

Appendix F: Implementation of Alcohol Brief Interventions across Scotland

Monitoring and Evaluating Scotland's Alcohol Strategy: 5th annual report.
NHS Health Scotland, March 2015

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Executive Summary

Background

In 2009 the Scottish Government launched their strategy to reduce alcohol-related harms across Scotland.¹ One specific aim of this strategy was to increase the delivery of Alcohol Brief Interventions (ABIs) in an attempt to reduce alcohol consumption and related harms. ABIs can be described as short evidence based, structured, non-confrontational conversations about an individual's alcohol consumption². In 2003, national clinical guidance (SIGN 74) was published which recommended that ABIs were delivered to harmful and hazardous drinkers in primary care settings and this had the potential to be expanded to accident and emergency (A&E) and antenatal settings.² In 2008, an NHS performance target (HEAT target) was established for ABIs delivered across priority settings (primary care, accident and emergency and antenatal care). This target was accompanied by increased funding and investment, training, resources and national coordination in order to embed ABIs into NHS practice. In 2012/13 the target developed into a standard and incorporated ABIs delivered across wider settings, with a minimum of 90% of the standard delivered across priority settings. The aim of the ABI implementation program was to increase the reach and quality of ABIs delivered to harmful and hazardous drinkers, to provide support to those who could benefit, and increase the detection and referral rate of dependent drinkers. In 2011 MESAS published the national ABI evaluation which aimed to assess how ABIs have been implemented across Scotland.

Aim

The aim of this paper is to review evidence on the implementation of ABIs across Scotland and build upon the national ABI evaluation published in 2011.

Methods

A rapid review of ABI implementation evidence across Scotland was carried out. Descriptive analysis was undertaken of ABI data released by Information Services

Division. Data were requested from NHS Lothian in order to carry out more in-depth analysis of ABI implementation within this area.

Key Findings

ABIs remain an important mechanism to reduce alcohol consumption and alcohol-related harm. The national ABI programme has been largely successful with over half a million ABIs being delivered since 2008, 45% above the combined HEAT standard set over this period. All health boards had a specific program for ABI delivery, with variation across board areas in terms of delivery model, payment structures and training provided. The successful implementation of ABIs has been largely facilitated by the HEAT standard, funding and investment, training and coordination.

The 2011 national ABI evaluation identified a number of gaps in this research area and unfortunately, a number of these gaps remain. For example, there were no data at a national level to establish the characteristics of those receiving ABIs, the quality of ABIs delivered and the impact on consumption levels. However, a rough estimate suggests that approximately 43% of the target population have been reached over the past seven years. There was variation in the extent to which health boards perceived that the ABI program resulted in improved detection and referral rates for dependent drinkers and no further data was available to assess this impact.

The majority of ABIs continue to be delivered across primary care settings. However, since the extension of the HEAT standard to include wider settings, a higher proportion of ABIs are being delivered in wider settings. This has the potential to target certain population groups which are harder to reach through primary care or other priority settings. However, the wider implementation of this should be considered alongside effectiveness evidence for delivery of ABIs within such settings.

Conclusions

ABIs remain an important mechanism to reduce alcohol consumption and alcohol-related harm and they have been widely implemented across Scotland. There were

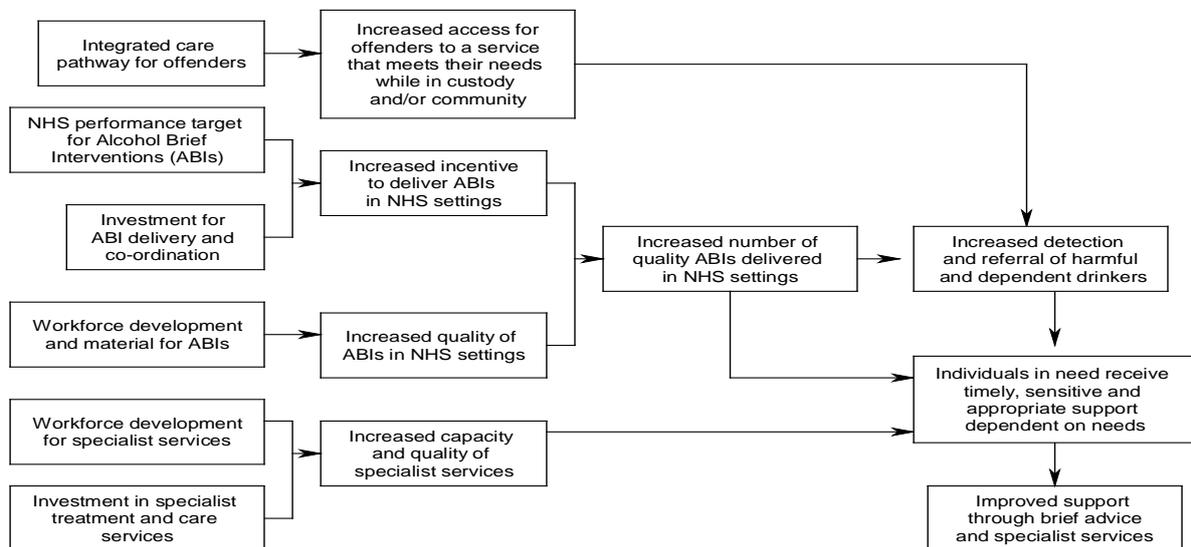
no data available at a national level to establish the quality of ABIs delivered, the characteristics of those receiving ABIs or the impact on individual alcohol consumption, however the effectiveness evidence base is strong for the impact of ABIs.

1. Introduction

In 2009 the Scottish Government launched their strategy to reduce alcohol-related harms across Scotland.¹ One specific aim of this strategy was to increase the delivery of Alcohol Brief Interventions (ABIs) to reduce levels of alcohol consumption. NHS Health Scotland was tasked with the evaluation of the alcohol strategy, and established the Monitoring and Evaluation of Scotland's Alcohol Strategy (MESAS) programme with NSS ISD. The MESAS programme has used a theory-based approach to the evaluation, having developed a theory of change to explain how the strategy might lead to changes in short, intermediate and longer term outcomes.³

One of the key intermediate outcomes within this theory of change is improved support for people with alcohol problems or those at risk of alcohol-related harm. Figure 1 shows the nested theory of change that proposes how the ABI programme may contribute to this intermediate outcome. The aim of this paper is to review evidence on the implementation of ABIs across Scotland.

Figure 1 Support for individuals in need nested theory of change



1.1. Background

Alcohol Brief Interventions (ABIs) can be described as “a short, evidence-based, structured conversation about alcohol consumption with a patient/service user that seeks, in a non-confrontational way, to motivate and support the individual to think about and/or plan a change in their drinking behaviours, in order to reduce their consumption and/or their risk of harm.”²

ABIs are designed to elicit individual behaviour change to reduce the risk of more serious alcohol-related problems for individuals displaying hazardous or harmful levels of alcohol consumption. There is a wealth of effectiveness evidence for the screening and delivery of ABIs for harmful and hazardous drinkers^{i,4,5} Effectiveness evidence for the delivery of ABIs for dependent drinkers is weak, therefore it is recommended that dependent drinkers are referred for more specialist treatments. ABIs are cost-effective and there is evidence they can reduce alcohol consumption up to 12 months post-delivery.⁴

In 2003, national clinical guidance (SIGN 74) was published recommending that ABIs were delivered to harmful and hazardous drinkers in primary care settings, with the potential to be expanded to A&E and antenatal settings.² Despite the publication of these national guidelines, SIGN 74 was not widely implemented.⁶ In 2008, an NHS performance target (HEAT target) was established for ABIs delivered across primary care, accident and emergency and antenatal settings. Between April 2008 and March 2011, health boards were required to complete approximately 150, 000 ABIs across the three priority settings (primary care, A&E and antenatal). This target was accompanied by increased funding and investment, training, resources and national coordination in order to embed ABIs into NHS practice. In 2012/13 this target developed into a standard and incorporated ABIs delivered across wider settings, with a minimum of 90% of the standard delivered across priority settings. The aim of the ABI implementation program was to increase the reach and quality of ABIs delivered to harmful and hazardous drinkers, to provide support to those who could benefit, and increase the detection and referral rate of dependent drinkers.

ⁱ The term ‘hazardous drinking’ is used to describe a pattern of alcohol consumption that increases someone’s risk of harm, while harmful drinking is defined as a pattern of alcohol consumption that is causing mental or physical damage (NICE, 2010)

1.2. National ABI evaluation

In 2011, MESAS commissioned an evaluation of the ABI HEAT: H4 programme (hereafter known as the 'national ABI evaluation').⁷ This evaluation aimed to assess the implementation of ABIs. It focused largely on the implementation of ABIs within primary care, but analysis of implementation in other settings was also included. The evaluation included quantitative and qualitative data collection, at both strategic and operational level, through a survey, patient and practitioner interviews, and analysis of routine delivery data⁷. Three health board areas were selected as case studies to provide additional detail regarding the implementation of ABIs (Box A).

Box A: Key Findings from the National ABI evaluation:

- The HEAT target acted as a key incentive to ABI implementation.
- It is difficult to establish reach and impact of the ABI programme.
 - Geography (rurality), age and gender were identified as potential gaps in terms of ABI reach.
- ABI implementation varied considerably.
- Investment in staff training was instrumental to building support for the delivery of ABIs.
- Development of simple universal data recording and monitoring systems is crucial.
- Different aspects of ABI delivery have been emphasised depending on Local Enhanced Service contracts.
- NHS staff recognised the value of ABIs and perceived them to be a good use of NHS resources.
- There was little objection from patients regarding the discussion of their alcohol consumption levels with a practitioner within primary care settings.
- There was some debate about the extent to which the ABI programme resulted in better detection of dependent drinkers for specialist treatment services.
- Taking a population wide approach to ABI implementation prevented stigmatisation relating to alcohol misuse for certain groups.
- Facilitators to implementation:
 - Availability of funding
 - Nationally co-ordinated and locally supported training opportunities
 - National, health board and individuals within local settings act as champions to support and encourage ABI implementation
- Barriers to implementation:
 - Lack of 'lead in' time to set up organisational structures
 - Competing priorities
 - Lack of adequately trained staff
 - Maintaining trained staff levels
 - Mechanisms for recording ABI delivery

The national evaluation identified a number of gaps, such as an understanding of the reach, quality and impact of ABIs delivered.⁷ In an attempt to address these gaps, an additional literature review and review of available research was carried out in 2015 and is reported here.

2. Methodology

This study was comprised of 3 components:

- I. **Trends in ABI delivery:** Data relating to the number of ABIs delivered across Scotland by setting were obtained from Information Services Division (ISD) 2014/15 annual report on ABIs.⁸
- II. **NHS Lothian case study:** Additional data relating to ABI delivery was requested from the ABI lead within NHS Lothian.
- III. **Literature Review:** Given the time limitations, a Rapid Evidence Assessment (REA) of the literature on ABI implementation in Scotland was undertaken.ⁱⁱ Studies conducted over the last 7 years (2008 – present) were included in the review if they focused on the implementation of ABIs across Scotland. The REA involved a search of electronic databases including: Medline; Cochrane; psycINFO; CINAHL; Google Scholar.

Grey literature search was also conducted using the following websites:

- **Health Scotland** <http://www.healthscotland.com/>
- **NHS Education for Scotland** <http://www.nes.scot.nhs.uk/>
- **Alcohol Concern UK** <http://www.alcoholconcern.org.uk/>
- **Alcohol Research UK** <http://alcoholresearchuk.org> >
<http://findings.org.uk/index.php>
- **Alcohol Policy** <http://www.alcoholpolicy.net/>

ⁱⁱREAs provide a balanced assessment of available evidence, by using systematic review methods to search and critically appraise existing research. REAs allow for rigorous assessment of the methods used, but don't go into as much detail as the systematic review process.

A combination of the following search items were used: alcohol; alcohol brief intervention; interview; motivation; implementation; delivery. Hand searching was also carried out to identify potential sources and articles that had been referenced within other journal articles, but had not been identified using the more formal literature search methods. 7 papers were found to be relevant and reviewed in full (further details in Section 5 below).

The AACODS checklist⁹ was used to support the critical appraisal of “grey literature”.ⁱⁱⁱ For qualitative research outputs and systematic reviews the CASP¹⁰ checklists were used to assess the quality of the material. The RE-AIM evaluation framework was used to guide the literature review and establish some evaluation questions.¹¹ The framework is made up of 5 components: reach, efficacy, adoption, implementation and maintenance. The evaluation of ABI implementation considers the combined effect across the 5 key components.

3. Findings

3.1. Reach

Evaluation Questions:

- What was the target population identified for ABIs?
- How many ABIs have been delivered? What proportion of the targeted population does this represent?
- Who are ABIs being delivered to?
- Where are ABIs being delivered?

The Informing Investment to Reduce Health Inequalities (III) Tool estimated that there were approximately 1 million hazardous and harmful drinkers (n=1,004,906) in Scotland¹². This is based on data collected from the Scottish Health Survey in 2012. Data published by ISD estimated that between 2008/09 and 2014/15 there had been 569,792 ABIs delivered across Scotland, 45% above the combined HEAT targets set over this period.⁸ The national ABI evaluation estimated that approximately 25% of

ⁱⁱⁱ Grey literature refers to literature produced by all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers."

individuals receiving an ABI were repeat individuals.⁷ Based on these figures, it can be estimated that approximately 427,244 ($569\,792 \times 0.75$) individuals received an ABI over the past seven years.

Comparing the estimated target population (number of harmful and hazardous drinkers estimated within the III report) to the number of ABIs delivered across Scotland, suggests that approximately 43% of the target population have been reached over the past seven years.

Despite the fact that over half a million ABIs have been delivered across Scotland between 2008 and 2015, there are limited data to establish the characteristics of individuals receiving ABIs. Therefore, very little is known about the recipients of ABIs. Studies have shown that men are more likely to receive an ABI than women.¹³ This corresponds to the fact that men are also more likely to engage in harmful and hazardous drinking.¹⁴ Additional data provided by NHS Lothian also indicates that a higher proportion (67%) of ABIs across primary care in 2013/14 were delivered to males (unpublished data shared with NHS Health Scotland).

The national ABI evaluation identified gaps in reach for age and gender⁷. Men between the ages of 16-30, older people and minority groups were described as 'hard to reach'. Reasons given for this included a lack of contact with primary care services or practitioners' preconceived perceptions of certain groups' drinking behaviours. Young people were identified as a potential gap and studies have explored the feasibility and acceptability of delivering ABIs to young people within social work settings.¹⁵ Data provided by NHS Lothian indicates that the majority of ABIs delivered across primary care in 2013/14 were delivered to individuals aged between 46 and 65, with fewer being delivered to individuals aged 16 to 45, suggesting that individuals within these age groups remain harder to reach through this setting (unpublished data shared with NHS Health Scotland).

There are no national data available to investigate the geographical spread of ABI delivery below health board level.

Box B: Case Study NHS Lothian: ABIs Delivered across Primary Care (unpublished data shared with NHS Health Scotland).

NHS Lothian provided data regarding ABI delivery across primary care. The following section illustrates the key findings:

- 85% of GP practices have signed up to contracts to deliver ABIs in 2015/16 (106 out of 125 practices).
- In 2013/14 there were 13,398 ABIs delivered across primary care:
 - 33% were delivered to females
 - 67% were delivered to males

The majority of ABIs were delivered to individuals aged 46-65yrs (with this age-group accounting for 46% of ABIs being delivered in 2013/14). Figure 2 compares the distribution of ABIs delivered by aged with the population age distribution for NHS Lothian based on the 2011 Scottish Census. This demonstrates that ABIs are disproportionately delivered to those aged 46+yrs, suggesting that those aged 16-45yrs are harder to reach through primary care settings.

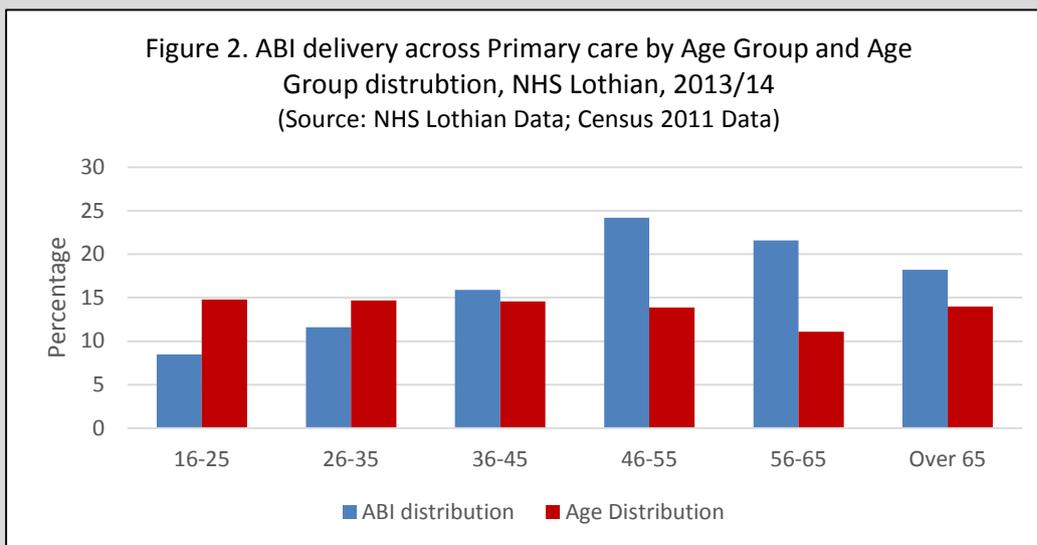
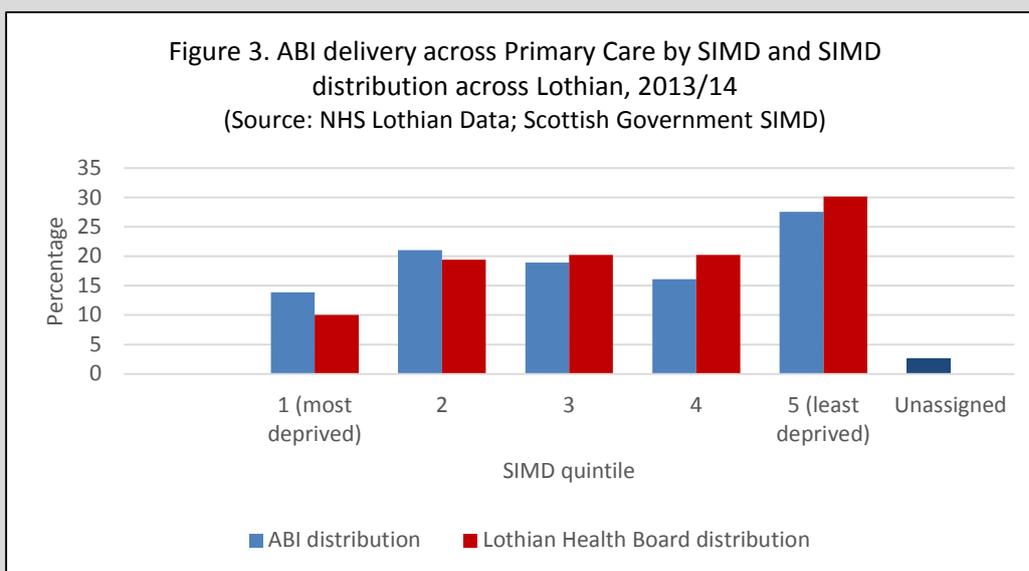


Figure 3 provides a breakdown of ABIs delivered across NHS Lothian by deprivation quintile. The highest percentage of ABIs have been delivered within the least deprived quintile. However this may be explained by the health board's deprivation profile, with almost a third of the population residing in SIMD 5. Figure 3 does suggest a degree of targeting, with a disproportionate amount of ABIs delivered in the SIMD 1, when deprivation profile is considered. Additionally these data do not account for those requiring specialist treatment (e.g. dependent drinkers), who are ineligible for ABIs, and may be influencing the distribution.



3.2. Efficacy

Evaluation Questions:

- How effective are the ABIs that are being delivered?
- Were there any unintended outcomes, either positive or negative?

Individual follow up to establish the effectiveness of ABI delivery across Scotland has not been undertaken at a national level. However, several studies have attempted to determine how ABIs impact on alcohol consumption. As previously stated, there is a wealth of effectiveness evidence for ABIs, particularly within primary care settings.^{4,16} There is also some effectiveness evidence for the delivery of ABIs within other settings, such as A&E¹⁷ and antenatal care¹⁸, although the evidence base is not as strong in comparison to primary care¹⁹ and systematic review level evidence is inconsistent. It is not that there is evidence of no effect, rather there is simply a lack of evidence in these settings.

The MESAS theory of change hypothesised that increasing the number of people screened for alcohol-related problems would lead to better detection and referral for dependent drinkers and, in turn, engagement in treatment services. It was theorised that engagement with services could lead to a reduction in alcohol consumption and alcohol-related harm for this population group. The national ABI evaluation revealed that there were significant variations across the different health boards on the perceived impact of ABIs for detecting individuals for further treatment services, although there were no quantitative data available to support this. Some health boards stated that there had been an increase in the number of referrals, with others reporting that there was no change.⁷ This literature review has failed to find any further research since 2011 that provides further insight into this.

Studies have attempted to investigate any potential negative consequence of ABI delivery with patients. Overall, studies have shown that patients perceive discussions with health care professionals about their drinking as positive.^{7,20} Additionally, young people were shown to be happy to discuss alcohol with practitioners, despite some practitioners being nervous about discussing the subject.¹⁵ However, studies have also shown that individuals feel more comfortable discussing their alcohol-related

issues with GPs or nurses, in comparison to more specialist alcohol practitioners, such as Alcohol Liaison Nurses.¹³

While ABIs are effective for population health improvement it is also useful to consider their impact on health inequalities, which may be affected by both who receives ABIs (that is, are any groups that might benefit from ABIs not being offered to them proportionate to need) and how they respond. ABIs are designed to instigate individual behaviour change and therefore, while effective for population health improvement, they may be less effective in addressing health inequalities.²¹ To investigate this further, researchers have attempted to model the impact of ABIs on health inequalities using the Informing Investment to Reduce Health Inequalities (III) programme of work. This has shown that ABIs have a modestly positive contribution to reducing health inequalities, but only when socially targeted.¹²

Data provided by NHS Lothian suggest a degree of social targeting, with a disproportionate amount delivered in the most deprived areas (Box B). Although this finding cannot be generalised to other health boards, if a similar pattern is found in other areas it is possible that ABIs could be contributing to reductions in health inequalities. NHS Lothian also provided some additional information on how their ABI programme of work contributes to reducing health inequalities (Box C).

Box C: Case Study NHS Lothian (unpublished material shared with NHS Health Scotland).

NHS Lothian completed an Equalities Impact Assessment for the ABI programme and identified specific examples of how it could impact on reducing health inequalities:

- The Homeless Practice staff have been trained and deliver ABIs with clients, many of whom have complex needs.
- Specialist midwives have been trained and deliver ABIs to transient groups, including Gypsy Travellers and temporary residents.
- Keep Well staff deliver ABIs to patients in areas of deprivation.
- HMP Edinburgh and HMP Addiewell have been identified as areas where staff can effectively address the health needs of prisoners by delivering ABIs and there is work in progress to develop a data recording system to evidence delivery.

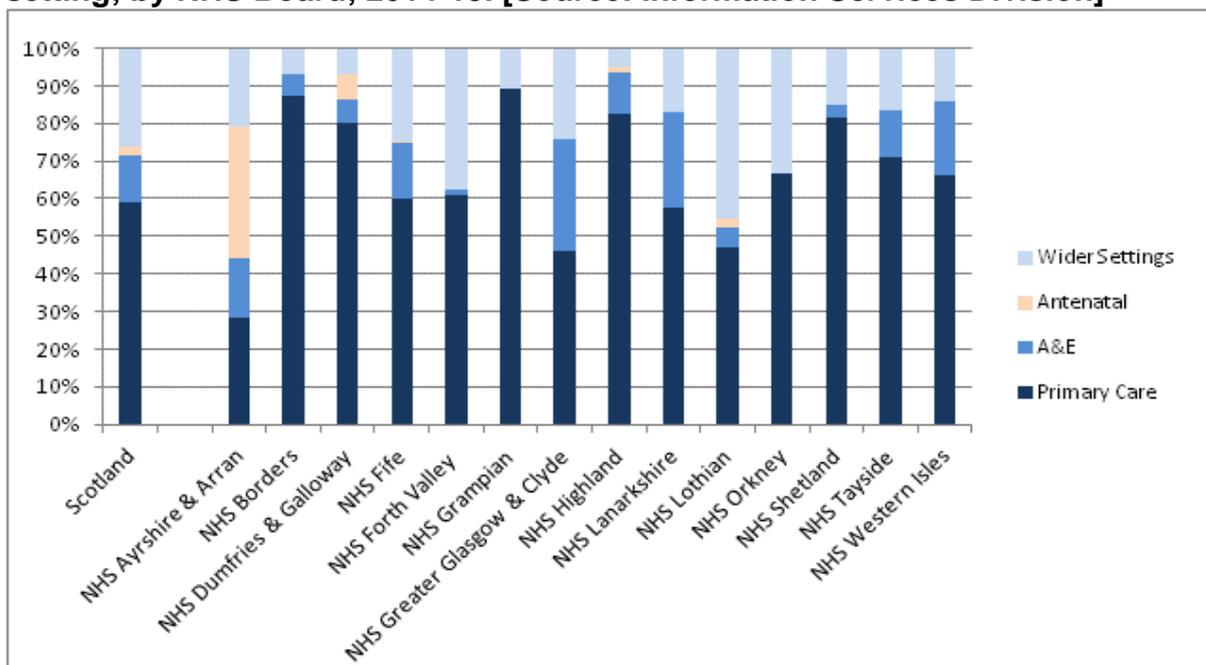
3.3. Adoption

Evaluation Questions:

- What proportion of ABIs were delivered across different settings?

In 2014/15 59% of ABIs were delivered in primary care, 12% delivered in A&E, 3% in antenatal settings and 26% in wider settings. The proportion of ABIs delivered within each setting varies across NHS Boards (Figure 4). For example, some health boards, such as Ayrshire and Arran delivered a higher proportion of ABIs within antenatal settings^{iv}, and other health boards, such as NHS Greater Glasgow and Clyde, delivered a higher proportion in A&E.

Figure 4. Proportion of alcohol brief interventions delivered within each setting; by NHS Board; 2014-15. [Source: Information Services Division]



^{iv} This is the result of different delivery practices, rather than being representative of a high volume of pregnant woman consuming alcohol within this health board.

In priority settings

Primary care: There is both qualitative and quantitative evidence to suggest that priority has been given to implementing ABIs in primary care settings.^{7,8} In 2014/15 59% of ABIs were delivered across primary care, although there was large variation with some health boards delivering almost 90% of ABIs within primary care, and others delivering only 29% in primary care.⁸ There are no data at a national level to establish the proportion of GP practices that are delivering ABIs. The national ABI evaluation revealed that not all GPs are signed up to deliver ABIs and in some instances, only a small number of practices within each board area are delivering.⁷ Additional data from NHS Lothian revealed that 85% of GP practices signed up to contracts to deliver ABIs in 2015/16 (106 out of 125 practices) (unpublished data shared with NHS Health Scotland). However, these findings cannot be generalised to other areas.

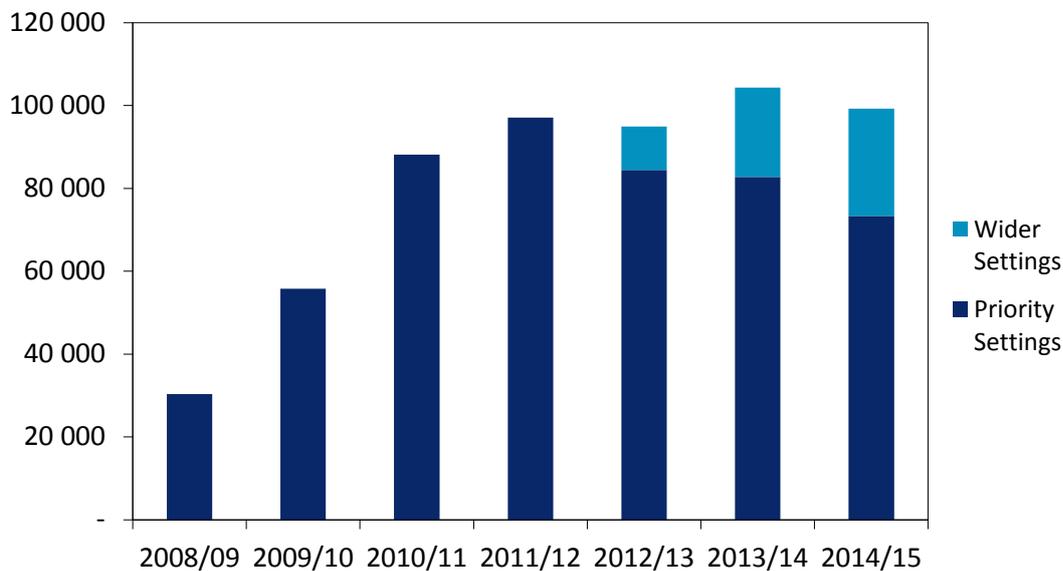
A&E: At the time of the national ABI evaluation (2011), only one of the three case study areas had begun to implement ABIs within A&E settings. Figure 4 above indicates that all but one health board delivered ABIs within A&E during 2014/15. Some health boards, such as Greater Glasgow and Clyde delivered almost a third of ABIs within A&E, with other health boards delivering very small numbers.

Antenatal: Delivery of ABIs within antenatal settings was the last of the three priority areas to be implemented. There has been varied adoption of ABIs within antenatal settings across Scotland, with some health boards delivering over a third of their ABIs within this setting and several health boards delivering none.

Wider settings

Data relating to the proportion of ABIs delivered in wider settings is only available from 2012/13 onwards when the HEAT standard was extended. Since then there has been a gradual increase in the proportion of ABIs being delivered in wider settings (Figure 5). Between 2012/13 and 2014/15 the number of ABIs delivered in wider settings has more than doubled from 10,500 to 25, 934.

Figure 5. Number of ABIs delivered in priority (Primary Care, A&E and Antenatal) and wider settings, for financial years 2008/09 to 2014/15. [Source: Information Services Division]



3.4. Implementation

Evaluation Questions:

- What proportion of ABIs were delivered as intended?
- What factors influenced how ABIs were implemented?

Delivered as intended

Establishing the proportion of ABIs that were delivered as intended is challenging and there have been no studies conducted to establish the quality of ABIs delivered across Scotland. Data from the national ABI evaluation revealed that up to 90% of ABIs were delivered after a positive screening⁷. However, this varied by board and by setting.

Given the large amount of variance for the delivery of ABIs it is almost impossible to establish what proportion of ABIs have been delivered in accordance with the SIGN guidance. Data collated from the national ABI evaluation suggested that the majority of ABIs delivered in primary care have been done opportunistically and, generally, in line with the guidance⁷. Additionally, in most cases, screening and ABIs have been delivered at the same time and this was thought to be the most effective method of delivery.⁷

Implementing ABIs across antenatal settings has varied across Scotland. In the majority of cases, screening was undertaken at the first contact with antenatal services. Most screening was delivered based on current drinking patterns, in line with SIGN74 guidance. However, one health board screened based on pre-pregnancy drinking patterns and this resulted in a large number of ABIs being delivered within this setting by this health board. Although research indicated that midwives were largely supportive of the ABI program, opportunities to deliver ABIs were limited due to the high proportion of women reporting that they were not consuming alcohol during their pregnancy.⁷ One study reported that midwives suggested pre-conception alcohol advice would be more beneficial than delivery of ABIs in antenatal care.²²

Training

Training has been identified as an important element to successful implementation of ABIs.^{13,20} Training data is no longer collected at a national level, so there is no way of establishing the number of individuals trained to deliver ABIs. The cascade model used to develop training for ABIs had some limitations, with some concerns raised around the quality of training being received being diluted. Inadequate training has been highlighted as a barrier to implementing ABIs and it has been suggested that training needs to be flexible and adapted to shorter sessions.²⁴ Studies have shown that, despite receiving training, some practitioners have not delivered ABIs.²⁵ Kaner et al. also indicated that practitioners who received face to face training and received follow up support and advice over the telephone delivered more ABIs to eligible patients than practitioners who only received face to face training or no training.²⁶

Box D below provides some additional information gathered from NHS Lothian around local approaches to ABI training.

Box D: Case Study NHS Lothian (unpublished data shared with NHS Health Scotland)

Additional data provided by NHS Lothian indicated that the ABI lead designed and developed an e-learning module which was launched in 2011. This allows NHS Lothian staff and community and third sector organisations to access the training and the course content has been adopted by a number of agencies including Police Scotland, Scottish Fire and Rescue Service and Edinburgh City Council.

Local Enhanced Service (LES) Arrangements

Rather than establishing a national system for LES arrangements, each health board had the opportunity to shape their LES arrangements with stakeholders, such as GPs. LES arrangements emphasised different aspects of delivery. For example, in some areas payments were attached to follow ups and other areas payments were attached to screening⁷.

HEAT Target

Studies have shown that implementation leaders found that ABI targets were useful gaining the support of senior managers who prioritised the delivery of ABIs.²⁴ Some health boards were even found to assign local targets to ensure that the implementation of ABIs was continued, regardless of any future changes relating to national ABI implementation.²⁴ Additionally, a few boards were found to assign targets to different settings across primary care, antenatal, A&E and wider ABI delivery settings. Although targets were perceived as a positive thing in terms of gaining momentum for implementation, it is possible that targets had additional unintended consequences. For example, it was noted that targets could lead to distortions in recording, resistance from staff delivering the ABIs and target fatigue.²⁴

Data recording and monitoring

Studies highlighted the importance of establishing robust and practical recording systems in order to capture and monitor implementation adequately and this is thought to be best established prior to implementation.^{13,24} There were a number of challenges with recording and monitoring ABIs particularly if robust monitoring systems were not in place. This could result in ABIs being delivered, but no details being recorded. Additionally, due to time pressures faced by practitioners, the minimum amount of information was recorded.

Staff Attitudes

Implementing ABIs have been shown to require significant support from senior staff.^{13, 24} Some research has suggested that negative attitudes from practitioners delivering the ABIs can impact negatively on implementation.²⁰

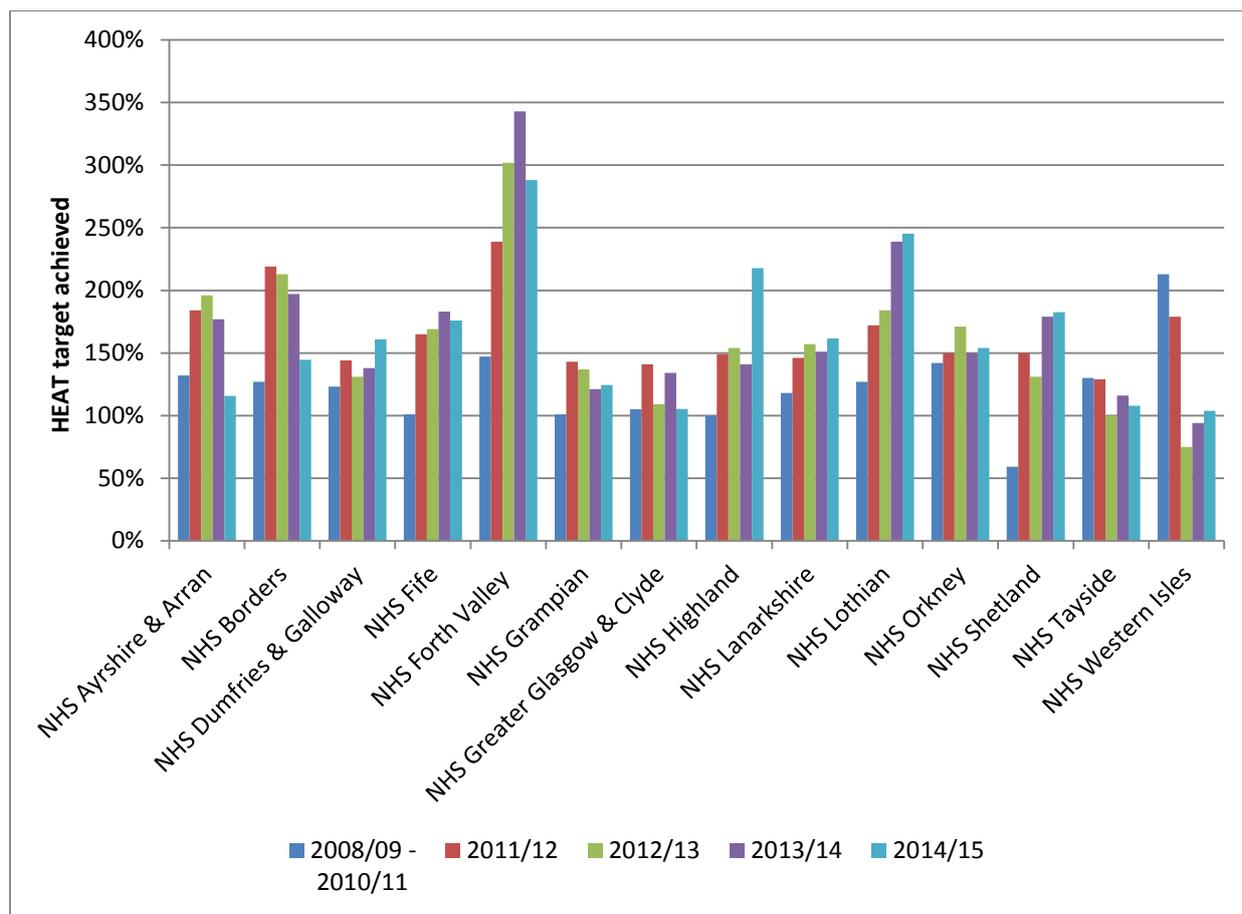
3.5. Maintenance

Evaluation Questions:

- Has the implementation of ABIs continued over time?

Data published by ISD provides evidence that the implementation of ABIs has continued over time. Figure 4 below presents the percentage towards target reached by each health board over the past seven years. Trends vary for each board, with some increasing the proportion of ABIs delivered in relation to the target, others decreasing the proportion delivered and other health boards showing less clear cut trends.

Figure 4. Delivery of ABIs in relation to the HEAT target for 14 Health Boards from 2008/09-2010/11 to 2014/2015. [Source: Information Services Division]



4. Conclusions

ABIs remain an important mechanism to reduce alcohol consumption and alcohol-related harm. The national ABI programme has been largely successful with over half a million ABIs being delivered since 2008, 45% above the combined HEAT target set over this period. All health boards had a specific program for ABI delivery, with variation across board areas in terms of delivery model, payment structures and training provided. The successful implementation of ABIs has been largely facilitated by the HEAT standard, funding and investment, training and coordination.

The 2011 national ABI evaluation identified a number of gaps in this research area and unfortunately, a number of these gaps remain. For example, there were no data at a national level to establish the characteristics of those receiving ABIs, the quality of ABIs delivered and the impact on consumption levels. However, a rough estimate suggests that approximately 43% of the target population have been reached over the past seven years. There was variation in the extent to which health boards perceived the ABI program lead to improved detection and referral rates for dependent drinkers and no further data was available to assess this impact.

The majority of ABIs continued to be delivered across primary care settings. However, since the extension of the HEAT standard to include wider settings, a higher proportion of ABIs are being delivered in wider settings. This has the potential to target certain population groups which are harder to reach through primary care or other priority settings. However, the wider implementation of this should be considered alongside effectiveness evidence for delivery of ABIs within such settings.

There was no data available at a national level to establish the characteristics of those receiving ABIs, the quality of ABIs delivered and their impact on individual alcohol consumption, however the effectiveness evidence base is strong for the impact of ABIs.

Title	Setting	Description	Checklist
Doi L, Cheyne H and Jepson R. Alcohol brief interventions in Scottish antenatal care: a qualitative study of midwives' attitudes and practices. BMC Pregnancy and Childbirth 2014;14(1):170.	Antenatal	Qualitative interviews with midwives and midwifery team leaders.	CASP
Doi L, Cheyne H and Jepson R. A realist evaluation of an antenatal programme to change drinking behaviour of pregnant women. Midwifery 2015;31:965-72.	Antenatal	Qualitative interviews with those involved in policy implementation; qualitative interviews with pregnant women, midwives and midwifery team leaders; two systematic reviews	CASP
Fitzgerald N, Platt L, Heywood S and McCambridge J. Large-scale implementation of alcohol brief interventions in new settings in Scotland: a qualitative study of a national programme. BMC Public Health 2015;15:289.	A&E; Antenatal; Wider	Interview study with key implementation leaders in 9 health board areas about how to approach ABI implementation in new settings.	CASP
Fitzgerald N, Molloy H, MacDonald F and McCambridge J. Alcohol brief interventions practice following training for multidisciplinary health and social care teams: a qualitative interview study. Drug & Alcohol Review 2015;34(2):185-93.	Health Care Settings; Community Based Settings; Wider Settings.	Qualitative interviews with practitioners and multidisciplinary teams following ABI training to establish impact on implementation.	CASP
Johnson M, Jackson R, Guillaume L, Meier P and Goyder E. Barriers and facilitators to implementing screening and brief interventions for alcohol misuse: a systematic review of qualitative evidence. Journal of Public Health 2010;33:412-21.	Primary Care; A&E; Antenatal & Wider Settings	Systematic review of qualitative evidence to establish barriers and facilitators to ABI implementation. Studies were drawn from international literature.	CASP
Parkes T, Atherton I, Evans J, Gloyn S, McGhee S, Stoddart B, Eadie D, Bryce S and Petrie D. An evaluation to assess the implementation of NHS delivered Alcohol Brief Interventions. Final Report. 2011: NHS Health Scotland; 2011.	Primary Care; A&E; Antenatal & Wider Settings	Qualitative Interviews with practitioners, patients, ABI leads etc.; quantitative data collection; strategic and operational level data; Case studies across Health Board areas;	AACODS
Stead M, Eadie D, McKell J, Bauld L, Parkes T, Nicoll A, Wilson S and Cheryl B. Process evaluation of Alcohol Brief Interventions in wider settings (Young people and Social work) (2012/13 RE007). Edinburgh: NHS Health Scotland; 2014	Youth and Social Work	Qualitative interviews with practitioners working with young people and interviews with young people; Analysis of relevant documents; case studies.	AACODS

Doi L, Cheyne H and Jepson R. Alcohol brief interventions in Scottish antenatal care: a qualitative study of midwives' attitudes and practices. BMC Pregnancy and Childbirth 2014;14(1):170	Antenatal	Qualitative interviews with midwives and midwifery team leaders	CASP
Doi L, Cheyne H and Jepson R. A realist evaluation of an antenatal programme to change drinking behaviour of pregnant women. Midwifery 2015;31:965-72.	Antenatal	Qualitative interviews with those involved in policy implementation; qualitative interviews with pregnant women, midwives and midwifery team leaders; two systematic reviews	CASP
Fitzgerald N, Platt L, Heywood S and McCambridge J. Large-scale implementation of alcohol brief interventions in new settings in Scotland: a qualitative study of a national programme. BMC Public Health 2015;15:289	A&E; Antenatal; Wider	Interview study with key implementation leaders in 9 health board areas about how to approach ABI implementation in new settings	CASP
Fitzgerald N, Molloy H, MacDonald F and McCambridge J. Alcohol brief interventions practice following training for multidisciplinary health and social care teams: a qualitative interview study. Drug & Alcohol Review 2015;34(2):185-93.	Health Care Settings; Community Based Settings; Wider Settings	Qualitative interviews with practitioners and multidisciplinary teams following ABI training to establish impact on implementation.	CASP
Johnson M, Jackson R, Guillaume L, Meier P and Goyder E. Barriers and facilitators to implementing screening and brief interventions for alcohol misuse: a systematic review of qualitative evidence. Journal of Public Health 2010;33:412-21.	Primary Care; A&E; Antenatal & Wider Settings	Systematic review of qualitative evidence to establish barriers and facilitators to ABI implementation. Studies were drawn from international literature.	CASP
Parkes T, Atherton I, Evans J, Gloyn S, McGhee S, Stoddart B, Eadie D, Bryce S and Petrie D. An evaluation to assess the implementation of NHS delivered Alcohol Brief Interventions. Final Report. 2011: NHS Health Scotland; 2011	Primary Care; A&E; Antenatal & Wider Settings	Qualitative Interviews with practitioners, patients, ABI leads etc.; quantitative data collection; strategic and operational level data; Case studies across Health Board areas;	AACODS
Stead M, Eadie D, McKell J, Bauld L, Parkes T, Nicoll A, Wilson S and Cheryl B. Process evaluation of Alcohol Brief Interventions in wider settings (Young people and Social work) (2012/13 RE007). Edinburgh: NHS Health Scotland; 2014	Youth and Social Work	Qualitative interviews with practitioners working with young people and interviews with young people; Analysis of relevant documents; case studies.	AACODS

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