the evidence is strongest. However, the evidence base for effectiveness in non-health contexts is not currently established. This paper considers the case of housing provided by social landlords, drawing on two research studies which were conducted concurrently. One study examined the feasibility of delivering alcohol IBA in housing settings and the other the role of training in delivering IBA in non-health contexts including housing. This paper draws mainly on the qualitative data collected for both studies to examine the appropriateness and feasibility of delivering IBA in a range of social housing settings by the housing workforce. Findings suggest that while it is feasible to deliver IBA in housing settings, there are similar challenges and barriers to those already identified in relation to primary care. These include issues around role inadequacy, role legitimacy and the lack of support to work with people with alcohol problems. Results indicate that the potential may lie in focusing training efforts on specific roles to deliver IBA rather than it being expected of all staff.

Introduction

Alcohol identification and brief advice (IBA) involves using a validated screening tool to identify individuals drinking at 'risky' levels and then giving brief advice aimed at reducing consumption to lower risk levels (see Heather, Lavoie, & Morris, 2013 for a detailed description). Within the UK, there is a current drive to encourage the delivery of alcohol IBA in a range of contexts beyond primary care and hospitals where the evidence for IBA is strongest, for example, education and probation. However, the evidence base for effectiveness in non-health contexts is not currently established (Thom, Herring, Luger, & Annand, 2014).

Housing, more specifically the social housing sector, is one of the contexts seen to offer opportunities for early intervention approaches, including IBA. The English Housing Survey classifies households as owner occupiers, private renters or social renters (Department for Communities and Local Government DCLG, 2016) (see Table 1). While most households in England are owner occupiers (64%), a

Keywords

Alcohol, identification and brief advice, housing

History

Received 17 December 2015

Revised 22 March 2016

Accepted 6 April 2016

Published online 12 May 2016

significant minority rent accommodation either from private landlords (19%) or from social landlords (17%) (DCLG, 2016). Social landlords are local authorities (councils) or not-for-profit housing associations and they provide a wide range of housing services, from properties for rent at low cost through to highly supported accommodation for people with complex needs. Access to social housing has been based on needs-based criteria and by law, certain groups are given 'reasonable preference': the legally homeless, those who are in inadequate or inappropriate housing (e.g. unsanitary, overcrowded), those who need to move because of a disability, or medical or welfare reasons (Shelter, 2016). Social landlords are financially regulated and funded by the government through the Homes and Community Agency (Homes and Community Agency, 2016) and the sector is overseen by the Department for Communities and Local Government (DCLG).

There has been a marked decline in size of the social sector, in 1981, the sector accounted for 5.5 million households (32%) but by 1991, this had dropped to 4.4 million households (23%) and by the end of the twentieth century, had declined further to 4.0 million households (DCLG, 2015, p.25). This decline is due to both low build rates and the 'Right to Buy' scheme introduced in the 1980s by the Conservative government which allowed existing council tenants to buy their homes at a discount on the market value (DCLG, 2015). Evidence indicates that the decline in the size of the social sector has been accompanied by a change in the profile of tenants, with the sector moving from housing a

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Table 1. Housing tenure in England 2014–2015.

Tenure type	Description	Number of households ^a (total 22.5 million)
Social renters Rent from local authorities/councils (LA) ^b & Housing associations (HA), Local housing companies, co-operatives & charitable trusts	LAs, HAs, often known as Registered Social Landlords (RSLs), operate on a not-for profit basis, invest surplus into maintenance of properties or building new	3.9 million (17%). Of these: 2.3 million (10%) rented from HA 1.6 million (7%) rented from LA
Private renters Rent from a private landlord & includes all whose accommodation is tied to their job, people living rent-free (e.g. in a flat belonging to a relative)	Properties typically owned by a private individual or a business & let as part of a commercial operation	4.3 million (19%)
Owner occupiers Living in accommodation which they either own outright, are buying with a mortgage or are buying as part of a shared ownership scheme	Individuals, who own or co-own a property which they live in.	14.3 million (64%) Of these: 7.4 million (33%) owned outright 6.9 million (30%) had a mortgage

Source: Compiled from English Housing Survey Headline Report 2014-15 (DCLG, 2016).

^aHousehold is defined as: one person living alone, or a group of people (not necessarily related) living at the same address who share cooking facilities and a living room or sitting room or dining area (DCLG, 2016, pp. 47/48).

^bIncluding Arms Length Management Organisations (ALMOs) and Housing Action Trusts.

broad spectrum of society in the 1970s to now housing the poorest and most vulnerable people in society, a process which has been termed ‘residualisation’ (Scanlon & Whitehead, 2008).

Within the UK, social housing has long been a site for the regulation of behaviours. For example, in 1998, the New Labour government introduced Anti-Social Behaviour Orders (ASBOs) which have become a key apparatus for controlling behaviours regarded as ‘unacceptable’ in neighbourhoods (McNeill, 2016). Social landlords are now expected to fully manage the ‘problem’ behaviours of residents (McNeill, 2016) and landlords have greater powers in the regulation and surveillance of any anti-social behaviour of residents (Anderson, 2011; Burney, 2009). In addition to the traditional needs-based criteria outlined above, access to social housing has been increasingly linked to behaviour (e.g. rent payment record, anti-social behaviour complaints) which acts to exclude people from social housing (McNeill, 2016; Sanders, 2016).

As a result of these shifts in housing provision and occupancy, the role of social landlords has changed from simply providing ‘bricks and mortar’ to a broader focus on neighbourhood and fostering vibrant communities. There is evidence to suggest that the role of the housing workforce is evolving to include interventions supporting health and well-being and housing services are being developed with the aim of delivering a positive impact on the health and wellbeing of residents (Patten, Scriminger, Baxter, & Leng, 2015). The shift to a broader role for the housing workforce necessitates a greater degree of partnership working with other services, in the case of alcohol, possibly local specialist and hospital services as well as primary early intervention services. The call for greater engagement in health and wellbeing is not without challenge and critics have pointed to the enormous variation in the local contexts which impact on the extent to which different parts of the housing sector may find it possible, or desirable, to take on an enlarged role with their tenants (Harding, 2013). As research on IBA delivery has shown, there is a tendency for professional groups to protect their work boundaries and to resist role expansion (Thom et al., 2014).

Training is frequently suggested as the solution to persuading professionals to adopt new approaches and practices; but the evidence suggests otherwise. Training alone does not secure change in professional behaviour. As Nilson (2010) notes, most research has concentrated on individual health professionals’ behaviour with much less attention on organisational and wider society level factors. Professional and organisational issues were considered in two research studies which were conducted concurrently by the authors. One study (Feasibility) examined the feasibility of delivering alcohol IBA in housing settings and the other (Training) considered the role of training in delivering IBA in non-health contexts including housing settings.

Methods

This paper draws mainly on the qualitative data collected for both studies. The qualitative approach was considered as most suited to exploring views in-depth on the appropriateness and feasibility of delivering IBA in housing contexts by the housing workforce. Key research domains which guided the data collection for both studies and which we address in this paper were:

- (1) *Current exposure to alcohol issues*: How, if at all, are alcohol consumption and related harms raised/discussed/responded to within current working practice?
- (2) *Understanding and perceptions of IBA*: What is understood by alcohol IBA? Is IBA (screening element, advice element) seen as appropriate for use with clients in this sector? What are the perceived barriers and challenges?
- (3) *Role perception*: Ideally, what would participants like to see implemented by way of addressing alcohol related harms in their client group? What do they consider as ‘best practice’ regarding addressing clients’ alcohol related problems?
- (4) What is needed to work towards implementing best practice (IBA? Other interventions?).

For the Feasibility study, focus groups and telephone interviews were conducted with staff and residents¹ among

four social landlords in four sites. While we were not aiming at a representative sample, the sites were selected to ensure that we had a geographical spread across England, both local authority and housing association providers, and a wide range of provision (i.e. general housing, supported settings and services).

Focus group interviews were conducted with residents and staff at three sites: Northern England, South coast of England and South East England. Brief telephone interviews were conducted with staff at the fourth site (London) as the dispersed nature of the services and working patterns (shift work, staff working across projects) made it impractical to convene a focus group. Telephone interviews were conducted with one manager at three sites (Northern, South Coast, London) and two at South East. Despite the considerable efforts of housing association staff and a variety of recruitment approaches (posters, emails, newsletters, asking individuals, snowballing), we were unable to recruit residents at one site. Attempts to recruit more general needs residents from additional sites and through personal contacts came to no avail.

The focus groups and interviews were directed but the schedules were sufficiently flexible to allow new issues to emerge. Focus groups with staff covered the domains noted above. Discussions with residents covered situations where they had had discussions around alcohol (e.g. consumption, health harms) with professionals (e.g. GP, pharmacist) and in a particular context (routine appointment, attendance at Accident and Emergency department). In addition, issues of acceptability and appropriateness were explored, particularly in relation to housing settings and staff.

Findings from the Training study draw on the results of the overall study but more specifically on the qualitative data from a housing case study. The case study involved hosting a workshop, which was attended by staff working in the social housing sector in a variety of roles (support, management) and settings (general housing, supported housing and hostels). The workshop drew on Appreciative Inquiry (AI), which is a change philosophy and methodology which focuses on developing an organisation's core strengths rather than seeking to overcome or minimize its weaknesses (Cooperrider & Srivastva, 1987). Thus, in line with the principles of AI, the workshop sought to *discover* the current 'best practice' in relation alcohol issues, *dream* about what in an 'ideal world' respondents would like see in place to address alcohol related harms within their resident group, think about and *design* how that could be done (Cooperrider, Whitney, & Stavros, 2003). The limits of the research project meant that we did not engage with the *destiny* stage of the AI model which entails translating the design into action. Four consecutive sessions were held with the same staff, each of which built upon the previous one. As part of the broader Training study, two people working in supported housing settings were interviewed and the transcripts of these interviews were included in the analysis.

The Alcohol Use Disorder Identification Test (AUDIT) was developed by the World Health Organisation as a simple method of screening for excessive drinking and to assist in brief assessment in primary care (Babor, Higgins-Biddle, Saunders, & Monterio, 2001). AUDIT comprises 10 items, questions 1–3 concern consumption and the remaining seven

concern consequences and harms associated with drinking (e.g. injuries, not being able to remember what happened the night before). Staff at the focus groups and the workshop were supplied with details (including the scoring systems) of AUDIT and the shortened version AUDIT C (Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998) which entails asking the three consumption questions and if the score is 5 or above, then the remaining questions are asked. Examples of patient information leaflets used in IBA were also provided.

Ethical approval for both studies was granted by Middlesex University's Ethics Committee. All participants were provided with written (and verbal) study information, assured that confidentiality and anonymity would be preserved and consent was obtained from all participants. Broad labels are used on quotes to protect the identity of individuals. The interviews and focus groups were, with permission, audio-recorded and transcribed in full. The data for the Training study was collected and analysed by two researchers (MB and RH) and for the Feasibility study by three researchers (RH, MB and JT). Verbatim transcripts were coded and thematic content analysis used to identify key themes (Robson, 2011). The researchers worked closely, discussing emergent themes and categories at each stage of the process to facilitate the identification of key themes, discuss and resolve any differences in opinion and double coding was used at the start of the coding process to ensure consistency (Lincoln & Guba, 1985). There were no significant differences in opinions about the key themes and consensus was easily reached.

Sample

In the Feasibility study, we did not aim for representativeness but did try to include men and women, a range of ages and people with different levels of support. Twenty adult residents participated in focus groups (see Table 2).

Six were general needs residents, the remaining 14 ranged from tenants who were living independently but receiving specific support (e.g. with finding employment) through to those living in highly supported settings (e.g. hostels for people with complex needs) spread over three sites. They each received a £15 shop gift card as a 'thank you' for their participation.

Thirty housing staff participated in interviews/focus groups for the Feasibility study (see Table 3). Participants held a variety of roles including neighbourhood manager, tenancy sustainment officer, project support worker and income management officer to allow us to explore what the opportunities and challenges for delivering IBA are for different staff.

For the Training study, 10 staff (four women and six men) were recruited from two housing associations to participate in the workshop. Participants held a variety of roles which were in line with those in the Feasibility study. The other two

Table 2. Tenants focus group participants (age and gender).

Gender/age	18–24	25–44	45–64	65+	Total
Women	1	1	4	2	8
Men	1	6	4	1	12
	2	7	8	3	20

Table 3. Housing professional participants.

	South Coastal	London	Northern	South East	Total
Staff	12	4	6	3	25
Managers	1	1	1	2	5
Total	13	5	7	5	30

participants (one man and one woman) included in the housing case study had been recruited for the broader Training study and both had been trained to deliver alcohol IBA and worked in supported housing settings. While the results of the focus groups with residents underpin and inform this paper, the primary focus is on staff experiences and perspectives.

Results

The vast majority of participants had limited knowledge of IBA and only a few had experience of delivering IBA in their day-to-day work. Participants had all undertaken alcohol awareness training, most attending a half or full day ‘basic’ course. Housing managers suggested that for the majority of their staff, alcohol awareness was the most appropriate training as their main role was to signpost to additional help and be aware of referral routes rather than to intervene directly. Staff working in homeless and/or with those who have complex needs settings had often had additional training around drug/alcohol issues. Only a small minority of staff had been trained to deliver IBA, but as part of the focus groups and workshops, participants had an opportunity to familiarise themselves with the AUDIT tool and discuss its potential benefits, drawbacks and identify opportunities to deliver IBA within their work.

Five key themes were identified which are discussed below under these headings:

- Alcohol as an (in)visible issue
- Delivering alcohol IBA
- Dual enforcement-support role
- Signposting and supporting change
- ‘Who the hell are you? You’re not my doctor’: questions of legitimacy

Alcohol as an (in)visible issue

Within general needs housing settings, alcohol use and misuse was not routinely considered and no information was collected, but alcohol was recognised as a key factor in anti-social behaviour cases, where the need for repeat repairs to accommodation and difficulties in sustaining a tenancy might often arise (e.g. rent arrears, deterioration of property, etc.).

“It becomes our problem when it starts to become antisocial behaviour and it’s starting to affect other tenants or just the general public basically. So once it starts to affect someone else, then it becomes our problem.” (Training study, manager, general needs).

In most instances, it was a neighbour who raised the ‘problem’. On other occasions, the computer system or customer care line had ‘flagged up’ that access had been

refused for routine visits, such as gas service checks, maintenance/repairs or that there were rent arrears. Importance was placed on following up such management ‘niggles’ and a manager would investigate by visiting the property, speaking to the tenant and neighbours and looking at the records on the tenancy. If there were concerns about possible alcohol misuse then a resident would be ‘signposted’ to receive additional help, which may be from within the housing association e.g. Tenancy Sustainment Officer (TSO) and/or an external agency e.g. local alcohol services.

Staff within general needs settings emphasised that the central concern was any breach of the tenancy. Alcohol related health harms were not a consideration:

“But we don’t really look at it from like a health perspective you know, our main concern is just whether or not there is peace in the community. . . . We do take that stance as well because in our schemes where there’s like flats and if somebody is causing a problem with antisocial behaviour because of their drinking or drug taking, we do take a harder stance, because it is breaking their tenancy. So the antisocial behaviour is you know whether it comes from whether it’s drink, alcohol, loud music.” (Feasibility study, neighbourhood manager, general needs).

The costs incurred by social landlords when a tenancy breaks down are substantial so the onus is on prevention. Interest in and action on alcohol thus stemmed from housing priorities rather than concerns around health.

Within general needs settings, having a problem with alcohol was generally equated with being ‘alcoholic’, and staff appeared to have a limited understanding of the complexities and breadth of alcohol-related harms. General needs housing staff described some of their residents as ‘functioning alcoholics’, of whom they were aware but who did not cause ‘problems’. Such residents would be left to lead their lives unless a problem arose which required intervention on the part of the housing association. These crisis points (e.g. rent arrears, complaints from neighbours) would generally result in an offer to refer the individual to a specialist service, which may or may not be taken up by the individual.

In homeless and complex needs’ settings, alcohol misuse was recognised as a key issue for many residents and staff had a more nuanced understanding of alcohol problems, with many having undertaken additional training. The overarching goal was to work with the individual to help them make positive changes within their lives, including reducing their drinking. Alcohol was built into broad routine risk assessments and assessed in terms of risk of ‘severity’ and ‘likelihood’ of risk to self and others. While health was a consideration, on a day-to-day basis, housing related priorities were to the fore, e.g. where alcohol consumption contributed to disputes between residents, damage to property and aggressive behaviour:

“There are people who they’ll start to drink and once they start to drink then they can start to cause issues. So they might start to be aggressive or too ‘friendly’, or start lending money, borrowing money, argumentative.” (Feasibility study, project worker, supported housing).

The visibility of alcohol-related harms appeared to be an important factor in the approach taken across the sites and is

perhaps linked to the focus on the impact of alcohol on housing priorities. If a resident causes a disturbance or is violent towards another resident in a hostel as a result of their alcohol consumption then the alcohol problem becomes manifest, while alcohol related health harms may be not recognised or hidden. An alcohol-related health crisis may bring the issue to the fore and prompt intervention, usually in the offer of a referral to specialist services.

Delivering alcohol IBA

Across the studies, there were two services that had embedded the AUDIT screening tool into routine assessments, one following a pilot of IBA and another following training of all staff to deliver IBA. Both provided services for individuals with complex needs. A manager explained that prior to the IBA training staff had conducted a broad risk assessment and would have only made a note if alcohol was a known problem, but the IBA training had directly led to changes in procedure:

“They (staff) do the AUDIT as a matter of course to be fair to them. It’s all part of risk assessment now, because rather than just doing it when, because you feel that someone has a drink, we do it with all kinds whether they’ve had a drink or not... it’s incorporated at the start of the, at the (first) meeting, so the resident knows where you are coming from first and foremost, because it’s a bit like professional boundaries, you’ve got to treat them obviously with respect, but you are the support worker, you’re there to provide support to them and these are the rules of engagement if you like.” (Training study, manager, supported housing).

Thus, there had been a shift, from responding to alcohol if it was an ‘issue’ to screening all residents and thus making visible any possible hidden harms. The decision to train all staff to deliver IBA was largely in response to a change in the profile of residents with an increasing number experiencing difficulties in relation to their alcohol use. While a small proportion of residents was identified as having a ‘primary’ alcohol need (around 5%), it was estimated that alcohol was of ‘secondary’ concern for about a third of residents. The housing provider is paid for the hours of support they deliver so if they are unable to support residents, and the care of the resident has to be taken over by another organisation, then the housing provider stands to lose money, as the manager explained:

“Our contract is 612 hours week and if I have to offload 30 residents because we can’t support them with alcohol issues then we start losing money”.

Thus, for this housing provider, a crucial factor in deciding to embark on training all staff was the financial implications of *not* doing so. The training also led directly to changes in policy and procedures. For example, staff working alone are no longer permitted to enter a property if the resident is drunk or has drunken visitors. Residents are made aware that they have to be sober when staff visit or else the appointment will be cancelled and rearranged.

Within the other service which had incorporated IBA, many of their residents had long standing alcohol problems. Staff found IBA useful as a starting point for ongoing dialogue and a pathway for more intensive work:

“It’s a good way to build relationships, it’s a good way to let the clients know that we are interested in them and we are

interested in how much they’re drinking and how to reduce that or know how to put harm minimisation interventions in place.” (Feasibility study, project worker, supported housing).

“...what I have found, even with the dependent drinkers, is that it (*AUDIT*) took me to having slightly different conversations with those guys than I might otherwise have done...for example I wouldn’t generally ask about guilt and shame you know, but one of the questions asks people about that, so you end up discussing that a bit. I wouldn’t necessarily ask if they have been injured in the last year, you know and then you find out that sort of information.” (Feasibility study, manager, supported housing).

Specialist (drug and alcohol) staff at this service reported using the AUDIT score as a baseline to set goals and then revisiting to explore progress. They also adapted the tool to make it more salient for their clients, for instance, using a shorter timeframe than the last 12 months (e.g. last 4 weeks) and setting aside the recommended drinking guidelines to work with the clients to reduce consumption (e.g. for those drinking 10 cans of high strength beer a day to gradually reduce to nine cans a day and so forth). Staff worked in conjunction with external drug/alcohol services to support their clients to make positive changes in a safe manner.

As already noted, the visibility of alcohol problems plays an important part in how services respond to alcohol related issues. Staff reported that the introduction of IBA had made ‘visible’ alcohol problems in individuals that may otherwise have been overlooked:

“...a guy who presented very smartly and very together, he was drinking on a unit basis more than anyone else I interviewed you know. So it isn’t always that you can spot the dependent drinkers who are drinking in a harmful way.” (Feasibility study, manager, supported housing).

Dual enforcement-support dual role

There was a general consensus that the role of social housing staff had altered over time and that they were being asked to take on additional roles, for instance, in relation to health and welfare. Participants felt that cuts to public services meant that housing staff are now working with people with far more complex needs and moreover, that housing staff are often the cornerstone of support. They highlighted that the role of social housing and consequently housing management had, as one participant explained, changed from being just ‘about enforcement, it’s now more about support and enforcement’. Support and enforcement were seen to go ‘hand in hand’:

“So it’s more about how can we support our residents to sustain their tenancies and obviously part of our role, to enforce a tenancy is to ensure that we are trying to support people as well.” (Training study, manager, general needs).

Furthermore, there is a legal obligation for a housing organisation to demonstrate how they have supported a resident prior to eviction:

“There are too many rules around the Equalities Act and you can’t, you wouldn’t be able to just enforce because you’ve got to be aware of everything and make sure you’ve done everything before you enforce. If you were just enforcing you wouldn’t be doing that.” (Feasibility study, staff, general needs).

However, the ability to sanction people was viewed as an important tool and that for some people the possibility of eviction could act as a ‘catalyst’ for positive change.

This dual enforcement-support role is reflected in the roles of frontline staff. In both studies and across all sites participants explained that their jobs were multifaceted and as one termed it, involved ‘wearing lots of different hats’. For example, a Tenancy Sustainment Officer explained how their job overlapped with the work of a neighbourhood manager because their primary aim is to maintain a resident’s tenancy. Since becoming a recently appointed health advisor, the Tenancy Sustainment Officer is now also expected to cover ‘health, wealth and wellbeing’.

‘I tend to deal with, or my team tends to deal with any issues to do with tenancy, antisocial behaviour, estate management is a big core part of our business as well, carrying out inspections on the estate, speaking to residents, signposting them to other areas of our organisation that might be able to assist them. Almost, it’s hard to explain, but almost all aspects of their lives we have kind of some involvement with from time to time.’ (Feasibility study, tenancy sustainment officer).

Having such a broad remit meant that staff described their role as falling somewhere between an authority figure and a care giver and/or a support provider. On the one hand they represented the landlord with whom residents have a contract; on the other hand staff may need to enquire about a resident’s private life when this could have a bearing on their ability to sustain a tenancy or housing agreement. Across various sites, staff described their relationship with residents as being paternalistic, but also the person who has to ‘tell them off’ or try to enforce tenancy rules. Occasionally staff struggled with this dual role but on the whole felt that these two sides were quite well integrated.

However, for some staff, this ‘two hat’ role was seen to hold inherent tensions, with the same worker having to be both ‘good cop’ and ‘bad cop’ which could create conflicting demands for the staff and be confusing for the tenant. Moreover, this dual role was thought to create barriers to communication and disclosure:

‘It adds barriers doesn’t it for somebody, if you are dealing with their antisocial behaviour and then they want come to you about another repair issue for example, it’s just, do you know what I mean because you are having to enforce something with them then it stops them from accessing you.’ (Training study, staff, general needs)

In relation to alcohol issues, the duality inherent in the staff’s role was seen as creating tension for residents, particularly early on in an intervention when it might initially discourage residents from engaging with services to which they had been signposted.

‘If we identified that someone may potentially have alcohol problems but they are particularly cagey about it to us, because we are more of an authority figure, you know people are less likely to admit that . . . they are less likely to kind of, you know it depends how you approach someone. But you know people tend to be like ‘Oh it’s my housing officer, I’m in trouble, I don’t really want to talk about the ins and outs of my life.’’ (Feasibility study, staff, general needs).

Managers highlighted that they are required to look at the ‘bigger picture’ and provide support to neighbours and the neighbourhood, as well as individuals, which can create tensions and challenges.

Signposting and supporting change

Staff across all settings emphasised the importance of establishing a relationship, based on trust with residents. They also reported that they are expected to talk about ‘everything and anything’ and it was a key requirement to be able to raise and discuss sensitive subjects. Housing staff viewed their role as to ‘signpost’ individuals with alcohol-related problems to specialist services. This ‘signposting’ function was not specific to alcohol related issues, rather it reflects the broader role of housing staff to refer on for additional support from within the housing association and/or external specialist services. Managers were aware that general housing staff already have a heavy workload and are being asked to take on additional roles, but there are limits to the level of support they can offer as they simply do not have the time or resources. ‘Signposting’ thus reflects the limits of their roles and resource constraints but also acts as a mechanism to maximise the support an individual/family receives:

‘I think what most people need to understand about all our roles is there’s just so much we can do and so much involvement we can have in people’s lives or to make those significant changes at that moment. As it stands we have so many referrals we make, employment, child poverty, troubled family, tenant welfare, safeguarding, Don’t Walk on By, ASB, it’s just endless.’ (Training study, manager, general needs).

Staff working with people who are homeless and/or have complex needs emphasised the importance of taking a person centred approach and were skilled at finding hooks and levers for change to help the individual to make positive changes within their lives, including reducing their drinking. Staff reported using motivational interviewing which seemed to be an ‘everyday’ approach which they were comfortable with using.

‘Who the hell are you? You’re not my doctor’: questions of legitimacy

Questions of legitimacy of staff to introduce or discuss certain topics, including their drinking, were raised by both staff and residents across the two studies. A number of aspects of legitimacy were identified all of which have implications for the delivery of IBA. First, residents needed to be able to see a direct connection between the concerns they raised and further discussions pursued by staff. Second, the expertise of staff and their legitimacy in gathering information about non-housing matters was questioned. Third, disclosing certain personal information that would be recorded could be seen as intrusive and there were concerns about how that information may be used.

The idea of being asked about issues such as alcohol out of context or unrelated to the concerns of residents was widely criticised by both staff and residents. Residents noted that this would either cause an ‘alcoholic’ not to disclose or deny their

drinking, or offend someone without a drinking problem. As one resident colourfully suggested, if their employment key worker raised issues about alcohol ‘you’d tell them to bugger off’. This view was mirrored by staff.

“[. . .]they’re talking about getting back into work and other things and then a discussion about alcohol can feel perhaps for the client, coming completely out of the blue, or it’s something that they feel very uncomfortable in discussing.” (Feasibility study, staff, supported).

Residents queried the legitimacy and expertise of housing staff asking questions about non-housing matters. Similarly, housing staff recognised that they are not part of the medical profession with whom residents are used to sharing personal information.

“If we are starting to talk about ‘Oh yeah did you know that drinking this much could have an adverse effect on your health?’, I could just imagine most of our tenants just being like ‘You know . . .’

What’s that got to do with my house?

Who the hell are you, you’re not my doctor, get out of my house.’ (Feasibility study, staff, general needs).

Staff also acknowledged that they are not experts in the advice they might be giving, especially in the case of health related information. They were apprehensive about introducing questions about personal issues that might uncover alcohol problems, previously unrecognised by a resident, which would then become a concern and raise expectations on the part of the resident which staff would struggle to meet.

Gathering personal, non-housing related information that would go on file was seen by both staff and residents as intrusive and there were concerns about how that information could be used:

“It’s a fine line for intrusions and asking for a reason, I think if they said to me, ‘Would you mind answering this question it’s because of this’, I’d probably say ‘Yes’. If they just asked me straight out I’d say ‘Well why, you know, why do you want to know. . .?’ Because you’re passing on information about yourself to somebody else.” (Feasibility study, resident, general needs).

“So if it’s about asking questions (*AUDIT questionnaire*) we can do that. But for me it’s more about actually what do we do with that information and what’s the purpose of us actually asking those questions, will the residents see us as confidants to disclose such information. You know all that kind of personal, it’s quite personal these questions.” (Training study, manager, general needs).

Some staff and residents thought that the emphasis should be on getting the basic housing issues right e.g. sorting out repairs, rather than undertaking ‘non-core’ work such as alcohol IBA. Questions were also raised about the practicalities of delivering alcohol IBA to general needs residents who may have limited contact with housing staff, its utility for staff and residents and there was a concern that if alcohol IBA was made mandatory it could become a ‘tick box’ exercise.

However, other staff felt that there were opportunities to deliver alcohol IBA to general needs residents, for example, at the ‘welcome’ visit or tenancy review. In addition, staff identified a variety of ways of raising awareness of alcohol

issues and improving information as part of the broader health and wellbeing role that they are developing, for example, health and wellbeing events, resident newsletters, information on housing providers websites.

Discussion

While the findings of these studies indicate that it is feasible to deliver alcohol IBA in social housing settings, it was also evident that there are challenges and barriers. As Thom et al. (2014) note, there is considerable consistency across the literature regarding some of the challenges faced when trying to implement alcohol IBA. Once again, these two studies highlight the saliency of issues around feelings of role inadequacy, concerns about role legitimacy and worries that there is insufficient support to work with people with alcohol problems – issues identified many years ago as barriers to delivery in primary care which are still relevant and highly important. Many staff, particularly those working in general needs settings, had a limited understanding of alcohol issues or the possibilities for intervention and were doubtful that alcohol IBA was ‘worth’ investing time and effort in. Whilst we know that training staff is not enough to guarantee delivery of alcohol IBA (Thom et al., 2014), what is not clear is what mechanisms are required to improve the understanding of alcohol problems and the range of evidenced interventions, to foster a belief that it is ‘worth’ addressing alcohol issues.

Sanders argues that housing policy is now based on a blend of ‘coercive and incentivising measures’, that act to bring ‘social landlords in as another policing agent to survey behaviour, encourage a return to work and manage anti-social behaviour’ (Sanders, 2016, p. 203). In general needs’ settings, there was uneasiness about the level of intrusion into the private lives of residents that alcohol IBA was thought to represent and reservations expressed as to whether alcohol was the legitimate ‘business’ of social landlords and a reluctance to take on this surveillance role. In contrast, in homeless/complex needs services, alcohol was seen as the ‘business’ of social landlords which is probably a reflection of the prominence of alcohol issues for this client group.

The breadth and diversity of the social housing sector presents a challenge in itself. Our findings indicate that ‘a one size fits all’ approach is unlikely to succeed and some thought is required as to where alcohol could ‘fit’ across settings. There is evidence from health settings that staff are more likely to deliver IBA if it makes ‘sense’ and if it is relevant and useful in carrying out their roles (Thom et al., 2015). Alcohol has high saliency in services for people who are homeless/and or have complex needs and staff are engaged in supporting people to set goals and make changes over time to enable them to live as independently as possible. Thus, staff are well placed to deliver alcohol IBA and there is room for development. Whilst there seems to be less scope within general needs settings, there were specific roles that appeared to have potential to deliver alcohol IBA, for example, Tenancy Sustainment Officer, Income Management Officer, but further exploration of feasibility and acceptability from the perspective of staff and residents is required. Thus, rather than train

everyone it may be more appropriate to train fewer but better placed staff.

Staff felt it was appropriate for housing organisations to involve themselves in some areas of a resident's personal affairs, such as support with money matters and employment; this is irrespective of whether there are problems or not, as there is a direct relationship between income, employment and maintaining tenancy. A similar pathway was not evident in the case of a resident's drinking habits, unless their drinking is creating problems in maintaining tenancy, they are causing trouble in their neighbourhood or have high support or more complex needs. Furthermore, there was uneasiness about the level of intrusion into the private lives of residents (in particular general needs) that alcohol IBA was thought to represent. In considering how IBA might be developed in housing settings, this 'invisible' pathway may need to be made more transparent or explicit to social landlords and staff to highlight the relevance of IBA in their setting.

In one housing association, the decision to train staff to deliver IBA and to embed it into routine assessment was rooted in potential loss of income if they did not and thus IBA made business sense for that organisation. Tenancy break-downs are costly for housing associations, with respondents emphasising the importance of prevention and alcohol IBA was seen as a potentially useful component of a broader package of measures. Further work is needed to establish whether alcohol IBA can contribute to achieving the core goals of social landlords i.e. maintain housing stock, sustain tenancies; if this is the case then social landlords might feel it warrants investing in (i.e. staff training, incorporating into data recording).

Widening the delivery of IBA outside clinical settings raises ethical issues. It is important to consider whether the ethical norms that people expect in a primary health setting can be honoured in other contexts and people need to believe that in housing settings, the same norms will be upheld. Issues of confidentiality and consent – taken somewhat for-granted in clinical settings – may present barriers to IBA delivery in housing settings – as in other occupational contexts, such as social work. As already noted, relationships between professionals and residents might be damaged by an ill-timed intervention or one that is viewed as inappropriate by the resident and this may negatively impact on engagement with housing staff and services. While there is supporting evidence for the delivery of IBA in clinical settings, to date there is a limited body of evidence to support delivery in non-health contexts (Thom et al., 2014). Recent work suggests that over half of those trained to deliver IBA in non-health contexts either do not carry out IBA or do so very rarely (Thom Herring, & Bayley, under review). This begs the question as to whether this is an appropriate use of resources.

In conclusion, then, several key points emerged from these studies and have implications for the 'mainstreaming' of IBA approaches to wider occupational contexts and professional groups. Perceptions of role legitimacy and role relevance need to be addressed and training and the proposed intervention tailored to take account of current practices and professional opportunities and constraints to implement IBA. There needs to be greater awareness of the dilemmas of wearing 'two hats' inherent in many working situations. The diversity of possible

roles needs further consideration – direct intervention, signposting and supporting change and other possible interventions may require separate forms of training and different implementation processes. Training might be more effective if more carefully targeted towards those working in specific, relevant contexts. Ethical issues which arise in implementing IBA beyond traditional health settings have received little attention in the literature but are clearly important for many professionals and interact with both professional and lay perceptions of the acceptability of IBA – or any intervention – which requires disclosure of personal information.

Acknowledgements

All views expressed are those of the authors and are not necessarily of the funders. We would like to extend our thanks to the participants for taking the time to share their thoughts and experiences with us and also to Dr Lyne Livesey, at the time Department of Health Strategic Partner at the National Housing Federation, for assisting in the recruitment of sites.

Declaration of interest

Betsy Thom has been a member of the research advisory group of IARD (International Alliance for Responsible Drinking, formerly ICAP) since 2012; she has recently assisted as consultant to the project on developing a web based guide to good practice in alcohol education programmes and has given a paper on this topic at a meeting supported by Spirits Europe (October, 2015). All authors drink alcohol. Other authors report no further interests to declare. The Training study was funded by a grant from Alcohol Research UK, Grant Reference No. R/2013/06. The Feasibility study was funded by Public Health England.

Note

1. Within both studies staff used a variety of terms to describe the people they worked with – tenants, clients and residents – which in part reflects the diversity of the service provided. For the purposes of clarity the term 'resident' will be used in this paper.

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