

An evaluation to assess the implementation of NHS delivered Alcohol Brief Interventions:

Final Report

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Executive Summary

Background and methods

There is mounting evidence that the health and well-being of a large number of people in Scotland is being seriously harmed, directly or indirectly, by higher than recommended levels of alcohol consumption (Beeston *et al*, 2011). With over 50 randomised controlled trials, alcohol brief interventions (ABIs) are currently the treatment modality best supported by research evidence in the alcohol field (Heather, 2011). The delivery of ABIs in healthcare settings is a significant component of the Scottish Government Alcohol Strategy and highlights the substantial role that the NHS in Scotland has to play in reducing alcohol-related harm. The Scottish Government established a health improvement target for NHS health boards in 2008; HEAT H4, supported by a substantial increase in funding for alcohol treatment and support services. This target required NHS Health Scotland to deliver 149,449 ABIs across three priority settings of primary care, A&E and antenatal care, between April 2008 and March 2011. A subsequent one year extension target to deliver 61,081 ABIs was introduced in February 2011 for April 2011-March 2012, with the aim of supporting the long-term embedding of ABIs.

This evaluation assesses the implementation of NHS delivered ABIs in Scotland and is one of seven projects within a larger body of related work being taken forward by NHS Health Scotland, on behalf of the Scottish Government, within the Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS). This workstream is tracking the implementation process, reach and outcomes of key actions in the alcohol strategy. The evaluation focused on implementation of ABIs in primary care but was also able to report on some dimensions of ABI activity in A&E and antenatal settings. The focus of the evaluation was on the processes of implementation. A multi-method approach was taken and incorporated national, health board, practitioner and patient level data, with most data collected or provided to the evaluation team in 2010.

Key findings

The long-term aim of the HEAT H4 target is to embed ABIs into NHS practice. The evaluation draws attention to what has already been achieved. Notably, the initial HEAT H4 three-year target was reached nationally, ahead of schedule, in March 2011 and examples of successful delivery in all priority settings clearly indicate the ability of health boards to do this work well. Most of this activity has been in line with Scottish guidance on delivery of ABIs, evidence-based practice and the international literature. There are examples where reporting of current practice would be a clear contribution to the international literature.

Importantly, the findings suggest that healthcare staff see the delivery of ABIs as a worthwhile activity for NHS staff, and a valid use of NHS resources, in the light of harms to health in Scotland brought about by excessive alcohol consumption. Interviews with primary care patients indicate that the vast majority accept that conversations about alcohol are part of a GP or healthcare worker's role and, in the main, appear to have no problem with being offered alcohol screening or brief interventions. Some health board leads expressed a view that there has been an increase in the 'right people' being seen in specialist alcohol services, despite

referrals not necessarily increasing substantially across all boards, in the way that may have been expected. Some health board leads suggested that those now being referred to specialist alcohol services appeared to be more motivated to seek help and create change in their lives.

The evaluation interviews suggest that the extent of reach and impact of the ABI initiative was mixed across Scotland; some health board leads were clear that there was much more work to be done in this regard while others felt that they had already outperformed, two years in to the HEAT H4 target. The population-wide approach was viewed as an effective and essential mechanism for preventing stigma associated with receiving an alcohol intervention. Gaps in coverage were noted, however, especially in rural and remote areas and in relation to age and gender. Some boards had developed innovative mechanisms to address such gaps.

The extension year for HEAT H4 provides further opportunity, with funding maintained at existing levels and infrastructure support, to build the capacity of staff in the NHS in Scotland to provide effective and evidence-based ABIs. However, findings suggest that this funding and infrastructure support is likely to need to continue for some time yet before mainstreaming into routine practice is guaranteed. As well as developing skills and knowledge, the investment in staff training has also been responsible for building support for ABIs at the grassroots level: those practitioners who had taken part in more in-depth training sessions expressed greater enthusiasm for the programme and enhanced motivation to become involved. While many staff have been trained, due to staff turn-over, the need for updating and renewal of skills and to reach those who remain untrained, the training infrastructure will need to continue to be adequately resourced to effectively 'bed in' more advanced levels of skill, confidence and competence across Scotland.

Findings on data collection and monitoring suggest the importance of developing more universal systems and standards for recording if enhanced public health surveillance is required. However, practitioners were clear that recording needed to be simplified if ABI activity is to be effectively mainstreamed. This represents one of the key tensions of this work: low demands on practitioners may make it easier to embed new activities into practice and therefore enhance possibilities for adoption, but the effectiveness and impact of such practices become more difficult to monitor where minimal data is recorded.

One of the most significant findings of the evaluation is the extent of variation across Scotland in terms of the implementation of ABIs. For example, findings indicate that different health board payment structures for ABI screening and delivery in primary care, through Local Enhanced Service contracts, have resulted in primary care practices emphasising different aspects of ABI delivery and developing different approaches and infrastructure for implementation. The evaluation findings describe the numerous ways that boards have found to localise the ABI programme, to fit their own social and geographic contexts. This indicates a willingness to be flexible and accommodating to the different issues that each health board has experienced in trying to successfully implement ABIs. The many commonalities and shared experiences that have also been detailed, however, enable substantial generalised learning for the mainstreaming of ABIs into routine health service practice in Scotland and more widely.

1. Introduction

1.1 Policy context

There is mounting evidence that the health and well-being of a large number of people in Scotland is being seriously harmed, directly or indirectly, by higher than recommended levels of alcohol consumption (Beeston *et al*, 2011). In terms of health harm, alcohol is linked to many disease conditions; both acute and chronic, and to injuries related to alcohol consumption (Grant *et al*, 2009). Indeed, alcohol is now one of the major risk factors for the burden of disease in established market economies (ISD, 2011a).

The levels of alcohol-related harm in Scotland are particularly acute. Scotland has one of the highest liver cirrhosis mortality rates in Western Europe (Leon and McCambridge, 2006). During 2008/2009, it is estimated that in Scotland approximately 107,414 consultations took place with a member of primary care practice teams for alcohol misuse (ISD, 2011a), with the consultation rate for alcohol-related conditions being 4.4 times higher in the most deprived areas compared to the least deprived areas (ISD, 2011a). In 2003, over one in 20 (7.3%) of all patient-specific hospital discharges in Scotland among adults aged 16 and over were estimated to be attributable to alcohol consumption. Among men aged 16-64 this rate rises to approximately one in ten (Grant *et al*, 2009). In terms of alcohol-related deaths, in 2003, 1 in 20 deaths (5.0%) in Scotland were from alcohol attributable conditions (Grant *et al*, 2009).

The health and social consequences of alcohol misuse affect individuals, families, communities, health and emergency services, and wider society. Overall costs of alcohol misuse in Scotland are estimated at between £2.47 billion and £4.64 billion per annum (with a mid-point of £3.56 billion) (Scottish Government, 2010a). The strategy document, *Changing Scotland's Relationship with Alcohol: A Framework for Action* (Scottish Government, 2009) outlined the Scottish Government's proposed actions to tackle alcohol misuse in Scotland in order to reduce alcohol related harm, together with legislative action through the Licensing (Scotland) Act 2005 and the Alcohol etc. (Scotland) Act 2010¹. The strategy draws on international evidence (Alcohol and Public Policy Group, 2003) suggesting that an effective alcohol policy is one that 'encompasses a range of interventions (including regulatory measures, support and treatment interventions and changes in culture and attitudes) delivered via a comprehensive approach aimed at the whole population with particular targeting for high-risk groups' (Scottish Government, 2009).

The delivery of alcohol brief interventions (ABIs) is a significant component of the Scottish Government Alcohol Strategy and as such highlights the substantial role that the NHS in Scotland has to play in reducing alcohol-related harm. In 2008 the Scottish Government asked NHS Health Scotland, in collaboration with national partners including NHS Education for Scotland (NES), NHS Quality Improvement Scotland (QIS), NHS24, Information Services Division (ISD), and Scottish Health Action on Alcohol Problems (SHAAP), to work closely with health boards to ensure

¹ These can be accessed at <http://www.legislation.gov.uk/asp/2005/16/contents> and <http://www.legislation.gov.uk/asp/2010/18/enacted>

that an effective programme of support was put in place to enhance the delivery of ABIs throughout Scotland, as part of the national Alcohol Strategy.

This report presents the findings from the national evaluation of the implementation of NHS delivered ABIs in Scotland. The evaluation is one of seven projects within a larger body of related work being taken forward by NHS Health Scotland, on behalf of the Scottish Government, within the Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS)². This workstream is tracking the implementation process, reach and outcomes of key actions in the alcohol strategy, assessing the extent to which attributable outcomes are achieved, and identifying any unintended outcomes or displacement effects including differential effects or outcomes that may impact on health inequalities (Beeston *et al*, 2011). A Theory of Change has been developed to map the pathways through which policies and interventions in the strategy are expected to achieve desired outcomes (see Beeston *et al*, 2011). This Theory of Change provides the theoretical underpinning for the portfolio of evaluation studies tracking the Alcohol Strategy's progress and, ultimately, to determine its success. Within this framework ABIs contribute to the strategic aim of improving the support provided to, and treatment of, people with alcohol problems or at risk of alcohol-related harm. The evaluation provides an understanding of how the processes of implementation can impact on the realisation of this objective.

1.2 Alcohol brief interventions and the evidence base

The detection of alcohol problems is known to be enhanced by the use of appropriate screening tools (Raistrick *et al*, 2006) and substantial research evidence now supports the use of ABIs in reducing health-related harm due to alcohol consumption. ABIs are time-limited interventions that focus on changing drinking behaviour and have been defined 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 behaviour in order to reduce their consumption and/or their risk of harm’ (HEAT H4 National Guidance on Data Reporting (NGDR), 2011, p3).

ABIs use specific techniques for helping people to change their behaviour and draw on the ethos of Motivational Interviewing (MI) (see Dunn *et al*, 2001 for an application of MI to brief interventions) and the FRAMES approach (Feedback, Responsibility, Advice, Menu, Empathic, Self-efficacy, see Bien *et al*, 1993). There is no strong evidence to suggest that multiple ABIs, or repeat sessions, are more effective in reducing alcohol consumption than single sessions (Kaner *et al*, 2007).

With over 50 randomised controlled trials, ABIs are currently the treatment modality best supported by research evidence in the alcohol field (Heather, 2011). Research suggests the effectiveness of ABIs in preventative terms, when delivered in a range of healthcare settings to patients over the age of 16 regularly drinking in excess of

² For more information and relevant reports and links on MESAS please see <http://www.healthscotland.com/scotlands-health/evaluation/planning/MESAS.aspx>

daily/weekly limits, defined as hazardous drinking, or who are already showing signs of alcohol related harm, defined as harmful drinking³ (Moyer *et al*, 2002). While the evidence for ABIs is strongest in primary care (Bertholet *et al*, 2005; Kaner *et al*, 2007; Poikolainen, 1999), there is evidence of effectiveness in accident and emergency (A&E) settings (Crawford *et al*, 2004; Gentilello *et al*, 1999; Longabaugh *et al*, 2001; Monti *et al*, 1999), and some evidence of effectiveness in antenatal care (Chang *et al*, 1999; O'Connor and Whaley, 2007; see Nilson, 2009 and Parkes *et al*, 2007)⁴. The use of ABIs with dependent drinkers is not considered to be effective⁵: current research and healthcare guidance suggests that dependent drinkers should be referred to specialist alcohol services for more intensive treatment (Fleming, 2004; NICE, 2010a; Raistrick *et al*, 2006; Scottish Intercollegiate Guidelines Network (SIGN) 74, 2003⁶).

1.3 Implementation of ABIs in Scotland and the HEAT H4 target

In 2003, and in view of the evidence base for ABIs, the Scottish Intercollegiate Guidelines Network (SIGN) recommended that ABIs should be delivered by general practitioners (GPs), and other primary care health professionals, to harmful and hazardous drinkers in primary care (SIGN74 Guideline, 2003). The SIGN74 Guideline also states that 'When conducted by specially trained and allocated staff offering and arranging follow-up, brief intervention can be beneficial' in A&E (p10). For antenatal settings the guideline states: 'Routine antenatal care provides a useful opportunity to deliver a brief intervention for reducing alcohol consumption' (p10).

Against a background of evidence suggesting limited implementation of the SIGN74 Guideline (Rome *et al*, 2008), and alongside continuing increases in alcohol-related harm, the Scottish Government established a new health improvement target for NHS health boards; HEAT H4⁷ supported by a substantial increase in funding for alcohol treatment and support services. The HEAT H4 target required NHS Health Scotland to deliver 149,449 ABIs across three priority settings of primary care, A&E and antenatal care, between April 2008 and March 2011. These priority settings were chosen because the evidence was strongest in these areas⁸. The first year of the target, 2008-2009, was a developmental year although, unlike other HEAT targets, boards were also expected to deliver ABIs as well as set up processes for delivery. A subsequent one year extension target to deliver 61,081 ABIs was

³ See SIGN74 Guideline (2003, p1) for elaboration on these definitions.

⁴ It should be noted that the evidence base is continuously developing in this field pertaining to a wide variety of delivery settings including criminal justice settings, dentistry and pharmacy, to name a few. See NHS Health Scotland website for information on the national work on alcohol and offending, for example. <http://www.healthscotland.com/topics/health/alcohol/offenders.aspx>

⁵ Cobain *et al*. (2011) find some evidence that the use of ABIs in acute hospital settings may help improve outcomes for dependent drinkers but the study's limitations suggest this needs further investigation.

⁶ The SIGN74 Guideline, on which the target is based, is due for routine review in 2011, a process which will consider evidence that has been published since the original guidance was published.

⁷ HEAT targets are NHS performance targets with HEAT standing for the key objectives Health Improvement, Efficiency, Access and Treatment. Local Delivery Plans reflect the HEAT core set that reflect Ministers' priorities for the Health portfolio. More information can be found at [http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHS Health Scotlandperformance](http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHS%20Health%20Scotlandperformance)

⁸ Scottish Government is supporting boards to expand the evidence base for ABI delivery in non-HEAT settings through the use of national and local pilots, most specifically in the extension year of the target where learning from these pilots will be used to inform future delivery.

introduced in February 2011 for delivery over the period April 2011-March 2012, with the aim of supporting the long-term embedding of ABIs. The HEAT H4 target states that screening for alcohol consumption should be introduced in the three priority settings, using an appropriate screening tool and followed by delivery of an alcohol brief intervention where required.

While the initial target was set for a three year period, the first year unofficially came to be considered as a developmental year by boards. During this first year, the boards were expected to develop delivery arrangements, build staff capacity through training and to work with Scottish Government and ISD to establish information systems and flows for data collection, monitoring and reporting, including arrangements to capture follow-up data. Each health board was given an individual target of ABIs to be delivered, both during the initial three year target and the additional one year target, based on population share⁹. It should be noted that recent statistics released by the Scottish Government/ISD show that the initial three year HEAT H4 target (2008-2011) has been exceeded at the Scotland level (ISD, 2011b), with all but one board having met their individual targets¹⁰. Over the three year initial target 174,205 ABIs were delivered.

1.4 National arrangements to support implementation of ABIs across Scotland

1.4.1 Financial and performance management arrangements

In terms of the financial arrangements for the ABI programme, investment in local services was more than tripled¹¹ with the first call on funding for ABIs¹². The additional resources could be used in a variety of ways to support delivery and infrastructure; such as to fund staff resource to coordinate roll-out and local delivery of training, to train trainers, to fund key staff to attend training, and to fund implementation in the key priority healthcare settings. Annual HEAT H4 health board visits, conducted by Scottish Government and including representation from NHS Health Scotland, were put in place in early 2009. The priority for the visits was to explore progress being made towards achieving the HEAT H4 target, to ascertain what further support might be useful to boards in implementation, and to discuss board plans for broader developments beyond the HEAT H4 target in relation to prevention, treatment and services for tackling alcohol misuse. A National ABI Coordinator within Scottish Government was put in place to co-ordinate and lead the

⁹ The targets were based upon estimates of the rates of alcohol-related presentations, in primary and secondary care, amongst adults over 16 years of age in Scotland. See <http://www.healthscotland.com/documents/3201.aspx> for information on how the target was set and the numbers of ABI deliveries each health board was expected to achieve. The 2008/09-2010/11 interventions targeted 75% of the at-risk population, the extension year target was therefore based on 1) addressing the remaining 25% of the at-risk population (only the 19% who present with a potential alcohol-related condition in primary care), and 2) 25% of the number of brief interventions delivered nationally in year one of the target. Information on the current board target numbers can be found at http://www.healthscotland.com/uploads/documents/15220-HEAT%20Target%202011_12%20guidance%20letter.pdf

¹⁰ See http://www.alcoholinformation.isdscotland.org/alcohol_misuse/files/abi_2010_11.pdf

¹¹ Scottish Government allocated £97 million to NHS Boards over the course of the spending review period (2008-2011).

¹² Please see the following link for the letter to health boards

<http://www.healthscotland.com/uploads/documents/9110-Supporting%20H4%20-%20additional%20funding.pdf>

programme of work and to ensure brief interventions become embedded into routine NHS delivery. National events were also organised as opportunities to share good practice and to enable strategic and operational board leads to learn from each other's experience.

1.4.2 The Delivery Support Team (DST) and DST sub-groups

During 2008, a Delivery Support Team (DST) was established to provide guidance and strategic leadership to health boards on the development of delivery infrastructure and implementation of ABIs in the priority settings. The DST includes representation from key national stakeholders and promoted ownership of the programme at health board level. Sub-groups of the DST for the A&E and antenatal priority settings were established in May 2009 to inform the development of setting-specific guidance and resources. The DST terms of reference also include the obligation to advise health boards on data collection and standards, and provide problem solving support¹³.

1.4.3 The national ABI training programme and resources

A national ABI training programme was put in place by NHS Health Scotland, with funding from Scottish Government, to support health boards to develop local workforce capacity to deliver ABIs as part of HEAT H4. The national training involved a 'Training for Trainers (T4T)' course and the subsequent roll-out of a 'Training for Practitioners' course. The T4T programme was based on the recommendations of the SIGN74 Guideline (2003) and drew upon the Alcohol Brief Interventions Training Manual (NHS Health Scotland, 2009). Training courses were piloted and rolled out from February 2008. Training was then delivered through a 'cascade' model where local board area trainers who had received the T4T training were expected to roll out/implement the training in their own health boards to practitioners who would be delivering ABIs¹⁴. Other training providers such as the Royal College of General Practitioners (RCGP) were also involved in providing training on ABIs. Training of health professionals was supported by additional NHS Health Scotland funding to each health board, proportionate to its size and the number of ABIs to be delivered. Funding was used to employ full or part time training coordinators, for trainer's backfill costs, for the development of local resources, for administration and resource costs and for backfill costs to allow front line staff to attend the training.

In addition, a national pool of trainers was set up to enable trainers to work across boards especially to support remote and rural boards who could not sustain full time trainers. The RCGP was commissioned to deliver blended learning courses using the online modules and one day face-to-face sessions. This provided an alternative option to local training for GPs and attracted over 260 GPs from across Scotland. NHS Health Scotland produced a training manual with a DVD of ABI scenarios,

¹³ See <http://www.healthscotland.com/documents/3275.aspx>

¹⁴ The Health Scotland report *Alcohol Brief Interventions Training for Trainers and Training for Practitioners Evaluation Final Report* (Henderson and Littlewood, 2010) provides extensive detail on the training methods and structure so these will not be reiterated here. The report is available at <http://www.healthscotland.com/uploads/documents/14743-Final%20ABI%20Training%20Evaluation%20Report%20December%202010.pdf>

online learning modules, along with setting-specific practitioner resource packs¹⁵ which included patient information booklets. This was with the intention of creating a coherent and coordinated approach to ABI delivery across Scotland. An ABI competency framework has also been developed in partnership with NHS Education for Scotland (NES)¹⁶ prescribing a set of competencies which are core to the effective delivery of ABIs¹⁷.

1.4.4 Data monitoring and reporting arrangements

Government guidance in the form of the National Guidance on Data Reporting (NGDR¹⁸, Scottish Government, 2009-2010 and 2011-12) stipulated that screening and ABIs had to be delivered in line with the SIGN74 Guideline (2003). The NGDR laid out the data collection, monitoring and reporting arrangements. The mandatory reporting requirement for HEAT H4 in the initial and follow-up targets was the total number of brief interventions delivered by the health board each year¹⁹. The number of recorded ABIs from each health board is published by ISD in an annual report. As noted above, the DST was tasked with supporting boards on the issue of data collection and monitoring. One aspect of the HEAT H4 DST was an 'information support' workstream led by ISD. In consultation with boards, ISD produced a core minimum dataset which was circulated to boards in December 2008²⁰. This core minimum dataset was envisaged to be able to 'enable practitioners and Health Boards to collect and report on the implementation and delivery of alcohol brief interventions in a consistent manner' (NGDR, u.d, Annex A). The onus was placed on local health boards to develop appropriate information technology systems that enabled reporting on delivery.

Supplementary reporting was also requested by the HEAT H4 DST for identifying good practice and any areas where support may be required, and for wider public health intelligence. Mandatory overall numbers of ABIs and supplementary data were requested through the Scottish Government Alcohol Brief Interventions and Alcohol Services: Management Reporting Template (referred to in this report as the Board Progress Reports). An ISD (2011c) report describing the learning from the collection of the HEAT H4 core minimum dataset²¹, notes that health boards tended to use these required operational reports (the Board Progress Reports noted above) to monitor performance on the ABI HEAT H4 target, rather than the proposed core minimum dataset. Various initiatives, including a Core Data Set Collection Project, were put in place to try to increase more widespread collection of the HEAT H4 core minimum dataset. The lack of engagement with the core minimum dataset has had a

¹⁵ *The Alcohol Brief Interventions: Professionals Pack* includes key terms and advice for practitioners on how to deliver interventions and separate practitioner resources have been developed for A&E and antenatal settings. These have been designed to be used in conjunction with the SIGN74 Guideline and NGDR. To access such resources please go to

<http://www.healthscotland.com/topics/health/alcohol/resources.aspx>

¹⁶ Available at <http://www.healthscotland.com/documents/4120.aspx>

¹⁷ Available at <http://www.healthscotland.com/documents/4120.aspx>

¹⁸ Available at <http://www.healthscotland.com/documents/5061.aspx>

¹⁹ The extension year target requires the mandatory reporting of the total number of brief interventions delivered in each quarter.

²⁰ See <http://www.healthscotland.com/documents/3207.aspx> for information on the HEAT H4 core dataset.

²¹ Available at <http://www.healthscotland.com/documents/5059.aspx>

number of implications for evaluating the implementation of the national ABI programme.

1.5 The national evaluation of the implementation of NHS delivered ABIs in Scotland

1.5.1 Focus of the evaluation

The long term aim of the HEAT H4 target is to embed ABIs into mainstream practice as one of the services routinely offered by the NHS. To support and ensure sustainable and evidence-based implementation of ABIs across the identified priority settings, there needs to be consideration of processes at a number of different levels; practitioner, organisational, local and national, that have supported delivery. In view of this, the overall focus of this national evaluation was to highlight processes and key learning points from ABI implementation, and to explore the extent of adoption and reach across Scotland, all of which can then inform ongoing implementation and mainstreaming into routine practice. Given that the implementation of ABIs was a population-level intervention (and, as such, there is no comparison group) together with the lack of systematic patient follow-up data, it was not possible to measure impact or effectiveness in this evaluation. The focus of the evaluation is therefore on the processes of implementation.

1.5.2 Aims and objectives of the evaluation

The four central aims of the evaluation were to address:

1. In what ways are ABIs being implemented at NHS Board level and at service delivery and practitioner levels?
2. To what extent are ABIs being implemented?
3. What are the financial costs of implementation at national and NHS Health Board levels?
4. What can be learned from implementation of ABIs to ensure that momentum is maintained and ABIs are embedded into mainstream delivery as part of the core business of the NHS in Scotland from 2011²²?

To address these questions the evaluation had seven key objectives²³:

1. To assess the organisational infrastructures in place to support the implementation of ABIs across and within NHS Boards
2. To assess the extent of adoption of screening for, and delivery and follow-up of, ABIs across and within NHS Boards
3. To describe the 'models of delivery' of ABIs
4. To assess the reach of ABIs
5. To explore patients' experiences of receiving an ABI and practitioners' experiences of delivering ABIs
6. To assess the broad financial cost nationally and at NHS health board levels of implementation of ABIs
7. To contribute the findings from the evaluation to the evidence being collected as part of the portfolio of studies monitoring and evaluating Scotland's alcohol strategy.

²² This became March 2012 with the extension year of the target.

²³ For more detail on the research objectives please see <http://www.healthscotland.com/documents/4087.aspx>

1.6 Methodology

1.6.1 Overview

The evaluation involved the collection of both quantitative and qualitative information; including strategic and operational level data, and incorporated the views of national key informants, board level strategic and operational/training leads, practitioners involved in delivering screening and delivery of ABIs, and patients who had been offered an ABI. The evaluation was designed to focus on implementation in primary care (where most activity was taking place) but, where possible, to include data and analysis relevant to A&E and antenatal settings. The lack of electronic quantitative data relating to delivery of ABIs in A&E and antenatal settings meant that only qualitative data was collected in relation to these settings. There were different time frames of data collection across the evaluation data sets gathered (see Table 1). For this reason, there are sometimes differences between the information presented in this evaluation report and information reported by ISD, Scottish Government or Health Scotland on aspects of ABI implementation and training. The study benefited from an external Project Advisory Group put in place by the project commissioners representing the Scottish Government, NHS Health Scotland and ISD.

1.6.2 National level data collection and analysis

As detailed above, there is a mandatory requirement for NHS health boards to report the total number of ABIs delivered to their patients in the three priority settings of primary care, A&E and antenatal. These figures are included in the NHS Board Progress Reports. In addition, supplementary data have been collected by a minority of health boards, reported on a 6-monthly basis, relating to five specific areas: overall ABI delivery, screenings, ABI delivery by setting, follow-ups and ABI delivery stratified by Scottish Index of Multiple Deprivation (SIMD) deprivation level. The Board Progress Reports detailing the total numbers of ABIs delivered to 30th September 2010 and, where reported by boards, the additional supplementary data, were provided to the evaluation team.

The national level qualitative component of the evaluation aimed to provide an overview of implementation and included interviews with relevant national and health board level ABI leads. Twenty-six semi-structured interviews were conducted involving a total of 17 key informants who held national lead roles and represented a range of aspects of ABI strategy and delivery, and a further 13 interviews with health board strategic leads, most of which were group interviews including staff with an operational or training lead role. Thirteen out of 14 boards were represented. These interviews took place between May and August 2010. Key documents such as Local Enhanced Service (LES) contracts and alcohol care pathways were also requested from boards.

1.6.3 Health board level 'case study' data collection

Three case study health boards were identified to provide more detailed insight into the delivery of ABIs and were selected to represent both urban and rural contexts and different models / approaches to delivery. Boards where there was already a large amount of alcohol-related research taking place were excluded to avoid over-researching and burdening these areas.

As noted above, health boards across Scotland were not collecting the core minimum dataset to a degree that would facilitate a robust or meaningful analysis at

health board level. To overcome this, in the three case study boards areas, quantitative data relating to primary care were accessed from the electronic reporting systems designed to collect data for practice re-imburement for the LES contracts. These systems (which vary between health boards) allow practices to enter information on a range of dimensions of ABI activity thereby enabling payments to be made and numbers verified. This case study board monitoring data²⁴ was the most comprehensive record relating to screening and ABI activity in the three case study health boards. It should be noted that, despite this being the most robust data available, the data were not complete enough to be able to answer all of the initial evaluation questions (see Appendix 1 for a summary of the limitations of the evaluation). Furthermore, for one case study board, all primary care practice information was available while for the other two boards data were available for the majority of practices. Data were anonymised and cleaned before being passed to the evaluation team who continued this work prior to data analysis.

Within each of the three case study health boards, interviews were conducted with primary care practitioners, patients in primary care who had been offered an ABI, and key informants in A&E and antenatal settings, to explore their views and experiences. Eight primary care practices, from the three case study boards (three practices from one board, three from another board, and two from the third smaller board), were identified to take part, with the support of the primary care leads in each board area, representing both high and low ABI recording practices. A total of 35 practitioners, including GPs, practice nurses and practice managers, were interviewed face-to-face within the practice setting and, in most cases, on a one-to-one basis. Twenty-five telephone interviews were also conducted with a sample of patients who had been offered an ABI in two primary care practices, one from each of two of the case study health boards. The majority of the case study data was collected in the second half of 2010 (see Table 1).

1.6.4 Data collection time periods and relationship to aims and objectives

For ease of reference, the respective timeframes of data collection for different datasets, and their association with the evaluation aims and objectives, are indicated below in Table 1.

²⁴ This generic term is being used throughout the report to anonymise the case study boards.

Table 1. Data collection time periods and relationship to aims and objectives

Data set	Data collection/ analysis	Time frame of data collection	Aims and objectives addressed
National level key informant / health board ABI lead interviews (13 health boards) and collation of key documents	Qualitative	May – August 2010	Aims 1, 2, 4 Objs 1-4, 7
NHS Board Progress Reports	Quantitative	ABI delivery up until 30th September 2010	Aim 2 Objs 2, 4, 7
Case study board monitoring data from three case study health boards	Quantitative & Financial modelling	Commenced at different time points in the three health boards – April 2008, Oct. 2008 and Feb. 2009 and data provided until March 2011, with some records also from April 2011	Aims 2-4 Objs 2, 4, 6, 7
Interviews in three case study boards (same as quantitative data above) at board level for all priority settings and practitioners and patients in primary care	Qualitative	Two broad waves of data collection: 1) Board key informant interviews conducted July – Sept. 2010 2) Practice interviews with practitioners and patients conducted Oct. 2010 – March 2011	Aims 1, 2, 4 Objs 1-5, 7

1.6.5 Ethics and Research and Development procedures

The project aims, objectives and proposed methods were reported to the West of Scotland Research Ethics Service (WORES) who deemed it to be service evaluation: submission to NHS Research Ethics Service processes was therefore not required. The relevant Caldicott Guardian protocols were followed to gain access to the practice level quantitative data (case study board monitoring data). Research and Development protocols were also followed in the three case study health boards to ensure all staff members were aware of the aims, objectives and purpose of the evaluation. Information sheets were devised and informed consent was sought in all cases prior to the telephone/face to face interviews. The qualitative case study data collection instruments and protocols were approved by one of the University of Stirling's ethics committees. Ensuring anonymity for health boards and all participants was prioritised at all levels of the evaluation process.

1.7 Report structure

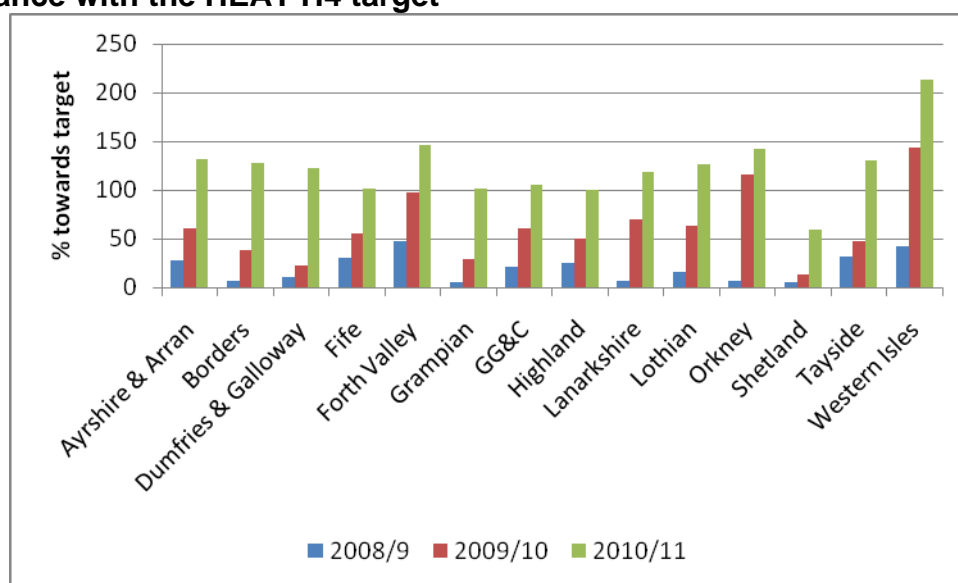
This report is a summary of the findings of the national evaluation and draws on all of the respective data sets noted above to address each of the aims and objectives. While attempts have been made to ensure clarity as to which data set is being used when reporting the findings, the discussion, conclusions and implications sections draw out key learning points for the mainstreaming of ABIs from across all data sets. The report has been organised to systematically address the aims and objectives of the evaluation. The main limitations of the evaluation are noted in Appendix 1.

2. Implementation of NHS delivered ABIs across Scotland – the national picture

2.1 Alcohol screening and delivery of ABIs across Scotland

Data published by ISD (2011) showed that the initial three-year HEAT H4 target had been exceeded by the end of March 2011. Figure 1 below presents the progress made over time in ABI delivery towards the respective targets (as a percentage of the overall target number of ABIs to be delivered over the 3 years) for each of the 14 health boards (all but one of which reached 100% delivery).

Fig. 1: Progress made over time towards respective targets of ABIs delivered by each of the 14 health boards during 2008/09, 2009/10 and 2010/11, in accordance with the HEAT H4 target



ISD Scotland: Note – these contain revised figures for the years 2008/09 and 2009/10²⁵.

Using the Health Board Progress Reports²⁶, the total number of ABIs delivered to 30th September 2010 showed that much of the progress made during 2010/11 occurred during the first six months. Four health boards reached (or over-reached) their targets, and another two reached over 90% of their target. However, ABI deliveries in two health boards fell well below 50% of the target at that time.

Four health boards included some level of supplementary data in their Progress Reports (these did not necessarily include the three case study boards) although because each one collected different aspects of these data they can only be

²⁵ See reporting at

http://www.alcoholinformation.isdscotland.org/alcohol_misuse/5866.html?32378786803

²⁶ There are sometimes differences between the numbers of ABIs delivered in the Board Progress Reports and the ISD data most specifically because data reporting, collection and monitoring systems were being developed during the first and even second years of the target so some figures had to be retrospectively revised by ISD.

compared on a few dimensions of activity. Due to one board having only very small numbers the supplementary data from only three boards are presented here²⁷.

In one of these boards, data showed that 72% of screenings took place in primary care, 15.1% as part of the Keep Well/Well North²⁸ programme, 11.2% in A&E and 1.7% in antenatal care. In terms of ABI delivery, 83.1% were delivered in primary care and 16.8% delivered in A&E. Only six ABIs were delivered in antenatal care. Analysis by age and gender showed that, in this board area, patients in the oldest age groups (over 65 years) were most likely to be screened, and patients in the most deprived quintile less likely to be screened, than those in other quintiles (for approximately half of the records for which the health board stated they were able to derive deprivation category).

In another of the boards, data showed that 83.9% of ABIs were delivered in primary care, 7.5% in A&E and 8.6% in antenatal care. 19.7% of men who had an ABI in primary care had follow-up after the ABI was delivered, compared with 16.5% of women. Analysis by age and gender showed that patients in the age group 45-64 years were most likely to be screened and most likely to receive an ABI in this health board. Patients in the most deprived quintile were less likely to be screened than those in other quintiles.

The third health board to provide some basic supplementary data reported that 92.4% of ABIs delivered were in primary care. Patients in the age group 45-64 years were most likely to be screened, with men more likely to screen positive than women, although there were no gender differences in delivery of ABIs.

2.2 Financial analysis

A substantial amount of financial resources have been used to deliver the 174,205 ABIs from 2008/09 until 2010/11. The resources needed to deliver these ABIs include those relating to set-up, training and development, those used in the actual process of delivery and other resources used to assist and encourage the implementation of ABIs. However, data were not available to quantify the extent of this. Data were also not available to model most of these costs, in particular, sufficient data were not available on the costs relating to set-up, training and development, and the other resources used to assist and encourage the implementation of ABIs.

On the basis of the available data, it is estimated that the cost of the actual process of delivering the reported ABIs in Scotland was approximately £4.4-£6.3 million, or

²⁷ The case study board monitoring data also add to what is known in relation to the sub-groups of patients being reached and are reported in section 5.1.2

²⁸ The aim of the Keep Well and Well North programme of inequalities targeted health checks, delivered through enhanced primary care services, is to increase the healthy life expectancy of our most deprived populations and thereby have a significant impact on unequal health outcomes (Annex D, Health Improvement Division HEAT targets: 2010-2011 and beyond. Available at <http://www.healthscotland.com/documents/5062.aspx> For further information on these related initiatives please see the national evaluation website at <http://www.healthscotland.com/scotlands-health/evaluation/programme/evaluation-%20KeepWell.aspx>

between £25-£36 per ABI delivered²⁹. A large number of assumptions were made in these calculations so they should only be regarded as indicative: actual resource costs used by health boards to deliver ABIs are likely to depend on the extent to which ABIs were conducted in different settings, what staff actually delivered the screening and brief interventions, and the financial and non-financial incentives for particular treatment pathways. Given the evidence on the cost-effectiveness of ABIs, in the majority of cases, the use of such resources to deliver ABIs were likely to be worth the cost.

2.3 National key informant and Scotland-wide health board views on the initial roll out of HEAT H4

2.3.1 Development of the HEAT H4 target and views on choice of priority settings
According to some participants, at national level and across the 13 health boards, ABIs and the HEAT H4 target were implemented during a rare political ‘window of opportunity’ that involved the coming together of a new government, an increased awareness and recognition of the scale of the alcohol problem as a public health priority nationally, and a growing evidence base surrounding the effectiveness of ABIs. HEAT targets were not, however, always viewed in positive terms by participants. There were, for example, mixed perspectives on the appropriateness of targets as a means of driving policy and practice forward, with some interviewees noting the danger that a programme becomes a ‘numbers exercise’. Some participants referred to targets as a ‘double edged sword’, generating knock-on effects or having ‘unintended consequences’. Others were ambivalent about the energy that had to be committed to targets which could, they believed, considerably detract from the energy and resources available to respond to other issues that may be more closely linked to local agendas.

National level participants stated that the priority settings chosen for targeting implementation of ABIs were derived from the SIGN74 Guideline (2003) and were those with the strongest evidence base to support implementation. All participants viewed primary care as a suitable setting for ABIs. Views on A&E were much more mixed with some national level participants believing that while A&E provided an opportunistic setting for screening they did not necessarily believe that this setting was an appropriate location to deliver the brief intervention component (something reflected in the national guidance provided to health boards). Views on the appropriateness of antenatal settings as a priority area were also mixed. Some national and health board participants were strongly supportive, while others believed that the evidence base was not strong enough to make it suitable as a priority setting. These mixed views towards ABI delivery in A&E and antenatal, across all levels of ABI delivery from national to practitioner levels, seem to have impacted on the ability of boards to secure the levels of ‘buy-in’ needed to swiftly progress the work in both these settings, as discussed further below.

There was a divergence of views within the national key informant and Scotland-wide health board lead interviews on whether having three priority settings had

²⁹ This was in line with the estimated costs previously modelled for NICE. See Purshouse et al. (2009) and the recent NICE Costing Report (2010b)
<http://www.nice.org.uk/nicemedia/live/13001/49071/49071.pdf>

'diluted' implementation efforts, or whether these settings were in fact too few and worked to limit innovation and the motivation and enthusiasm of practitioners and services to engage in the work. The sense of dilution of effort was related to the extent of the implementation challenges some boards had experienced, with such challenges sometimes differing in each setting, or with resistance being present in more than one setting. Across Scotland, some board participants expressed the view that trying to get ABIs established in three different settings over the same time period had indeed spread available efforts too thinly, something that had negatively impacted on overall delivery.

Other board leads considered ABIs 'best practice', wherever they were delivered, and wished to see a far more inclusive approach to delivery, despite understanding that the evidence base was under-developed. Many boards encouraged implementation of ABIs in non-priority settings, despite such numbers not counting as part of the HEAT H4 target. This was in part due to a desire to build the evidence base in the area of ABI delivery across health and social care settings. This was also described by board leads as having the intention of extending reach to those who may not access more traditional settings, such as the priority settings. Some spoke of a desire to 'run with' what was felt to be a growing motivation in many health and social care services and practitioners to engage with alcohol related problems in the health service and be part of 'the solution'.

2.3.2 Views on the national support for ABI implementation

Generally, both national and health board lead participants across Scotland were positive about the amount of funding provided for ABI implementation, viewing it as 'reasonable', 'very beneficial', 'extremely favourable' or 'unprecedented'. All acknowledged that implementing ABIs would have been considerably more challenging without this level of financial support. The fact that money was provided at the start of the target was welcomed by local level participants because it allowed boards flexibility in the amounts and area of spending, and allowed the start-up costs to be covered without boards having to worry about playing 'catch up'. The funds which, according to some board respondents, provided for widespread service improvements, such as the realignment of alcohol services to prevent 'bottle necking' and 'huge waiting lists', were welcomed.

While the DST was experienced positively in the main, many national and board level participants believed it could have been more effective. Some national interviewees believed that a major barrier to the effectiveness of the DST was the fact that it was not particularly well connected to people 'on the ground'. Some felt that the DST did not have a clearly identified role which also served to limit its effectiveness and impact. Others felt the DST was put into place too late in the process: receiving guidance from DST after they had started to implement the programme seemed to have caused significant frustration to board leads. The DST subgroups, on the other hand, were seen as positive and effective in terms of the way they had managed to engage with practitioners, mostly because they were perceived to have been reasonably open and transparent, helping to gain credibility amongst health board practitioners. Again, however, these subgroups were considered to have been set up very late in the target period. As a result, some board leads believed that aspects of local implementation had to move forward by 'trial and error'.

The HEAT H4 national events were highly thought of by all respondents. The health board visits were also viewed by all national and health board participants as very useful and productive for monitoring what progress was being made, and to resolve issues that were arising in the course of implementation. Support from Scottish Government ABI National Coordinators was described as very helpful by board leads. Aspects of national support for implementation that board leads believed could have been improved related more to the set-up of the target, and delivery infrastructure, rather than the day to day support provided by government. Having more lead-in time, for example, or a development year that was not also about delivery in order to establish processes and identify roles, was stressed by many of the board leads.

3. Implementation of ABIs in primary care

3.1 Local Enhanced Service (LES) arrangements

Delivery in primary care is most commonly supported by Local Enhanced Service (LES) agreements or contracts and the first task for the majority of the 13 boards, on announcement of the target, was to develop the contracts. This was viewed by some board participants as a collaborative process, their development involving negotiation with key stakeholders such as GPs. The LES sometimes included explicit devices such as fees, targets and bonuses to engage, retain and incentivise involvement and performance. A number of board leads reported resentment amongst non-primary care partners in their local areas regarding primary care being provided with significant incentives to leverage involvement, in comparison with A&E and antenatal settings.

Health boards are provided with autonomy over decision making, viewed as best placed to judge the needs of their local population and to design services appropriately. In keeping with this current policy, boards were expected by Scottish Government to devise their own LES arrangements. National interviewees described the drawbacks of trying to impose a national system for LES arrangements. Instead, the national infrastructure arrangements such as board visits and the DST were designed to support boards with the development of their LES contracts. The LES contracts therefore varied significantly across the country and accentuated different elements of ABI delivery. This has led to divergent and localised approaches prevailing and there were different views on whether this diversity was useful and appropriate. The general feeling amongst board leads across Scotland was that they would have liked to have had more help in this area, to avoid repetition of effort or to gain more from the learning of other board areas. A number of board leads noted that they had indeed drawn upon the experience of other boards' LES arrangements, if there was an indication that these had been successful.

Once LES contracts had been formalised, health board efforts then turned to persuading primary care practices to sign up to them. There was variation across the country and across boards in the willingness of practices to engage with ABIs and the HEAT H4 target. In some areas the programme was received positively and, generally, the sign-up rate amongst practices was good, with boards reporting uptake rates of between approximately 75-90%. However, many board participants reported having to engage in 'fairly robust PR processes', or 'lengthy processes of negotiation', to persuade practices to become involved. Even after significant effort many practice chose not to get involved, according to board interviewees, citing the administrative 'burden' associated with LES contracts/HEAT targets. Board leads described how, on occasion, they had to meet with GPs on an individual basis to outline the benefits to practices, individual doctors and their patients.

While, some board respondents across Scotland reported that the numbers of practices signed up to the LES contracts seemed to have increased over time, other board participants suggested that the numbers of practices involved were falling. Reasons given for this by board leads were various, including; impact in 2009 of the H1N1 flu virus, workload pressure from a large and ever growing number of enhanced services, confusion amongst practices as to whether the LES was continuing beyond April 2009, and tighter reporting later into the programme due to

audits taking place which had sometimes revealed reporting anomalies. Practitioner interviews in the three case study areas also alluded to the 'target fatigue' brought about by recording requirements being greater than expected. It should also be noted that having practices signed up to a LES did not always equate to expected levels of delivery: board leads explained that some practices signed up but then delivered very low numbers of ABIs³⁰.

According to board level respondents, whether or not a practice decided to sign up to participation in the programme seemed to be a 'business decision'. Financial differences in the LES contracts seemed to impact on the extent to which practices saw it as having 'earning power'. Case study data suggest that practices decided to sign up to their local LES based on a consideration of patient benefits and an assessment of the payment level against the amount of work entailed. However, this should be viewed within the prevailing budgetary context where most practices seemed to experience a level of compulsion to sign up to all enhanced service contracts in a climate of declining incomes brought about by changes in practice payment methods. While not the only motivator for practices to come 'on board' with the initiative, there certainly seemed to be a financial aspect to such decision making. It should be noted that there were substantial differences between boards across Scotland in the payments made per patient activity included in the LES contract. In some boards low remuneration contracts were sometimes given as a reason for the low relative priority given to the ABI LES, in comparison to other LES contracts/practice activity.

In addition, practice level quantitative and qualitative data for the three case study boards seem to indicate that different payment structures for ABI screening/delivery resulted in primary care practices emphasising different aspects of ABI delivery. For example, where a payment was attached to follow-ups³¹, support was broadened using a combination of telephone call-backs and invitation letters to encourage patients to return to the practice. In case study board areas where payment was exclusively focused on the delivery of ABIs, emphasis was placed on promoting opportunities for screening. In one board, payment was linked to the ability of practices to screen a specific percentage of the practice population. This resulted in practices making more extensive use of patient clinics to generate the screening numbers required to meet the board's target. This may help to explain the larger than expected number of negative screens experienced in this board area, raising a question about the value of setting practice screening targets as an incentive for promoting ABI delivery.

3.2 Models of / approaches to implementation in primary care

National, board and local practice level case study qualitative data suggest that ABIs have been delivered in primary care opportunistically and, on the whole, in line with the SIGN74 Guideline and NGDR as part of a front-line, clinical consultation. GPs

³⁰ Practices could also give notice on the LES and stop their involvement, should they wish, as noted in the LES contracts.

³¹ The follow up consultation is intended to ascertain the effectiveness of the brief intervention in achieving change and to reinforce it. Patients may be asked about their current alcohol use, sometimes re-screened and offered further support and advice, as appropriate. Most boards across Scotland did not pay practices for follow-up in the LES arrangements.

and practice nurses were responsible for delivering the ABIs, while practice managers were responsible for managing the local contract and setting in place the systems for monitoring and recording delivery. From practice level interviews, it was clear that practice managers played a pivotal role in the implementation of ABI delivery and invoked a variety of strategies to maintain practitioner focus, many directed towards improving levels of reporting or providing feedback on practice performance.

There has been a substantial reliance on Keep Well and Well North in the board areas that have these initiatives (with an associated impact on Keep Well and Well North activity, such as the need for staff to be trained in ABIs and the length of time Keep Well and Well North assessments took). ABIs were described by some board leads as having been 'ported in' to Keep Well/Well North processes of assessment and intervention. There was also a reported reliance on delivery of screening/brief interventions in sexual health clinics, where these services were deemed to be part of the primary care setting. There was evidence from the local case study data of primary care practices systematically integrating screening questions into chronic disease management clinics run by practice nursing staff.

In both opportunistic and clinic-based methods, practitioners reported using the SIGN74 Guideline alerts to help identify relevant patients and patient groups, a practice that was corroborated by patients' own accounts of their reasons for attending a GP. Whilst the initiative seems to have helped to reinforce and broaden practitioners' awareness of potential signs and symptoms of alcohol misuse, there were also instances where practitioners chose to go beyond recommended guidance. For example, some practices relied upon flu vaccination clinics to boost screening numbers, while some practitioners deliberately targeted younger patients when the opportunity arose because they felt this was a priority group that would particularly benefit from the intervention. Interviews with some board leads highlighted that in a number of boards there had been difficulties with practitioners not differentiating between dependent and hazardous and harmful, drinking patterns or levels. These leads stated that the early intervention and preventive nature of the ABI programme had needed to be stressed in various forums to change existing models and practice where there had been a focus on dependent drinkers.

Data from the three case study areas suggests that, in the vast majority of cases, screening and brief intervention were being delivered together which some participants viewed as an important dimension of the approach in primary care. For example, practitioners felt that the screening tool, and the way in which it was administered, brought a greater degree of objectivity to a consultation. Systems requiring patients who screened positive for hazardous or harmful alcohol consumption to return for brief intervention, as was the case with some practice nurses who delivered screening, were experienced by practitioners as less effective; the impetus for intervention seemed more frequently to be lost, with patients not agreeing to a referral or not turning up for the repeat appointment.

Using the case study level data again, variations appeared to exist in the extent to which primary care practitioners actively engaged with the intervention and followed models of recommended practice. Some adopted a relatively 'perfunctory' approach, treating it as a tick-box exercise, while other practitioners described going into the

topic of alcohol in some depth with patients, engaging them, tailoring their response to the patient's circumstances, and helping them to develop strategies to moderate their drinking. This divergence seemed to be partly explained by a practitioner's understanding of what constituted an ABI, their level of confidence and skills in the area, and the level of training they had received³².

3.3 Primary care practitioner and patient attitudes towards ABIs

Qualitative data from the three case study board areas indicate that practitioners in primary care, despite variations in engagement with the programme, were generally supportive of practitioners having an active role in addressing alcohol related harms. It was recognised that excessive consumption of alcohol was a major problem in Scotland and that interventions designed to reduce rates of harmful drinking were therefore required. Coupled with this was a widely-held belief that primary care represented a valid setting in which to intervene, and that health promotion is a relevant role for frontline staff working in this setting. Less favourable comments were directed mostly at practicalities, such as time constraints and the nature of LES contracts and targets. While the majority of GPs interviewed stated that they felt comfortable raising the issue of alcohol consumption with their patients, and saw it as part of their clinical remit, others found it difficult to broach the issue. This level of discomfort seemed to be affected by the social and geographical context of the practice, with those practising in affluent communities indicating patients were more resistant to discussing their consumption.

Patient interviews on the ABI process broadly accord with accounts given by practitioners. Patients were, on the whole, able to describe the screening and intervention process in some detail and identify the reasons why alcohol was raised in the consultation, although there were a few instances where patients appeared to misunderstand the purpose of the intervention. While few patients actively welcomed discussions regarding their alcohol consumption, all reported experiencing the consultation and discussions concerning their drinking as tactful and, in some cases, handled with considerable skill and sensitivity. Significantly, most appeared to accept that these conversations were part of a GP's role with only one participant out of the 25 interviewed raising a concern about the consultation. Many of the patients had established strong alliances and trusting relationships with their GP. Patients largely believed that discussion on alcohol was an incidental part of the consultation and, for most, of limited consequence.

In terms of the actions following an ABI, many of the patients who were interviewed as part of the evaluation indicated that the intervention had not made any difference to them. However, a few indicated it had prompted them to consider their drinking

³² It should be noted that the qualitative findings reported here are based on small numbers of interviews and are not generalisable or necessarily reflective of the Scotland-wide picture of implementation. They are provided as illustrative of some of the issues that have emerged in interviews with the different sets of people engaged in ABIs. As noted earlier, the Health Scotland report *Alcohol Brief Interventions Training for Trainers and Training for Practitioners Evaluation Final Report* (Henderson and Littlewood, 2010) provides extensive detail on the training methods and structure so these will not be reiterated here. The report is available at <http://www.healthscotland.com/uploads/documents/14743-Final%20ABI%20Training%20Evaluation%20Report%20December%202010.pdf>

behaviour with some also reporting it had encouraged them to try and cut down. Two of the 25 who took part reported that they had stopped drinking altogether following an ABI. Whilst the intervention was in some cases instrumental in triggering change, in many cases other factors, such as social factors, seemed to have had a more influential role. These social factors included a person's life-stage, drinking norms, lifestyle and social opportunities, their beliefs about the nature of 'problem drinking' and other priorities / co-morbidity issues, such as mental health problems. The patient interviews indicate that some of those who had received brief interventions were already known by their GPs to have significant drink related problems requiring additional specialist support, a finding supported by the quantitative analysis. However, as indicated in Appendix 1, the sampling approach used in the selection of patients for interview limits the extent to which these findings can be generalised.

4. Implementation and adoption of ABIs in A&E and antenatal settings

4.1 Extent of adoption and implementation in A&E and models used

Interviews with strategic level leads across Scotland suggest that boards attached a higher priority to implementing ABIs in primary care, with alcohol screening and brief interventions taking place in A&E settings to a very variable extent across the country. In the health board interviews it was clear that the majority of boards had got some activity going in this priority setting. However, despite the advanced stage at which the evaluation interviews were undertaken in the HEAT H4 cycle, only one of the three case study health boards, for example, had made advances in integrating the intervention as part of practice in A&E. Across the country there were also different models being used, with some boards widening A&E to include unscheduled care, for example³³.

Where a health board had a history of taking a lead in alcohol-related work, this seemed to be a factor in helping to promote positive attitudes towards ABIs in this setting. Sometimes this was due to good collaborative relationships with specialist substance misuse or alcohol services locally, or to having a lead clinician who took an active interest in, and advocated for, ABIs. Indeed, having a clinical lead with dedicated time based within the hospital setting seems to be important for establishing local champions and building the types of relationships with frontline staff necessary to both deliver training and set in place systems for delivering and recording ABIs.

According to national, health board and case study interviewees, A&E is a setting where there has been considerable resistance to the delivery of ABIs, although this resistance did not seem to be present, or as strong, in all health boards. Some interviewees also described it as having diminished over the time of the HEAT H4 target. Meetings with A&E staff were described as sometimes being 'difficult' and 'uncomfortable' when discussions took place about programme implementation. A number of reasons were offered for such resistance, relating to practical and organisational constraints as well as to issues of principle. These included:

- 'cultures of practice' that were not amenable to ABI delivery
- the perceived need to focus on the acute episode and the more immediate needs of the patient
- the belief that preventive health approaches are the domain of primary care

³³ As part of the wider Health Promoting Health Service: Action in Acute Care Settings strategy, set out in CEL 14(2008)

(<http://www.healthscotland.com/topics/HealthySettings/NHSprogrammes/CEL.aspx>), health boards are required to implement opportunistic screening of patients in A&E who present with clinical conditions as indicated in the SIGN74 Guideline and, as appropriate, deliver an ABI. For the purposes of the HEAT H4 target, delivery of an ABI in this context would only be included if delivered in an A&E setting in accordance with the HEAT H4 National Guidance on Data Reporting. A revision of CEL 14 (2008) is due to be issued in Autumn 2011.

- a concern that being drawn into health screening and chronic disease prevention activities could compromise the quality of service, being ‘the thin end of the wedge’
- the belief that many patients were unlikely to be receptive to advice, particularly those who presented under the influence of alcohol
- a fear that raising the issue of alcohol consumption could adversely affect the patient-practitioner dialogue
- a concern that intervention could disrupt patient flow through the department (especially given the range and scope of the conditions identified in the SIGN74 Guideline as potentially indicating harmful or hazardous drinking)
- a view that HEAT H4 prevented progress on meeting the HEAT A7 emergency access waiting time target that assumed a higher priority than the H4 target
- a perceived lack of management commitment to providing the staff and infrastructure necessary to support delivery
- a lack of time, and appropriate venues, for training staff.

There was also an emphasis placed by both strategic and operational leads on the amount of ‘ground work’, and therefore additional resources/costs, required to establish ABIs in this setting, for example, the perceived need for specialists to ‘shadow’ staff before they felt comfortable to take on the extended role.

Such resistance, and the additional work required, was noted to have resulted in some health boards developing ‘innovative’ or ‘light touch’ approaches to implementing ABIs in A&E settings that did not impose such a heavy reliance on frontline staff. One of the main ways that this became operational was in the pragmatic separation of screening from brief interventions³⁴. This model most commonly involved an invitation post-screening³⁵ and call-back or follow-up referral for the ABI to be done in another setting. These follow-ups could be done in minor injury or outpatient fracture clinics, at the patient’s GP practice, with a local addictions team member or a specialist such as an Alcohol Liaison Nurse.

Data from a number of boards (using the health board lead and case study interviews) suggest that where the model separated screening from delivery of the brief intervention it was not particularly effective. Logistically, follow-on appointments were described as difficult to organise, with patients not wanting to come back or to be referred on to another person/ part of the service to discuss their drinking. Follow-up appointments were described as vulnerable to considerable patient attrition (Did Not Attend), with some board representatives reporting less than 50% attendance. Other boards, however, reported that the ‘signpost and refer on’ model had in fact worked well for them, with a 60% take up rate for follow-up. This was experienced as an achievement and a demonstration that such a ‘split’ approach could work. The variation in this model’s success may be due to logistical differences taken in

³⁴ According to NGDR, ABIs can be delivered where care is ‘initiated in A&E’. There is research evidence to support the feasibility of the screen and refer on model in A&E (see Crawford *et al*, 2004).

³⁵ Screening tools used in A&E are FAST or PAT, as recommended in the SIGN74 Guideline (2003).

organising the follow-ups and the extra effort, care and resource put into this aspect of the work³⁶.

4.2 Extent of adoption and implementation in antenatal settings and models used

Many national and health board lead participants described antenatal settings as being the last of the three priority settings to begin implementation of the ABI programme, with some board areas still not having an established programme in place at the time of interview (see Table 1 in section 1.6.4 for respective timeframes of data collection for the evaluation). A proportion of these areas, however, confirmed that they had concrete plans for rolling out the programme into antenatal settings. Methods of implementation varied widely across Scotland. Some boards had decided to run pilot sites as a prelude to taking a more widespread approach to adoption, although when these pilots indicated that difficulties were going to be substantial they did not necessarily lead on to a straightforward roll-out. In other boards, there was a decision to ensure all midwives were trained during a specific lead-in time, before rolling out the initiative. A number of boards described processes of trial and error in this regard, but also where they learned from other boards who had successfully established programmes. Despite the challenges, considerable enthusiasm in antenatal settings was reported in many local areas with some board leads describing work in this setting as 'particularly successful'.

Despite differences in levels of engagement in antenatal settings, the case study findings demonstrate strong consistency in delivery approach. All three boards sought to screen all women attending the booking interview conducted at 6-10 weeks gestation at antenatal clinics (as suggested in NGDR). These clinics were normally run in local health centres although occasionally booking interviews were conducted in a woman's home. Intervening at an earlier stage, while acknowledged as preferable, was not considered practical in the vast majority of cases. However, it was believed that providing information and advice at booking was also likely to benefit future pregnancies. Whilst the client group were seen to be particularly receptive to information at this stage in their lives, and midwives had the capacity and skills to provide health information, the booking interview did impose certain constraints. More specifically, it was reported that midwives were required to cover a wide range of issues in a relatively short period of time, typically an hour, and that this had a moderating effect on what could be delivered. To help deal with these time pressures, the distribution of information materials was used to reinforce and expand upon the advice given at interview.

A variety of screening tools had been adopted, including clarification of consumption using the Scottish Woman Held Maternity Record (known as the SWHMR) alcohol in pregnancy question, and modified versions of the FAST, TWEAK³⁷, T-ACE³⁸ and

³⁶ One example was the use of text reminders to let patients know about appointments although there were confidentiality concerns noted with such practices.

³⁷ The TWEAK alcohol screening test is a short, five-question test which was originally designed to screen pregnant women for harmful drinking habits. It includes three of the CAGE questions and also asks about a woman's tolerance and blackouts. Please see the SIGN74 Guideline and NHS Health Scotland information on TWEAK for more information on use in the Scottish context of ABIs.
http://www.healthscotland.com/uploads/documents/12105-ABI_3_TWEAK_AlcoholScreeningTool.pdf

AUDIT. Those using SWHMR defined positive screens as those consuming any alcohol at the time of booking, in line with the care pathway outlined in the national ABI Antenatal Professional Pack resources³⁹. Different recording methods were also employed, with most health boards describing a reliance on traditional 'pen and paper' methods, although some had piloted new systems such as incorporating the screening tool into electronic recording systems.

From the practitioner's perspective, the level and nature of the dialogue regarding alcohol consumption was in large part influenced by a woman's willingness to describe their drinking status and amounts consumed. Where women indicated abstinence, as was the response in the vast majority of cases, then dialogue could be limited. It was widely reported during interviews at national, health board lead and case study level that women may choose to under-report their drinking at time of booking for fear of being judged as causing harm to their unborn baby or being seen as a bad parent. For this reason, some lead midwives reported using the assessment of pre-pregnancy drinking as an opportunity to establish a dialogue on the subject of alcohol. Though sometimes couched in terms of future drinking, such advice was often delivered with the intention of influencing current drinking behaviour⁴⁰.

³⁸ The T-ACE test has four questions, including three found on the CAGE test and has been proved to be more accurate in diagnosing alcohol problems in both men and women.

³⁹ *The Alcohol Brief Interventions: Professional Packs* is available at <http://www.healthscotland.com/topics/health/alcohol/resources.aspx>

⁴⁰ Only drinking during pregnancy will count for the purposes of the HEAT H4 target. Any ABIs delivered based on pre-pregnancy drinking are not valid for HEAT H4.

5. Reach and impact of implementation of ABIs

5.1 Reach

5.1.1 Findings from the national and board level interviews on reach

The extent of reach and impact of the ABI initiative was considered to be mixed across the health boards. Some board level participants expressed the view that they had achieved 'good geographic coverage' and that they had 'out-performed' in terms of reach. For ABI leads, the population-wide approach was seen to be an effective mechanism for preventing any stigma associated with receiving an alcohol intervention and for reaching all social classes where 'everyone is the target group'. Board leads who had a Keep Well or Well North programme in their area described the increased reach gained for ABI roll out through utilising this generic health improvement initiative to access those in disadvantaged communities. The need for a pragmatic approach to reach was also noted, with board participants stating that they had to go with the primary care practices who were interested in working on ABIs, and was 'opportunistic' in this sense, rather than being able to choose practices in certain geographic areas.

Gaps in coverage were noted, especially in rural and remote areas and gaps connected to age and gender. Keep Well and Well North helped to access men 40 years and over; a group that was thought to be less likely to attend mainstream services for preventive health. Board leads also described men aged between 16-30 years as another group that was 'harder to reach', because of their lack of attendance in primary care services and their reluctance to talk about alcohol in A&E settings. In addition, older people were described as a group that could be missed because of stereotypes held amongst health professionals, including the view that older people do not drink at levels which would be harmful to health. A number of other sub-populations were being missed, according to board level respondents, particularly groups who were not regular users of mainstream health services e.g. people who are homeless, recent migrants from Eastern Europe or people who may consume alcohol to hazardous or harmful levels but who are from minority ethnic groups among whom drinking alcohol is taboo.

Some boards had developed mechanisms to address such identified gaps to try to ensure that potentially under-served populations were being reached. For example, boards had engaged with partner agencies such as voluntary sector organisations to access both young and older people, people not engaging with primary care, and high-risk groups such as people with mental health and substance misuse problems. Other boards had used innovative communication methods to extend reach, such as using text messaging to engage with young people. Board respondents also described attempts to create improvements in the way health services were designed and delivered to reach those with highest need, such as changing the method of screening and expanding settings to include chronic disease clinics. As is reported below, such clinics (e.g. diabetes and hypertension clinics) were used in some board areas in primary care to conduct ABI screening⁴¹.

⁴¹ As noted in section 5.1.2 below, however, this 'blanket' screening approach may be generating a large number of negative screens and may, therefore, not be an efficient use of resources.

The central importance of training for extending reach should also not be underestimated. In the Health Board Progress Reports it was commonly noted by board leads how crucial an inclusive approach to training staff was to both embed ABIs into mainstream delivery and to extend reach and impact.

5.1.2 Analysis of case study level quantitative data

The analysis of quantitative data for the three case study health board areas provided a number of insights into the implementation of screening for alcohol problems and delivery of ABIs in primary care, relevant to the question of reach. Before moving to specific reach issues, however, it is important to provide some general context to this data.

The Fast Alcohol Screening Test (FAST) was most commonly used in primary care in the case study boards, reflecting one of the recommendations from the SIGN74 Guideline (2003). However, in reviewing the case study board monitoring data, the operational delivery of ABIs was not as straightforward as the indicative/explanatory patient flowcharts in some of the LES contracts would suggest. For example, in some practice settings, the case study board monitoring data suggested that an ABI was offered with no record of full screening taking place. It is unclear if this was because screening was undertaken but not recorded by the practitioner in the case study board monitoring data, or whether this reflected actual practice. Although primary care practitioners are able to enter screening outcomes in the electronic system, for the majority of screenings in one case study area (66%), no result was ascertainable, with much lower proportions of 'missing' results in the other two case study areas⁴². This lack of standardised and comprehensive record keeping for screening results makes comparative analysis difficult.

What the analysis of the case study board monitoring data did show was that there was considerable variation between case study areas in terms of proportions of screenings that were positive. This might indicate a more focussed approach to ABI delivery in those areas with high rates of positive screenings. Evidence from the case study board monitoring data indicates that whether or not an ABI was delivered after a positive screen for harmful or hazardous alcohol consumption also varied widely between the three case study areas. Whilst one area achieved over 90% of patients receiving an ABI after a positive screening, another area achieved less than 50%. This may include variation in the numbers of patients that refused the intervention, post positive screen, but patient refusal numbers were not well-recorded so this cannot be further clarified.

The case study board monitoring data indicates that one of the three case study health boards appeared to be successful in largely excluding those who screened negative for hazardous or harmful drinking from receiving an ABI, with less than 4% of this group being offered an ABI. In the other two health boards a significant proportion of those who screened negative for hazardous or harmful drinking were recorded as being offered an ABI (10% and 19%). Data from the qualitative interviews from across the three priority settings suggest that practitioners accepted

⁴² This issue was also raised by some board leads who had highlighted one of the challenges of the data systems used was that they did not have the ability to record the FAST screening result.

patient under-reporting of alcohol consumption levels as an inevitable part of the process. This may go some way toward explaining why practitioners in primary care may have offered patients an ABI where the screening result was negative (an aspect of individual clinical judgement).

In addition, in one case study board area, there was some indication from the data⁴³ that attempts were being made to identify and screen out dependent drinkers and not deliver ABIs to this group. However, there was also evidence from the case study board monitoring data to suggest that in the other two case study boards some of the primary care patients who received a brief intervention could be described as dependent drinkers, rather than having harmful or hazardous drinking patterns⁴⁴. There were suggestions from the practice level qualitative interviews with patients that this was occurring (see section 3.3). This issue was also apparent in interviews with a number of board leads which highlighted that changing practitioner focus from dependent drinkers to preventive early-intervention had been a challenge from the start of the programme.

The case study board monitoring data suggest that a notable proportion of people who received an ABI were recorded as being seen again, for some ABI related reason⁴⁵, at least once within a 12 month period of being offered their first ABI. There was, however, considerable variation between case study areas, ranging from 16% to 38% of individuals being seen again within 12 months of their initial ABI. Only one area explicitly recorded information relating to whether these visits were formal ABI follow-ups, with 33% of individuals being recorded as followed-up at least once within 12 months of being offered their first ABI (only 2% were followed-up more than once). Within these additional visits there was also some evidence of ABIs being offered more than once within a 12 month period, and again, this varied significantly between case study areas with 4% - 17% of people who were offered an initial ABI offered another ABI at least once more within 12 months. Caution is needed when interpreting these results however. It is unknown, for example, whether an offered ABI resulted in an actual ABI delivery; some of these additional ABIs may thus be the result of an initial offer being refused. While the SIGN74 Guideline does not indicate that there are possible contra-indications associated with the receipt of multiple ABIs, the long-term effectiveness of repeated interventions is unknown (Solberg *et al*, 2008); and the NGDR in fact regards the delivery of ABIs to the same patient in one or more priority settings over the course of a year as 'double-counting', noting that 'it is anticipated that these instances will be rare' (p1).

Again, drawing on the qualitative findings may be helpful here, although this is not intended to be conclusive. Some practitioners, in the case study board with comparatively high rates of primary care patients being offered/receiving more than

⁴³ Those who scored the highest for the FAST test were less likely to have received an ABI than those who tested positive but with lower FAST scores.

⁴⁴ In one area 91% of those who screened positive were given an ABI on the same day even though, based on the 2003 Scottish Health Survey it might be expected that approximately 20% of those who screened positive would be dependent drinkers and thus referred on to other treatment services rather than given an ABI (Drummond *et al*, 2009). This (20%) figure also coincided with data from the one case study area where there were clear attempts to identify dependent drinkers.

⁴⁵ Where it was recorded that the patient was either asked about their alcohol consumption, screened, given an ABI or followed-up.

one ABI within a 12-month period, reported concerns that the same patients were receiving repeat ABIs as a consequence of regular attendance at chronic disease management clinics run by practice nurses. In addition, some practices in the same board introduced blanket screening policies, often appending screening tools to, for example, flu vaccination consent forms. Such activity could be motivated by financial or target-driven imperatives imposed by the LES contracts or ambitious practice level screening targets, or could be a feature of a board trying to extend the reach of ABIs, (as described in section 5.1.1).

As stated above, ABI delivery in the three case study areas analysed varied from one board to another. Using the 2008 Scottish Health Survey to estimate how many people engaging in hazardous or harmful drinking were likely to visit their GP annually⁴⁶, in one board it was estimated that primary care practices screened approximately 41% of the estimated number of hazardous or harmful drinkers, with the other two areas each screening approximately 30%.

Based on the case study board monitoring data in the three case study areas, patterns of ABI screening and delivery by age, gender and deprivation also varied considerably by health board⁴⁷. In terms of sub-groups, the data suggest that younger people (under 25 years of age in this analysis) were more likely to screen positive but *less* likely to be offered/given or accept an ABI. Reach to younger age groups would thus be indicated as being an area for improvement in ABI delivery, something also highlighted in the qualitative interviews with board leads and practitioners. In one out of the three case study areas, those from less deprived groups, and women, were more likely to be screened, even though these groups were less likely to screen positive, which may be more characteristic of a blanket screening approach. In the other two case study areas the converse was true, with men and more deprived groups more likely to be screened, perhaps indicating a more targeted approach to screening. As noted above, primary care practices in one case study area were especially effective at delivering ABIs after a positive screen, regardless of gender, age or deprivation. The likelihood of receiving an ABI after a positive screening in a second case study area was slightly lower for those in more deprived areas.

5.2 Impact

It is important to preface this section by restating that due to a lack of systematic data on outcomes through patient follow-up, for example, this process evaluation has only been able to focus on participant perceptions of the impact the ABI programme was having. The patient interviews also explored the process of assessing actions and intentions following an ABI.

A number of health board leads across Scotland spoke about the numbers of screenings and ABIs that were being delivered across the priority settings as 'disappointing'. This was connected to the fact that at the time of the interviews with

⁴⁶ Data on drinking status and GP attendance was used to predict the annual number of hazardous and harmful drinkers in each health board that could be expected to see a GP.

⁴⁷ The supplementary data presented from three health board's Progress Reports in section 2.1 also outlines some connections on reach to particular sub-groups. These were not the same as the three case study boards.

board leads many felt they were still in the early stages of implementation. Some board leads reported that numbers had started off slowly but were becoming more promising over time. The general consensus from the practitioner level interviews was that they did not have a clear picture of what impact the programme was having, with many looking for evidence to support or reward the work that they were putting in. This inability to assess impact seemed to affect how a number of stakeholders, not just front-line practitioners, responded to or engaged with the programme. Providing feedback on shorter-term effects such as demand for specialist services, where this demand exists, and other outcomes that arise, may be helpful here.

Perceptions of the impact of ABIs on referrals to specialist alcohol treatment and care services varied significantly across the country. Some board leads had noted increases in the number of patients referred to specialist services, suggesting that this seemed directly associated with implementation of the HEAT H4 target and associated workforce development and training. Other board leads indicated that they had not experienced a noticeable change in referrals to specialist services since the introduction of the HEAT H4 target, contrary to their expectations.

Some participants felt that referrals data alone was inadequate to determine what, if any, impact screening and ABIs had had, and that in order to identify the long-term impact, follow-up on the person's pathway and outcome was necessary. Indeed, many board participants were hesitant in assuming a causal relationship between the ABI implementation and an increase in specialist referrals, despite referral numbers rising in their board area, especially in lower-tier services⁴⁸.

A variety of confounding factors were described. For example, the increase in resources available for specialist services that had become available in conjunction with the HEAT H4 target funding, allowing for expanded alcohol treatment and support services, was cited as one factor that may have impacted on referrals. Some participants noted that it was self-referrals rather than GP referrals that had increased in their area, and had interpreted this as a reflection of the increased 'messaging' around alcohol-related health problems and information about specialist services. The speed that referrals increased also varied across the health boards, with rates ranging from rapid increases that seemingly corresponded directly to the HEAT H4 target, to slow and steady increases taking place over a number of years. Overall, the increase in referrals was not viewed as problematic, as programmes had anticipated increases and prepared for them, through building capacity in specialist services using the additional alcohol monies, or by improving care pathways between GPs and specialist services⁴⁹.

Generally, there was a belief that there had been an increase in the 'right people' being seen in specialist alcohol services. An interesting related observation noted by board leads was that the population coming through specialist services now felt

⁴⁸ Lower-tier services are part of the tiered interventions/stepped care approach described in work on integrated treatment systems as outlined in *Models of Care for Alcohol Misusers* (National Treatment Agency for Substance Misuse/Department of Health, NTASM/DH, 2006).

⁴⁹ These findings are relevant to the current A11 alcohol and drugs waiting times target. See <http://www.scotland.gov.uk/Publications/2010/06/02115503/2> for more information on this target.

'noticeably different'; 'much more motivated to seek help and create change', than those prior to implementation of the target.

While there was evidence from the primary care practitioner interviews that the ABI programme had encouraged greater dialogue between patients and practitioners regarding alcohol consumption, few practitioners felt that it had resulted in them making more referrals to specialist alcohol addiction services or community services. The case study board monitoring data does not record information on referral post-screening or post-ABI. Interviews with antenatal respondents in the three case study areas suggest that the ABI programme did not boost numbers of referrals from antenatal settings to specialist alcohol services either. In many instances clients have a known history of substance use and, to a lesser extent, alcohol-related problems. There were, similarly, no reports in the three case board areas of the ABI programme in A&E settings increasing demand for such services.

6. Organisational infrastructure in place to support ABI delivery

6.1 Factors informing different operational models and the implications

For a small number of boards, learning did not start from zero on initiation of the HEAT H4 target. Indeed, for these boards, organisational learning was already in place from prior work, such as having an existing LES to deliver ABIs through the earlier Scottish Enhanced Services Programme, and such boards had a 'head-start' in their ABI work. This was the case even if their learning had been through experiencing many of the challenges of the work: a number of health board leads stated that their 'pilots' had not produced the results expected or required. As noted above, some boards looked to the experiences of others and adopted approaches that they thought would work well in their own context. Good organisation and planning and clear arrangements for accountability helped boards to get facilitative operational arrangements in place. Some boards put in place formal bodies, or sub-groups, responsible for the ABI HEAT H4 governance structure and for the development and negotiation of the LES contracts for the delivery of ABIs in primary care. A number of boards described their work on ABIs, and the organisational infrastructure that was put in place, as a process of 'trial and error'.

It was notable that some boards talked about alcohol as a 'cross-cutting' issue or problem requiring a 'whole system' integrated approach, not only across different health care settings, but also across different sectors. For these boards, partnership was essential and much effort was placed on getting the 'right people at the table', early on in the process of development, in order to provide leadership as well as representation for their particular sectors and organisations (the 'right people' varied across boards but was likely to include those from health promotion, substance misuse, public health, midwifery/antenatal, primary care and acute /acute hospital settings, professional leads, and representatives from community health partnerships (CHP) and Alcohol and Drug Partnerships (ADPs). There was a realisation, according to some board leads, that early involvement of, and engagement with, key 'stakeholders' was essential to obtaining agreement on the approach to be taken. These people could be champions and advocates for the work and help to 'push open doors'. Having this in place supported the substantial degree of external (to boards) and internal strategic 'buy-in' that was needed to support partnership working across multiple sectors/domains of related activity. Strategic planners and programme managers were noted to be important in facilitating such support: these roles had a lead responsibility for the 'integrity of the partnership' between the board and other key agencies and individuals at local levels.

Taking a localised approach was relevant to external strategic buy-in. Some boards had undertaken multi-sector collaborative work such as developing local alcohol needs assessments or integrated alcohol care pathways, sometimes in advance of the ABI HEAT H4 target coming into place, on which to base the ABI work. Associative collaborative structures were therefore more likely to already be in place at a local level. Local alcohol partnerships, if they were considered to work well in achieving their aims and enabling good partnership working, were perceived to be important in this respect.

Alternatively, some boards had found it very difficult to engage other agencies, sectors, and even some parts of their own organisations, in the ABI work. At times

this was a credibility issue: the programme could be, or was seen by elements of leadership and staff on the ground as 'just another target' and did not motivate staff to engage at either strategic or operational levels. Generally, if the spirit of the programme was viewed as a genuine attempt to address the problem of alcohol misuse in local communities, with associated health and social improvements, then the credibility of the programme was more likely to be established and buy-in obtained in return. This underlines the point made by one health board lead on 'cultures of practice' that are not amenable to ABIs, and the time that is needed to change such cultures.

In some cases, board leads described situations where even the lead role responsibility for ABIs was not particularly clear, being described as 'ad hoc'. The absence of a key lead role was believed to negatively impact on a board's ability to design and put in place effective delivery models.

There were clear differences across the boards but the evaluation has not been able to map organisational styles and approaches with success, in terms of meeting board targets, in the respective priority settings.

6.2 Training and staff development for ABI implementation⁵⁰

The SIGN74 Guideline (2003) and the NGDR are both clear that training is required to deliver effective brief interventions and must be provided to those who are responsible for delivering them. Across the country a substantial investment has been made both nationally and locally to plan, create, deliver and sustain a number of high quality training initiatives to meet the needs of practitioners. Resources have also been developed to supplement this training, at national and local levels. Considerable capacity has indeed been developed.

The ABI training was generally positively received, although this tended to differ in accordance with the types and duration of training on offer and the way in which training sessions were organised (as noted in section 1 above, there were a number of different types of ABI training run across the country). National training data provided to the evaluation team for the period 1st April 2008-1st March 2011 show that a total of 8,267 HEAT practitioners were trained across Scotland. In addition 646 practitioners working in HEAT settings (but not counted as HEAT staff) and 3,636 practitioners working in non-HEAT settings also accessed ABI training during this period. While it is difficult to calculate total numbers of staff members trained as a percentage of all practitioners eligible to deliver ABIs in Scotland, figures of 35% and 31% are noted in this data as estimates for percentages of primary care/Keep Well doctors and primary care/Keep Well nurses reached, respectively⁵¹.

⁵⁰ As stated earlier, the report on the evaluation of ABI training is available at

<http://www.healthscotland.com/uploads/documents/14743-Final%20ABI%20Training%20Evaluation%20Report%20December%202010.pdf>

Training was discussed in both the national and case study level qualitative interviews and is therefore highly relevant to the ABI national evaluation. It should be noted that because of the different samples, participants, methods of data collection and time-frames there may be differences in the accounts and views provided on ABI training between the two pieces of evaluation.

⁵¹ Data provided from Training Delivery Report submitted to NHS Health Scotland, March 2011 reporting on training delivery in HEAT and non-HEAT settings from 1st April 2008 to 1st March 2011.

Health care professionals seemed to appreciate training being provided by someone from the same professional background e.g. by GPs to GPs and by midwives to midwives. The NHS Health Scotland national resources were very well received. For some staff, the training was viewed as the key part of the initiative and the element most commonly described as having altered practice. As well as developing skills and knowledge, this investment has also been responsible for building support for the approach at a grassroots level, with those practitioners who have taken part in more in-depth training sessions expressing greater enthusiasm for the initiative and enhanced motivation to become involved.

For all boards, the training of primary care staff was the initial priority, with A&E and antenatal covered in years two and three⁵². Having said this, some boards took a very inclusive approach to ABI implementation and as such to the training of staff. This has meant that nationally, a wide range of professionals across voluntary as well as statutory sectors, and social and community sector staff as well as health sector staff, have received training in screening and ABIs⁵³. While all boards who participated in the evaluation recommended training to their staff and earmarked funding for local training support, boards differed in the priority they gave to different staff groups.

Training uptake was slower than expected in some priority settings, especially at the start of the programme when it was being rolled-out across boards. This was partly due to difficulties rolling out training over large geographic areas, in some cases, or challenges arranging backfill (staff cover) for those on training. There were also problems initially with trainers getting qualified and getting them in place promptly enough and, then, keeping them in place. According to many board leads, high staff turn-over seemed to negatively impact on implementation more generally, especially in the first two years when boards were trying to get systems, structures and processes in place to support delivery. It is of note that a number of strategic level participants drew attention to the limited workforce available to draw upon in Scotland for programmes such as this. Thus, capacity building, although extensive through the life of the HEAT H4 target and extension year, will need to continue for a number of years to effectively 'bed in' these more advanced levels of skill, confidence and competence in delivering ABIs and training others in ABIs in the health care sector⁵⁴.

⁵² The Health Scotland report *Alcohol Brief Interventions Training for Trainers and Training for Practitioners Evaluation Final Report* (Henderson and Littlewood, 2010) provides a breakdown of staff trained in each setting including the percentage of target staff trained in primary care and antenatal.

⁵³ Groups mentioned were health visitors, community pharmacists, sexual health nurses, mental health nurses, community firemen, social work and social care workers, out of hours nurses, acute care nurses, occupational therapists, criminal justice workers, Lifestyle Advice and Support Service advisors, genitourinary medicine nurses, fracture clinic nurses, occupational health staff, healthcare support workers and student nurses.

⁵⁴ This said, at the time of writing (August 2011), there are 103 ABI trainers active in Scotland. This seems to indicate that there has been a significant amount of progress made in the past 12-18 months in terms of making ABI training accessible for trainers and, by implication, also then for practitioners. See Henderson and Littlewood (2010) for more information on reach and impact of the national ABI training and note that there will be differences in perceptions of this issue of training reach, as with other issues discussed in this report, depending on the time data is collected in the process of implementation.

For a number of reasons, training across boards, settings and practices was considered by participants to have been inconsistent and it appears that a considerable number of staff involved in alcohol screening and brief intervention activity in the practices involved in the evaluation had not received any formal training at the time of the data collection reported here⁵⁵. Limitations of the 'cascade' model were highlighted by all levels of interviewee: it did not always happen effectively and, where it did, knowledge transfer could be limited to practical instruction on accessing screening tools and recording requirements. Some interviewees expressed the view that the quality of the training was not always retained when taken back to local areas and practices, particularly more complex skills of applying Motivational Interviewing (MI) techniques and in communicating the values that underlie the ABI approach.

In primary care, in particular, the level of training received seems to have been very variable, as noted in case study interviews with primary care practitioners. While one and two day sessions were generally considered more beneficial to such staff, their length appeared to act as a disincentive, limiting the number who could attend from any given practice. Shorter sessions fitted staff availability thereby having further reach to practice staff but some practitioners interviewed felt these lacked depth and appeared to have little legacy for practitioners attending. In terms of solutions, some boards attempted to make ABI training compulsory, which was responsible for training reaching a larger proportion of staff, but this created some resentment, especially among GPs. Overall, getting 'buy-in' from practitioners on the ground, and full engagement in the ethos as well as process of ABI delivery, seems to have been harder if staff had not accessed the more intensive versions of the training that were available. In some cases, doubts arose amongst these practitioners as to their level of competency in delivering ABIs⁵⁶.

In A&E settings, training was at different stages of delivery across the health boards related to the fact that ABI delivery was also at very different stages. ABI training coordinators stressed the importance of delivering training around staff availability, sometimes restricting training to one-hour awareness-raising sessions delivered onsite. Different levels of engagement in training experienced across boards could be explained by different levels of investment and priority given to ABI training and delivery in general in the A&E setting. Building staff capacity in this setting may therefore require considerable time or negotiation and planning with key staff and lead clinicians.

⁵⁵ This was most apparent from the eight case study practices where practitioners and practice managers was asked what training had been received. Experiences were wide ranging. In practices where the health board attached a high priority to training, most GPs and PNs had attended a training event. In others, representatives from the practice had attended a training event, while one practice had no practitioners who had been formally trained beyond attendance at a poorly-rated one hour lunch time briefing session. This is an observation not a critique of the local training coordinators, or the national training programme, where considerable efforts have been applied to make training accessible for those delivering screening and ABIs across the different priority settings.

⁵⁶ These data were based on eight practices in three case study boards so may not necessarily be representative of wider national picture but illustrative of issues of relevance to many of the evaluation aims and objectives such as mainstreaming and reach. See Henderson and Littlewood (2010) for information on confidence levels reported by staff undergoing national ABI training.

Boards were at an earlier stage in delivering training in the antenatal setting at the time of the national and case study interviews and in some cases training had been subject to substantial delays. Low attendance was reported in a number of board areas, and resulted in modifications to local training programmes. Service restructuring issues and staffing problems, particularly in more outlying rural areas where midwives could be more stretched, were identified as contributing to some of the difficulties and delays experienced. Despite these kinds of problems, co-ordinators and trainers from many board areas across Scotland reported participant feedback to be positive, with midwives described as one of the most engaged and enthusiastic practitioner groups targeted by the programme. Similarly, those who had taken part generally found the training beneficial as it addressed an area in which few had previously received any specific training and therefore has helped to build upon their existing health promotion knowledge and remit. As in primary care, the training was the element of the initiative considered to be most likely to make a difference to practice.

The issues noted here have led to calls from some practitioners for training to be incorporated as part of undergraduate or pre-qualification training. Education and training on alcohol awareness and ABIs in addressing alcohol misuse are topics that are now being included in pre-qualifying education across Scotland. Placing a range of health issues under a generic health behaviour change training approach was also suggested as a way to address some of the problems of staff capacity noted above, particularly in smaller, rural boards where a limited workforce exists to be trained and to deliver these interventions.

6.3 Data collection and recording for monitoring

Recording ABI delivery was an area that presented significant challenges, particularly where there was a reliance on traditional pen and paper methods (typically in A&E and antenatal settings), or where time pressures and busy workloads could mean recording was missed or forgotten. There was a concern that ABIs were sometimes being delivered but that data capture systems were not sufficient to record such practice. This was a significant concern for many boards that they needed to address, in order to be able to monitor whether or not they are meeting the HEAT H4 target. In a number of reported cases, it was clear through board audits that ABIs were being delivered but not recorded. This seemed to be a feature of data collection in all three priority settings. In addition, a reliance on a wide variety of local recording systems seemed to have been responsible for high variability in levels and quality of recording, both between and within board areas and between and within settings.

In the primary care setting, local recording systems and the computer competencies of practice staff delivering ABIs appeared to have had an influence on data collection and recording. Use of the computer screen also seemed to have an impact on recording rates, with those practitioners who used it as an interactive screening tool with the patient as part of routine practice (e.g. practice nurses) indicating that recording was undertaken on a more systematic basis. In contrast, GPs who typically delivered the intervention opportunistically, often recording after consultation, described being more likely to forget to input data or data getting lost. Some practice managers noted that they relied upon a small number of practitioners who were

known to routinely record when they had screened for and/or delivered an ABI to maintain recording levels.

Time pressures were a major factor affecting what information was electronically recorded with, for example, practitioners choosing simpler templates where these existed, opting to complete only those fields on computer screens that were mandatory, or developing shorthand methods of recording by including patient notes in free text fields. These pressures and practices help to explain the large amount of missing data found in the case study monitoring data. Having a straightforward system for recording data was therefore considered essential to effective monitoring, perhaps most specifically by those practitioners who appeared to have limited motivation and attached a low priority to the initiative. Recording levels were also reported to fluctuate in accordance with the reporting cycle and demand for data returns, and as priorities shifted with new initiatives constantly being introduced. These findings point towards a need to develop more universal systems and standards for recording if enhanced public health surveillance is seen to be required. However, practitioners were clear that recording needed to be simplified if ABI activity was to be effectively mainstreamed. This represents one of the key tensions of the work: low demands on practitioners may make it easier to embed new activities into practice and therefore enhance possibilities for adoption, but the effectiveness and impact of such practices become more difficult to monitor where minimal data is recorded.

Investigating the methods of data recording and reporting in the case study primary care settings illuminated a number of factors that seem to have impacted on the ability of practice staff to provide the levels of data that were expected. There have been reported difficulties with, for example; extracting relevant information from clinical systems used on enhanced service systems, data being entered on clinical systems such as chronic disease management reviews but not being entered into the enhanced service system, time lag effects where practitioners have not kept up to date with changes made to recording systems, practices failing to install relevant software, and difficulties navigating the recording systems due to unhelpful layouts and slow computer speeds.

7. Mainstreaming ABIs into routine health service practice

7.1 Facilitators and barriers to ABI implementation

7.1.1 Facilitators and strategies that have helped embed ABIs into practice

Many of the factors that would be considered to be acting as facilitators or strategies to support embedding ABIs into practice have been discussed in detail throughout the report so most will not be reiterated. Instead, a few will be highlighted.

Attitudes are one of the key factors affecting levels of adoption across the range of staff involved in implementing the ABI programme, from those 'on the ground' to those at the most senior levels in boards and other supporting organisations, such as ADPs. A positive staff attitude towards incorporating alcohol interventions into their everyday work, and towards the cultural change needed to embrace the work, seems to have been significant in this respect. Staff, including those in leadership and management positions, have engaged with the initiative in very different ways; some have 'got behind' and embraced the work and the challenge while others have been less enthusiastic. When a board managed to harness the motivation and enthusiasm of a wide range of people who were essential to the delivery process, the effect seems to have, unsurprisingly, positively impacted on adoption and implementation. As noted above, having credibility across the full range of partner organisations was likely to have been a factor influencing adoption of ABIs. With enthusiastic and supportive leadership in place, or the presence of individuals in specialist leads that were prepared to 'go the extra mile', this seemed to pay dividends in building such credibility. Other factors that seemed to support staff getting 'behind' the work were attending high quality training that enthused them to see addressing alcohol problems as part of their role, and having leads 'on the ground' who could work with front-line staff to encourage, facilitate and support delivery.

Flexible and responsive approaches to training and support were important across all settings: what worked for one practice or setting did not necessarily work for another. Some ABI leads worked on an individual basis with practices and delivery teams to accommodate their preferences and provide exactly what was said to be needed to support implementation in a particular setting. This involved, for example, delivering training in practices, shadowing staff, regularly attending staff or practice team meetings, and timing or tailoring training to suit staff needs and delivery contexts. Specialist alcohol workers and primary care lead roles were frequently identified as essential in trying to make things as easy as possible for different local contexts to get involved.

In addition, the following factors emerged from the evaluation as facilitating implementation:

- Scottish Government showing leadership in tackling alcohol misuse through the Alcohol Framework, backed up by legislation and investment, alongside a supportive approach to target performance, to maintain board and practitioner motivation and enthusiasm for the work
- opportunities to share learning across local/ board contexts facilitated by board leads and Scottish Government

- the use of pilots to enable staff to try out approaches before mainstreaming or other ways of 'preparing the ground' first
- wide ownership of the programme with representatives from key stakeholder sectors/organisations sharing both leadership and responsibility
- having a wider alcohol integrated care pathway into which ABIs could be 'slotted'
- partnerships between specialist and non-specialist staff, and generalist staff having good access to specialist services e.g. an integrated Alcohol Service Team or secondments
- the presence of staff with lead roles specific to the ABI programme (or potentially linked with other very specifically-related initiatives such as smoking cessation) to lead, provide advice and guidance, motivate, facilitate, organise, manage, train etc.
- working at the pace of practitioners to try to get a sustainable outcome rather than forcing change more rapidly for short-term gain
- active and motivated practice managers who take steps to monitor practice performance for screening, ABI and follow-up and promote enhanced performance in delivery and reporting of this activity in their practice
- the ability to build ABIs into other health systems and health improvement initiatives to allow for a more holistic approach that does not single out alcohol and hence reduces potential stigma
- administrative support, especially for coordination and monitoring, including support to record data onto relevant systems
- having the ability to make changes to data recording systems to make them more 'user-friendly' for practitioners
- having high quality, accessible and tailored professional resources for each priority setting
- easy to use and time-efficient alcohol consumption screening tools e.g. FAST, aide memoirs for the screening questions/procedures and summaries of the SIGN74 Guideline, desk-based prompt cards or electronic prompts, 'pop-ups' and alerts to record delivery.

7.1.2 Barriers to implementation

According to national key informants and board leads across Scotland, the most significant barriers to ABI implementation included:

- a lack of lead-in time for development prior to the target period starting
- not managing to establish local ownership and 'buy-in', both internally in health boards and externally, or, conversely, having too much ownership for the ABI programme held external to the health board
- embedding new systems into existing cultures with 'personalities that don't want to be involved'
- difficulties establishing effective mechanisms for coordination
- concurrent service re-design that meant resources and energy had to be focused in a different direction or a general lack of local resources to help put in place the necessary infrastructure
- competing priorities e.g. H1N1, other LES contracts and other HEAT targets
- an initial lack of a skilled and qualified workforce to deliver ABIs; staff turn-over resulting in unfilled strategic and/or operational roles; delays in getting key staff in place to coordinate and lead delivery and training roll-out

- time constraints in all priority settings on delivery of screening/ABIs and on training staff to be confident and competent
- a perception that GPs did not 'feel' the urgency of HEAT targets and a lack of clarity/confusion on the part of some GPs regarding their responsibilities in relation to the LES e.g. the need to deliver ABIs in the practice rather than referring patients on post screening for an ABI to be done in a separate service, or problems coding interventions accurately
- a perceived lack of understanding amongst key staff in the priority settings of the evidence-base for ABIs, or a lack of experience in using the FAST screening tool and how to deliver ABIs but, alongside this, a lack of interest or willingness to receive training
- a perceived resistance and lack of motivation to get involved in alcohol related interventions due to staff attitude or service culture
- difficulties establishing effective mechanisms for recording and reporting.

At the primary care practitioner level, the main barriers to ABI implementation and recording were perceived to be: time constraints, problems with remembering to deliver and record delivery, computer interface issues, interpersonal dimensions of the encounter and under-reporting.

7.2 Ensuring momentum and mainstreaming ABIs

7.2.1 Views on mainstreaming

All board participants across Scotland interviewed expressed the view that they wanted the ABI work to continue, given the extent of progress made thus far. Many felt that it was important to keep up the momentum that had been gained through the 'huge effort' in getting things underway for the HEAT H4 target. Some board participants were confident that their ABI work was already fairly well embedded. In these areas there was a sense that sufficient progress had been made to get to a 'tipping point', particularly concerning the cultural acceptance by health professionals of being involved in alcohol interventions. Sometimes a board's confidence was due to the dovetailing of ABI work with other health improvement or disease prevention initiatives, such as through Keep Well and Well North, or where there had been one or more years of prior development work which boards had been able to build upon. With none of these aspects available to support implementation, other boards were still experiencing being 'in the middle of it' or 'just getting our teeth into it', making it hard for them to have the time or space to think about the next stage of mainstreaming. Some board participants expressed feeling that they were still learning some hard lessons from the first few years of implementation⁵⁷.

Generally, primary care was viewed as an ideal place to embed or mainstream the delivery of ABIs, as practices are enabled to take ownership of this work and move it forward. While board respondents described this as happening in many practices, there seems to be a need to further embed ABIs into the day-to-day practice of primary care professionals. Using the Keep Well/Well North health improvement programme to embed ABIs into the mainstream work of the NHS was a suggestion made by a number of board leads with these programmes in their area. Other

⁵⁷ Early findings from this evaluation, such as these, were used to inform the decision to extend the target into another year.

settings within which boards saw the potential for mainstreaming ABIs were: community pharmacy, genitourinary medicine (GUM)/sexual health clinics, mental health and criminal justice.

Scotland was viewed by many as leading the world in this area, with the consequent need to share learning more widely than Scotland. Reviewing progress before moving forward was, however, seen as important in terms of improving on the work done thus far. Continuing to develop the evidence base in settings other than the current priority settings, to support the reach and impact of the programme, was felt to be essential by many board leads. Some participants felt there was a need to collect data on patient pathways and follow-on post ABI, including patient feedback on the process, before concluding that the programme had been effective. The need to give the programme time to 'bed-in', and for the outcomes or results to be clearer, was also frequently highlighted. In terms of the most critical next steps, some national level participants stressed the importance of commending and celebrating the progress that has been achieved so far, including providing opportunities to share and showcase learning and good practice with others to help other boards avoid similar problems. Other participants, at national and health board lead level, highlighted the need for an exit strategy to be put in place, which shifted the emphasis away from meeting targets to proving the benefits of ABI delivery to the patient, community and wider society.

7.2.2 Supporting mainstreaming

National and health board participants, Scotland wide, identified a range of activities for supporting mainstreaming and embedding ABIs into routine practice. Some participants were clear that the ABI work, and practitioners undertaking it, required the political and financial measures at national level to back it up, so that they could feel that the health improvement agenda concerning alcohol was not left to them alone. Use of other policy and improvement tools were noted as potentially helpful in this regard, including the Healthcare Quality Strategy for NHS Health Scotland (Scottish Government, 2010b) and the Essential Services Working Group: Quality Alcohol Treatment and Support (QATS) (Scottish Ministerial Advisory Committee on Alcohol Problems, 2011) planning, in order to set brief interventions into the 'bigger picture' of wider systems of strategic service planning.

At the board level, getting the job description right for ABI facilitators/coordinators was felt to be absolutely key to successful embedding of ABIs into the mainstream health sector. Indeed, this role was considered to be crucial to the roll out of ABIs within primary care, from both a training and implementation perspective. These roles had an important advocacy dimension including, for example, the 'lobbying' of new primary care practices to get involved in the work and running awareness-raising events in communities to increase the knowledge of alcohol problems and effective interventions locally. These roles were also deemed essential to the sometimes considerable support provided on an on-going basis to practices to continue the work e.g. through practice visits.

National and board level participants expressed the view that if the programme was to be mainstreamed, workforce development and training was a key priority and that on-going training needed to continue to be provided. Both full sessions, to compensate for staff turnover, and short 'update' sessions, to maintain

competencies, were seen as important, as was the widening of training to reach those priority staff missed as part of the current round. Some participants recognised the utility of Motivational Interviewing (MI), and expressed the view that ideally training on MI and ABIs would be provided in medical, nursing and midwifery school curricula.

A suggestion from a number of the board informants was to join up some of the discrete target areas of alcohol, tobacco, physical activity and cardio-vascular health in a more integrated way in order to embed practice into the mainstream NHS (i.e. as health improvement most generally and under the generic intervention of health behaviour change). Related to this was the idea of bringing together all enhanced services into one discrete package, or creating a national enhanced service through combining separate funding streams together.

Incorporating screening into relevant and appropriate assessment processes in each of the priority settings was also a frequent recommendation with regards to embedding ABIs, indeed, some suggested that until health care staff came to view screening for alcohol problems as part of a holistic health care assessment, it would not become mainstreamed. The need for communication and increased joint working between different parts of the health care system was emphasised in order to better to enable relevant information to a patient's pathway to be followed up on. This could be facilitated by effective local alcohol care pathways.

Both national and board level participants believed it would be important to readjust the focus from purely counting the numbers of screenings and brief interventions delivered to an approach that took into consideration the quality of interventions. This included a suggestion to tie additional funding to enhanced reporting on the quality of the intervention, in order to reduce the apparent 'box ticking' element of the work.

7.2.3 Finance and mainstreaming

Almost all board lead participants were hesitant to commit to any mainstreaming of ABIs with no money attached. Continued financing was seen by the majority of board leads to be absolutely essential to extend the work further, including into other settings and with new populations. In particular, money was required for the LES contracts; participants were adamant that GPs would not do this work without being paid. According to some, additional funding makes it easier to deliver longer appointments in primary care and to incentivise GPs to do the work amidst their other demands. Financing was also needed for the key posts that were sometimes directly responsible for making progress e.g. the ABI coordinator role, sometimes called the primary care facilitator, or in antenatal or A&E settings, the substance use liaison post. Funding to ensure the continued administrative elements of the process was also considered to be essential, in part to support the data collection and reporting components of implementation. Even those boards that were making some progress towards embedding ABIs into mainstream practice discussed funding in terms of needing to work out 'really difficult priorities'. However, national participants placed more responsibility on boards themselves to find the needed resources for mainstreaming the initiative, believing that a small amount of money could go a long way in this work. A minority of board participants were more optimistic about their abilities to mainstream ABIs without additional funds.

7.2.4 Embedding ABIs in primary care

In primary care settings, using the case study data, there is evidence of the embedding of ABIs into practice, although this varies across practices and among practitioners. Embedding is most evident in the activities of practice managers and their support staff to integrate ABIs into routine practice, for example by incorporating it into chronic disease management clinic reviews and new patient screening, and using alerts as reminders for screening and follow-ups. These activities, and in particular the need to formally record consumption, has had the effect of raising the profile of alcohol intervention and placing it on practitioners' agenda. As a consequence, there is clear evidence that recording and calculating alcohol units has taken place more systematically, and quite possibly more widely, and that practitioners are now more likely to raise the issue with patients.

Whilst it is clear that some practitioners have delivered ABIs on a more systematic basis as part of practice, during the LES contract period, it is less clear if these practices would continue after the contract ended. Practice managers reported that termination of the financial incentive would remove the requirement to continue to record, and along with this, any need to routinely raise awareness of ABIs at, for example, practice meetings. In view of this, most predicted that this would lead to an inevitable drop in the number of ABIs completed. That said, in those cases where practitioners judged the programme had made a qualitative difference to their practice, there was a sense in which this change would endure beyond the LES contract and that they would continue to raise the issue, albeit in a more 'perfunctory' manner. Others felt that once the contract came to an end, and other new LES contracts assumed prominence, the practice would lapse entirely.

Again, as with the health board interviews, there was a widely held belief amongst primary care staff that if ABIs were to be adopted as part of routine practice, some form of financial incentive had to be retained or carried on for a longer period. For this reason some suggested that the Quality Outcomes Framework (QOF) could provide an appropriate vehicle; this was seen as the main mechanism for managing practices' core business. Incorporating ABIs as part of QOF may then help to raise the profile and priority attached to ABI delivery, shifting it from being an add-on to a necessity. It was generally noted that, as well as being a familiar interface, achieving QOF points was a point of pride for practitioners and something many practices used to gauge their relative performance against other practices, as well as being their main source of income.

Whilst not all practitioners in the case study areas interviewed had undergone ABI training, those who had were more likely to identify enduring benefits of the programme and to recognise ways in which the new learning acquired would continue to inform practice. Practitioners who were less engaged noted that they would continue to give particular attention to those who presented with more serious alcohol problems. This was an issue of particular relevance to those working in one of the case study practices located in a deprived community where health problems associated with high levels of alcohol consumption were widely reported. Some practitioners who had undergone training emerged as strong advocates of the approach.

8. Conclusion and implications

8.1 Conclusion

The long-term aim of the HEAT H4 target is to embed ABIs into NHS practice. This evaluation has described many achievements. Notably, the initial HEAT H4 three-year target was reached nationally, ahead of schedule, in March 2011 and examples of successful delivery across the three priority settings clearly indicate the ability of health boards to do this work well. Much of the activity described here has been in line with Scottish guidance on the delivery of ABIs, evidence-based practice and the international literature. There are examples where reporting of current practice would be a clear contribution to the international literature. Importantly, the interviews suggest that healthcare staff see the delivery of ABIs as a worthwhile activity for NHS staff, and a valid use of NHS resources, in the light of the growing harms to health in Scotland brought about by excessive alcohol consumption. Interviews with primary care patients indicate that the vast majority accept that conversations about alcohol are part of a GP or healthcare worker's role and, in the main, appear to have no problem with being offered alcohol screening or brief interventions. There is also a sense that there has been an increase in the 'right people' being seen in specialist alcohol services, despite referrals not necessarily increasing substantially across boards. Some felt that those now being referred to specialist services were more motivated to seek help and create change in their lives.

The extension year provides further opportunity, with funding maintained at existing levels and infrastructure support, to build the capacity of staff in the NHS in Scotland to provide effective and evidence-based ABIs. However, the learning described here indicates that this funding and infrastructure support is likely to need to continue for some time yet before mainstreaming into routine practice is guaranteed. The momentum that has been gained, both in terms of training and up-skilling staff, and in terms of delivery, is still vulnerable and is likely to remain so at the end of the extension year in March 2012 because of the extent of cultural change needed to fully embed this work into the core of NHS business.

While many staff have been trained, staff turn-over, and the need for updating and renewal of skills and to reach those who remain untrained, means that the training infrastructure will need to continue to be adequately resourced to effectively 'bed in' more advanced levels of skill, confidence and competence in delivering ABIs. As well as developing skills and knowledge, the investment in staff training has also been responsible for building support for ABIs at the grassroots level: those practitioners who have taken part in more in-depth training sessions express greater enthusiasm for the initiative and enhanced motivation to become involved.

Findings on data collection and monitoring suggest the importance of developing more universal systems and standards for recording if enhanced public health surveillance is required. However, practitioners were clear that recording needed to be simplified if ABI activity was to be effectively mainstreamed. This represents one of the key tensions of the work: low demands on practitioners in terms of recording may make it easier to embed new activities into practice but the effectiveness of such practices become more difficult to monitor.

One of the most significant findings of the evaluation is the extent of variation across Scotland in terms of the implementation of ABIs. For example, findings indicate that different health board payment structures, through Local Enhanced Service contracts for ABI screening and delivery in primary care, have resulted in primary care practices emphasising different aspects of ABI delivery. Each board participating in the evaluation could therefore be viewed as unique, with its own strengths, challenges and opportunities. The evaluation findings describe the numerous ways that boards have found to localise the ABI programme, to fit their own social and geographic contexts, indicating a willingness to be flexible and accommodating to the different issues that each one has experienced in trying to successfully implement ABIs. The many commonalities and shared experiences that have also been detailed, however, enable substantial generalised learning for the mainstreaming of ABIs into routine health service practice in Scotland and more widely.

8.2 Implications of the evaluation

The following points aim to distil the key learning from this evaluation into a series of implications relevant to those working at different levels to implement, deliver and mainstream ABIs. For ease, these have been listed by the relevant topics / themes.

8.2.1 Implications for national and local policy and policy-makers

Strategic support and funding:

- Continued prioritisation of ABIs as an area of investment is essential to ensure that the benefits of the investment are fully realised and sustained.
- There is a need for sufficient time for programme infrastructures to be developed before expecting evidence of performance. A developmental year should be included in future HEAT targets, where at all possible, to allow time for guidance to be issued, and systems and supports to be developed, prior to expectations of delivery.
- To address the concerns that HEAT targets are seen by some frontline practitioners as a bureaucratic tick-box exercise, local and community-driven priorities need to be considered in relation to, and in tandem with, national priorities.
- Acknowledge target ambivalence and ‘fatigue’ and consider ways to bring together individual targets into more encompassing programmes, for example, incorporating different elements of health promotion or health behaviour change. In primary care, the Quality Outcomes Framework (QOF) has the potential to act as an important driver for integrating ABIs within mainstream practice activity.
- Cultural change in implementing such a programme takes time. Working at the pace of those delivering ABIs was highlighted as key to success and sustainability.

Training and staff roles:

- Specialist roles for ABI coordination and facilitation are considered to be essential to continued implementation of ABIs in board areas. These should be maintained through resourcing, if at all possible, to maintain momentum and continue to build on the gains that have been made.

- Training still needs to be rolled-out further to include all staff who are delivering ABIs. In addition to existing national training provided by NHS Health Scotland and the Royal College of General Practitioners (RCGP), ABI training should be mainstreamed into pre-qualifying education of healthcare professionals, something that has already begun.
- Provide increased and continued support for practitioners to attend the longer and more in-depth versions of training, in addition to more accessible, shorter forms. The evaluation suggests that these forms of training increase motivation and build capacity, the benefits of which are likely to continue to be realised beyond the life-time of the ABI delivery programme.
- Care needs to be taken to emphasise that ABIs are only effective with harmful and hazardous drinkers and should not be used as a routine method of intervention with dependent drinkers.

Partnership working:

- Partnership working and integrated approaches should be prioritised and incentivised on 'cross-cutting' health issues such as alcohol.
- Continue to find ways to enable boards, and other key delivery organisations such as ADPs, to celebrate the successes and share the learning from ABI implementation in order to capitalise on the substantial process that has been undertaken.

Data recording:

- Encourage and incentivise the collection of electronic data on ABI delivery that has the potential to enable enhanced monitoring and evaluation, where this does not detract from practitioner willingness to engage in ABI activity.

Models of delivery:

- Models of delivery appropriate to one healthcare setting, or even one geographic area, may not be appropriate for other settings so localised and tailored models and approaches should be explored, in line with the evidence-base.
- Keep Well and Well North are ideal health improvement vehicles in which to embed ABIs to enable mainstreaming and enhance reach and impact.

Evidence building:

- Build on the Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) (2011) report recommendation: *to build on the current HEAT H4 target, the Scottish Government, in collaboration with Alcohol and Drug Partnerships (ADPs), should support the continued delivery of alcohol brief interventions (ABIs) in evidence based settings. As the evidence develops a wider range of settings may become appropriate.* Continue to encourage boards and other delivery organisations to develop the evidence base for ABIs as an effective tool for behaviour change, i.e. what works and what does not, in different healthcare settings. Scotland has much to add to the international literature in this area after such significant investment in ABIs.
- In extending implementation of ABIs, reach becomes more important and needs to be measured more effectively. Innovative forms of delivery in settings that are not a current priority may enhance reach in important ways.

Reaching younger age groups was one area highlighted in the evaluation as an area for improvement.

8.2.2 Implications for those implementing and delivering ABIs

Strategic support and funding:

- There should be continued prioritisation of ABIs as an area of investment in board and ADP spending decisions.
- Maintain the use of financial incentives in primary care to help establish delivery as part of routine practice. Ensure financial payments for aspects of delivery (screening, intervention and follow-up etc.) are sufficient to cover perceived costs and to incentivise delivery and recording.
- Strategic buy-in at the most senior levels of health boards seems to be essential for effective and successful delivery of ABIs. Board 'divisions' that are relevant to such an initiative, such as public health, health promotion and addictions, should be represented and involved, and their 'buy-in' and engagement encouraged.
- In settings where there may be greater resistance to the introduction of ABIs, considerable lead-in time needs to be built in for the planning and negotiation of service delivery, a process where the support of senior management is essential and where the embedding of an ABI coordinator in the intervention site can be crucial to facilitating capacity building and setting in place monitoring procedures.
- Expect ambivalence amongst some settings and practitioners and actively work to engage and persuade people that it is an important issue and that they can make a difference. Expect resistance and actively work with it, rather than expect immediate and unconditional buy-in.

Training and staff roles:

- Staff members whose role it is to ensure effective coordination and organisational mechanisms that also ensure effective coordination of ABI implementation, should be kept in place, where at all possible, to ensure effective mainstreaming of ABIs into routine practice.
- Ensure that key roles of strategic and operational leadership/representation are maintained, even if individual staff members leave post.
- Provide ABI training to those who have not yet received it and focus on those staff groups in each local board area that are currently under-represented in training numbers. It may be helpful to have less of a reliance on the 'cascade' approach to training at practice level as practitioner data indicates that those who have received more intensive training have limited scope to disseminate the more complex aspects of the training, such as motivational interviewing, to their colleagues and peers.
- Providing additional training for practice managers on how they can usefully support the ABI delivery may also be of value, particularly for those managers who express less enthusiasm for the programme.
- Find ways to demonstrate different areas of impact of the ABI programme to practitioners in order to maintain momentum and enthusiasm. Given the 'up-

stream'⁵⁸ nature of this population-level intervention, ensure staff members also understand that the impact on many different levels (national, local/community, individual) may not be detected or realised for a number of years to come. This does not mean ABIs are not working. Related to this, acknowledge target fatigue and try to find ways to make the work meaningful to all involved. The evaluation indicates that training is a key mechanism for achieving this.

Data recording:

- Reliance on traditional pen and paper methods for recording screenings or ABIs delivered can be a barrier to recording progress in A&E and antenatal settings. Developing an electronic recording system, or gaining access to existing electronic systems, can be an important route to overcoming these barriers. In all settings encourage the use of electronic recording and the recording of more information on the consultation, where the time available permits, including levels of consumption, positive screens, follow-up, repeat ABIs and referral on to other agencies, in order to better understand care pathways.
- Prioritise the collection of follow-up data on patient outcomes, where possible, to allow evidence and feedback on impact.

Models of delivery:

- Delivery of screening and brief intervention together as part of the same consultation would appear to be more effective in most settings. However, in A&E, 'light touch', context-appropriate and evidence-informed models should be used if they enable effective implementation in this setting, and are acceptable to patients. For example, in particularly time-limited settings such as A&E, there may be advantages in restricting staff involvement to screening only, with those who screen positive being referred to other services and departments for brief intervention. That said, establishing the commitment of frontline staff in A&E and antenatal settings to ABIs seems to be essential to delivery being accepted as part of routine practice. The long-term sustainability of services where the delivery model is designed to minimise or circumvent the involvement of frontline staff is likely to be limited.
- Avoid the setting of ambitious local screening targets based on proportions of practice populations: this may result in repeat screenings and less efficient use of resources. The facilitation of shared learning could be a more effective mechanism to incentivise ABI delivery at practice level. Local targets and LES arrangements should encourage focused screening and should discourage the practice of giving ABIs to those who screen negative or those who are dependent drinkers and encourage the referral of dependent drinkers to other treatment services.

⁵⁸ Upstream interventions target the circumstances that produce adverse health behaviours or, in other words, deal with population-wide influences on health, such as policies surrounding income distribution, education, public safety, housing etc. See http://www.nice.org.uk/nicemedia/documents/Economic_appraisal_of_public_health_interventions.pdf

Tools and resources:

- Simpler screening tools, such as FAST, are easier to use/remember and are therefore more likely to facilitate accurate recording. Adoption of effective screening tools that are sensitive to the needs of patients in different health care settings is important to the identification of those likely to benefit.
- Use of information materials by practitioners with patients should be encouraged as this helps to underline key messages, and is particularly valuable where consultation times are limited.

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Appendix 1. Limitations of the evaluation

In relation to the quantitative data contained in the NHS Health Board Progress Reports and Scottish Government supplementary data, it is unclear how health boards have derived and collated the data for reporting, making results difficult to verify. There are also no consistent data reporting systems in place, making comparative analysis between health boards problematic. For the case study quantitative work, it should be highlighted that case study board monitoring data are collected primarily for the purpose of re-imburement for services delivered in primary care, rather than for evaluation purposes. Considerable proportions of some data fields were therefore either missing or were not formatted in such a way as to be analysable. The evaluation team have therefore been unable to address several of the initial evaluation questions. Although case study board monitoring data were available for all GP practices in one case study area, in a second case study health board area they were available for only 85 out of 125 practices (GP practices had to opt-in to allow their practice data to be used), and in the third area no data were available for one constituent region/geographical area. It is therefore difficult to determine how representative the case study board monitoring data were of all practices in two of the three case study areas.

In relation to the analysis of the financial implications of ABI implementation, a large number of assumptions have been made due to the lack of readily accessible or comparable data across health boards. In order to provide a more robust economic analysis of the costs involved, data recording and collection needs to be improved and standardised across boards to help make more meaningful comparisons. In addition, the resources used to manage and promote the implementation of ABIs, such as staff time used for the co-ordination of planning, service modelling, delivery of ABIs plus feedback to stakeholders in terms of performance, need to be recorded in more detail and consistently across health boards so that the impact of this resource use on ABI implementation can be explored more fully.

The evaluation team scoped the potential for using routinely collected data to analyse ABI implementation in A&E and antenatal settings. With regard to A&E, enquiries made to one hospital identified as being proactive in the delivery of ABIs concluded that there were no electronic data available for analysis within the time-frames of the project. While requests were submitted to access and utilise antenatal records held by one case study area, permissions and access arrangements were not available in sufficient time to enable analysis within the project timescales.

The limitations of the national level qualitative findings relate most specifically to the fact that one health board declined the invitation to participate, impacting on the ability to provide a Scotland-wide picture. The limitations of the qualitative case study elements relate to the generalisability of the findings and to the sampling approach which covered three of the 14 boards. There was a relatively small sub-group of practices within these boards from which practitioners and patients were recruited. All the sub-group of practices had signed up to their local LES contract. However, care was taken in the selection process to include a range of different aspects of ABI delivery. Insights into delivery in antenatal and A&E settings within the three case study boards were limited to key individuals positioned to provide an operational overview. No practitioners were interviewed in these settings.