The Scottish Government

Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) Essential Services Working Group

Quality Alcohol Treatment and Support (QATS)

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MINISTERIAL FOREWORD

The evidence is clear that reducing the overall average population consumption of alcohol delivers improved outcomes for everyone. Previous approaches have targeted particular groups, such as those with alcohol dependency or young people, and over-relied on the promotion of general health information and education campaigns. The World Health Organisation has stated that alcohol interventions targeted at vulnerable populations can prevent alcohol-related harm, but that policies targeted at the population as a whole can have a protective effect on vulnerable populations *and* reduce the overall level of alcohol problems. As a Government, we consciously adopted a whole population approach to tackling alcohol misuse and alcohol-related harm, placing the need to tackle problematic alcohol use at the heart of the public health agenda. We have achieved consensus that action on a wider scale, both population-based and targeted to particular groups, is required.

The approach encompasses all drinkers, including those who may never get drunk but are nevertheless at increased risk of harming themselves by regularly drinking more than the sensible drinking guidelines. It is not about demonising young people or focusing only on people who offend or behave in an anti-social way when consuming alcohol. Neither is it only about targeting those with chronic alcohol dependency or those who suffer the greatest health inequalities. It is clear, however, that for those people for whom alcohol-related harm is a reality, person-centred supports and interventions are essential.

In our Alcohol Framework we committed to update guidance on core services for alcohol treatment and support. We commissioned a working group of experts to revisit the principles underpinning the 2002 Alcohol Problems Support and Treatment Services Framework; identifying and updating effective interventions; and setting out guidance on developing integrated care pathways.

This report is the output of that working group. It makes encouraging reading in terms of the integrated way alcohol services already operate at a local level. This comprehensive report speaks for itself and I am pleased to fully endorse a series of robust, practical recommendations for Government, for Alcohol and Drug Partnerships (ADPs) and for specialist services. I acknowledge these recommendations are ambitious and appreciate they will take time to fully embed into practice. Having said that, I am aware much evidence-based practice already exists locally and look forward to seeing this work progress, between Government, and local partners, to implement these recommendations in service planning, design and delivery.

Shona Robison MSP
Minister for Public Health and Sport

INTRODUCTORY MESSAGE

Alcohol is a popular substance enjoyed by many. Some people will, however, encounter difficulties as a result of their alcohol use and there is no doubt that alcohol claims many hundreds of lives in Scotland each year. Although the level of consumption is roughly similar across all social groupings in Scotland and people who experience difficulties with their drinking can be found in all sectors of society, a disproportionate level of damage is found in more socioeconomically deprived groups. Although this report looks primarily at treatment and support services for those experiencing harm as a result of their alcohol use, rather than on prevention and early intervention, it reinforces the need for a strategic approach across the spectrum based on thorough needs assessment.

Responding to alcohol problems requires an understanding that those who experience problems have exactly the same aspirations in life as those who do not, and I am encouraged to see the importance attached to user involvement and the person-centred approach within this report. This places active participation by service users at the heart of their own recovery, which may be about a great deal more than simply managing their alcohol problems. Although this approach already exists within the alcohol and drug field, I welcome the renewed commitment this report promotes.

The wide range of actions to tackle the problematic use of alcohol that have arisen from the recent step-change in policy, complemented by targeted specialist but inclusive treatment, as outlined here, supports the assets approach to health that I set out in my 2009 Annual Report. By developing assets which support health in individuals rather than by doing things to them, thereby undermining a sense of control and self-esteem, it becomes more likely that a positive attitude to health and wellbeing will be created, which is an important factor in turning around our relationship with alcohol.

Harry Burns
Chief Medical Officer

EXECUTIVE SUMMARY

This report delivers on a key commitment within *Changing Scotland's Relationship with Alcohol: A Framework for Action* - to establish a subgroup of the Scottish Ministerial Advisory Committee for Alcohol Problems (SMACAP) to update core services on alcohol treatment and support.

The report builds on existing guidance contained both within the *Alcohol Problems Support and Treatment Framework* (2002) and the Scottish Advisory Committee on Drugs Misuse (SACDM) *Essential Care* report (2008) and continues to advocate for a stepped care, tiered approach to alcohol treatment and support.

The target audience for this report ranges from policy makers to those involved in frontline delivery including: Community Planning Partnerships (CPPs), NHS Chief Executives, Alcohol and Drug Partnerships (ADPs), service planners and commissioners, clinical leads and specialist alcohol treatment and support services. Representatives from these groups, in addition to services users and people in recovery, were consulted with throughout and played a key role in the development of the report recommendations.

Key recommendations are outlined to be actioned by Scottish Government, ADPs, service commissioners and specialist alcohol treatment and support services. Many of the issues covered and recommendations highlighted will also apply to drug treatment and support.

This report focuses on tier 3 and 4 alcohol treatment and support services and advocates for a person-centred, recovery-focused approach, ensuring the unique needs of individuals are identified and met. It does not provide tailored guidance for the needs of specific priority groups.

The recently launched *Healthcare Quality Strategy for Scotland* (2010) has informed this report, most notably the importance of person-centred treatment and support and the focus on outcomes. Quality alcohol treatment and support is part of the spectrum of treatment services that NHS Boards, ADPs and their partners commission/provide to meet the person-centred and Quality Ambitions embedded in the Quality Strategy. We are mindful that many specialist alcohol services have been incorporating these ambitions for some time but the recommendations within this report seek to strengthen this approach and improve consistency of service planning and delivery throughout Scotland, meeting required standards and effective practice.

Key recommendations, highlighted throughout the report, for delivery by the Scottish Government, Alcohol and Drug Partnerships and specialist alcohol services, are set out below. If these recommendations are achieved and embedded in practice it is anticipated that people affected by the problematic use of alcohol will receive improved support and outcomes as a result.

RECOMMENDATIONS

1. Local services should be based on a "stepped care" approach, within the tiered model as set out in the Alcohol Problems Support and Treatment Services Framework (2002) (s*ee diagram 1).*

2. All Alcohol and Drug Partnerships and services should embed the Healthcare Quality Ambitions, incorporating a person-centred, safe and effective approach to treatment and support.

3. Alcohol and Drug Partnerships must ensure service users and people in recovery are represented within the partnership and that services have meaningful service user involvement both in service design and delivery. Services should be underpinned by a recovery ethos which supports and builds on the strengths and assets within individuals, and they should consider adopting the principles contained in the Bill of Rights (s*ee annex B).*

4. All alcohol services delivered locally and supported by public funding must be commissioned on the basis of delivering evidence based interventions according to identified need and subject to adequate and appropriate outcome measurements.

5. All Alcohol and Drug Partnerships and commissioned services must have, and review on an ongoing basis, robust needs assessments and Equality Impact Assessments (EqIAs) to ensure the needs of all groups within their community are identified and met, paying particular attention to those most at risk of harm.

6. We recommend that the Scottish Government continues to reinforce that Alcohol and Drug Partnerships are responsible for strategic decisions on spend to deliver priority outcomes. We further recommend that ADPs are proactive in taking responsibility for this decision making process. NHS Boards are held accountable to Scottish Government on funding for alcohol services.

7. The Scottish Government should seek to develop clearer lines of accountability and reporting mechanisms for local Community Planning Partnership outcomes in Alcohol and Drug Partnerships, ensuring alignment to national priorities, Single Outcome Agreements (SOAs) and whole population approach outcomes.

8. Alcohol & Drug Partnerships and all (statutory, third and private sector) services need to demonstrate effective, published service (outcome) specifications and explicit contract monitoring processes.

9. In line with feedback received from service users, services should develop links with peer support, mutual aid and self-help organisations.

10. The Scottish Government and Alcohol and Drug Partnerships must jointly develop core outcomes.

11. The Scottish Government should fund the development of a national outcomes-focused alcohol treatment database. Alcohol and Drug Partnerships should effectively support local services in the delivery of this.

12. Services should be adequately staffed and all staff working in alcohol services should be adequately qualified, trained, supported and enabled to deliver their agreed roles.

13. To build on the current HEAT H4 target, the Scottish Government, in collaboration with Alcohol and Drug Partnerships, 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.

14. All specialist alcohol services must undertake routine screening for harm against women and children as part of a thorough, ongoing assessment process to ensure provision of a package of support. Staff should be trained to deliver such screening and to provide effective support.

Chapter 1

INTRODUCTION

Purpose of this report

1. This report provides expert advice to Scottish Ministers about action required to ensure effective services for people affected by problematic alcohol use are in place across Scotland. Its focus is on tiers 3 and 4 specialist alcohol treatment (within the tiered model as set out in the *Alcohol Problems Support and Treatment Services Framework* (2002)) (see diagram 1). Everyone linked to or working in the alcohol field has an interest in this report, in particular Alcohol & Drug Partnerships (ADPs), service commissioners and service providers.

2. The National Treatment Agency (NTA) *Models of Care for Alcohol Misuse* (MOCAM) 2006 identifies three categories of problematic drinker: hazardous, harmful and dependent. This report focuses on treatment interventions and related services for harmful and dependent drinkers.

3. The report reflects on recent policy and practice developments, and aims to set out a realistic and pragmatic assessment of best practice in care and treatment of those affected by problematic alcohol use in Scotland. It promotes the need for a person-centred approach to the provision of services, and the importance of local solutions based on local needs assessment. It focuses on the importance of working towards outcomes. When referring to a "person-centred approach" within this document, a term that is firmly incorporated in the *Healthcare Quality Strategy for Scotland* (2010), we are describing a treatment approach which we know is well embedded in current service design and delivery in a variety of specialisms. For the purposes of this report, we are defining "person-centred" as a warm, empathetic, open and non-judgemental approach which meets the specific needs and aspirations of each individual. It identifies recommendations outlining key actions for the Scottish Government, ADPs and services.

4. An Equality Impact Assessment of this report has been completed and can be accessed on the Scottish Government website[1].

The scale of the problem

5. Ninety percent of Scotland's four million adults currently drink alcohol. Alcohol sales data suggests that population surveys significantly under-estimate consumption levels. NHS Health Scotland estimate that at least 50% of men and 39% of women exceed recommended sensible drinking guidelines. Latest research (NHS National Services Scotland, 2009) suggests that alcohol contributes to 1 in 20 deaths in Scotland. The cost of alcohol misuse to the Scottish economy is estimated at £3.56 billion per year, or £700 per man, woman and child in our population.

[1] http://www.scotland.gov.uk/Topics/Health/health/Alcohol/resources/QATSEQIA

6. In July 2009, Scottish Alcohol Needs Assessment (SANA), the first comprehensive needs assessment to take place in Scotland, was published. It sought to determine the size of the problem in terms of both prevalence, and the provision and accessibility of services. Findings, based on data gathered in 2006, highlight that 17,000 individuals across Scotland were engaged with alcohol treatment services. Conclusions were drawn that for every person who is accessing specialist alcohol services there are a further 11 in need who are not. Such findings evidence that Scotland could be facing considerable capacity issues.

Changing Scotland's Relationship with Alcohol

7. In 2009 the Scottish Government published *Changing Scotland's Relationship with Alcohol: A Framework for Action,* setting out for the first time a whole population approach to problematic alcohol use. The Framework makes clear that a new and visionary approach is required if Scots are to reach their potential as individuals, families and communities and as a nation. The Framework identifies the need for sustained action in four key areas:

- reduced alcohol consumption;
- supporting families and communities;
- positive public attitudes, positive choices; and
- **improved treatment and support**.

8. Action is underway to take forward many of the measures outlined in the Framework, which are designed to build an environment that will support cultural change over a longer period.

9. The development of the Alcohol Framework was underpinned, in 2008, by the Scottish Government's unprecedented investment in tackling alcohol misuse. Almost £100 million was committed over a 3 year period, the majority of which has been invested in early intervention and treatment and support services.

Improved treatment and support

10. As well as increased investment into service provision, NHS Scotland (working with relevant partners) is currently implementing key actions to improve treatment and support including those pursued via two HEAT[2] targets:

- HEAT H4 - to embed screening/early identification of alcohol misuse and delivery of brief interventions in the core services offered by NHS Scotland. This target seeks to shift interventions upstream by delivering 149,449 alcohol brief interventions (ABIs) between April 2008 and March 2011 in the priority settings of Primary Care, Accident & Emergency and antenatal care with an extension to deliver an additional 61,080 ABIs by March 2012;

[2] HEAT stands for **H**ealth Improvement, **E**fficiency, **A**ccess to services and **T**reatment. It is a Scottish Government NHS performance management system that includes targets that support National Outcomes, from the Scottish Government's National Performance Framework. NHS Boards (working with relevant partners) are accountable to the Scottish Government for achieving HEAT targets.

- HEAT A11 - to ensure that people affected by problem alcohol or drug use receive fast access to appropriate treatment. This target will ensure that by March 2013 90% of clients will wait no longer than 3 weeks from referral received to appropriate (tier 3 and 4) drug or alcohol treatment that supports their recovery.

11. In 2002, the then Scottish Executive published the *Alcohol Problems Support and Treatment Services Framework*. The purpose of this was to assist local areas in the planning, commissioning and management of support and treatment services for those with alcohol problems. It set out the core principles for alcohol services setting them in a tiered, stepped care model (see diagram 1). It identified the existing evidence base for treatment of alcohol problems and called for an integrated spectrum of care, with an underlying person-centred approach to care planning, taking into account service user, carer and family views. Encouragement was given for the development of local integrated care pathways and service evaluation.

Recommendation 1:
Local services should be based on a "stepped care" approach, within the tiered model as set out in the Alcohol Problems Support and Treatment Services Framework (2002) (s*ee diagram 1).*

12. The Audit Scotland report: *Drug and Alcohol Services in Scotland*, published in 2009, set out recommendations for both the Scottish Government and local public sector bodies with regards to quality assurance, integrated working and performance management. It identified the need to set clear national minimum standards for drug and alcohol services including their range, quality and accessibility.

13. It was considered to be both timely and relevant to reappraise and update what range of alcohol treatment and support services are essential for local areas, taking into account the current evidence base on effective interventions; how services should be delivered; and the outcomes that should be monitored. Recent policy and practice developments in the wider substance misuse and mental health fields have, where appropriate, also been considered.

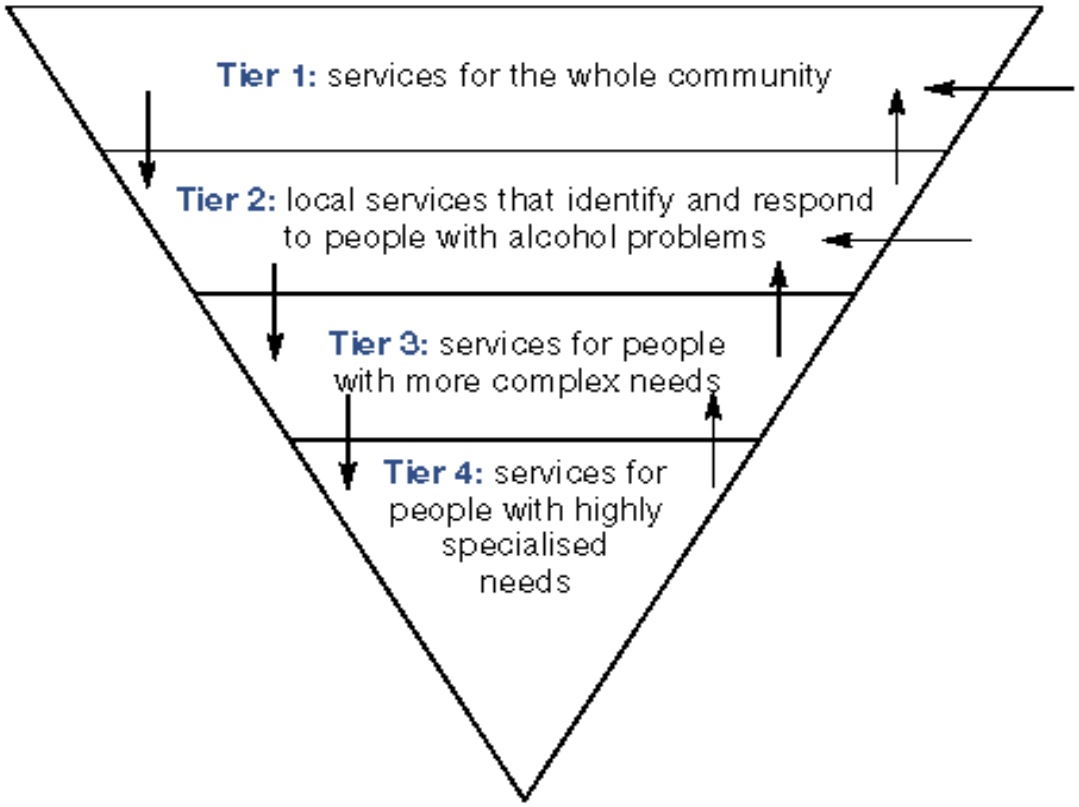
Changing Scotland's Relationship with Alcohol therefore set out the following action:

We will establish a working group to update core services on alcohol treatment and support. This will revisit the principles underpinning the Alcohol Treatment Services Framework; identify and update effective interventions; and set out guidance on development of integrated care pathways which take into consideration multiple and complex needs.

14. The Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) therefore established the Essential Services Working Group in December 2009 to take forward this key action from the Alcohol Framework. It has met on a monthly basis since January 2010. Membership of the group represented a wide range of experts from across the NHS, local authorities, Alcohol and Drug Partnerships (ADPs), Government and Third Sector, and is set out at annex A. To inform the final report, focused consultation was undertaken with key stakeholders, service users and people in recovery.

Diagram 1

Alcohol Treatment and Support: Four Tier Structure



Arrows denote that:

- people may move between tiers as their needs are assessed or change over time
- people need not necessarily move sequentially between tiers
- people should be able to gain direct access to tiers 1 and 2

Wider context

15. *The Healthcare Quality Strategy* (2010) promotes a person-centred approach to treatment and support. Services should be enabling individuals with alcohol problems to live as meaningful and satisfying lives as possible. There are many paths to wellbeing and recovery and a person's attempt to deal with their problem alcohol use is a unique and personal process. It is important that a full range of high quality and accessible services are available at the point of need for all those affected, both directly and indirectly. A continuum of care is required which balances the undisputed need to reduce the harm associated with problem alcohol use while maximising the opportunity to engage with healthier lifestyles and activities whenever this is realistic. Recovery can, but may not necessarily, mean abstinence.

16. It is imperative that person-centred, evidence-based, effective service provision is readily available to those affected by problematic alcohol use. The Scottish Government's additional investment in tackling alcohol misuse supports the development and building of capacity in treatment and support services to respond to this identified need.

17. At national and local level, identification and delivery of services for people affected by problem alcohol use must address inequalities (including health inequalities). The public sector has a duty to address inequality and promote equality across gender, age, race, disability, sexual orientation and religion and belief. Although problematic alcohol use occurs across all groups, harm related to alcohol falls disproportionately on disadvantaged populations, and as such interventions must be designed to address that disproportion.

Chapter 2

PHILOSOPHY OF CARE

18. The problematic consumption of alcohol straddles a wide demographic and adversely impacts on people from all walks of life. In response to this, ADPs must ensure that individuals from all parts of the local community have access to effective services. Such services will take a holistic approach, recognising the person's family, relationships, education and employment, housing and legal position and their aspirations in these areas. Some will achieve those aspirations by sustained reduction of their drinking whereas, for many, complete abstinence will be necessary. It is in achieving these aspirations that recovery is experienced.

19. The development of local Integrated Care Pathways (ICPs) is vital in setting out who delivers what care to whom, at what point and to what end – recognising that individuals and those close to them may need access to other services and support and ensuring that services are delivered in a joined-up and person-centred way, as outlined in the *Healthcare Quality Strategy* (2010).

Recommendation 2:
All Alcohol and Drug Partnerships and services should embed the Healthcare Quality Ambitions, incorporating a person-centred, safe and effective approach to treatment and support.

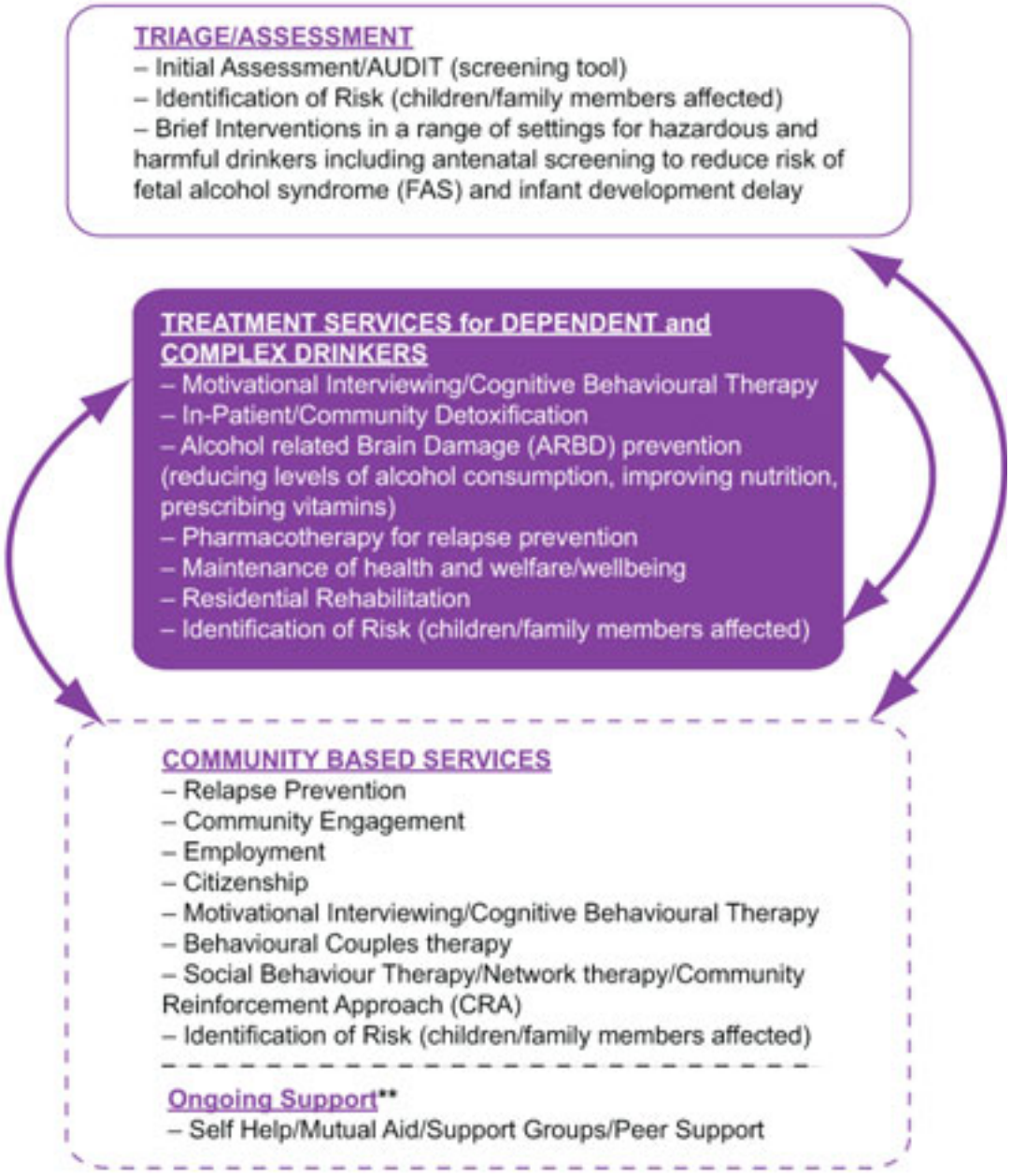
20. Both the stepped care approach and the Healthcare Quality Strategy recognise that the needs of those with alcohol problems are diverse. These range from detection and early interventions for those whose drinking may be at harmful levels but who as yet have experienced limited or no obvious health impacts, to intensive treatment and support for those with alcohol dependency and for those who may be unwilling to engage with services and are particularly hard to reach. Such services may be provided by a combination of health service, local authority and third sector bodies.

21. The provision of services to each individual should take into account other issues – such as mental health, related harm, childhood abuse, drug use, finance, criminality, employability and housing – which may be significant factors in that individual's recovery. Those around the individual, particularly children and partners, may also require support. It is also important to acknowledge and reinforce the positives in the lives of people affected by problematic alcohol use. Below is a diagrammatic representation of a suggested functional structure (focusing on tiers 3 and 4) to ensure adequate service provision from the point of initial contact.

Diagram 2

Recovery Pathways*

Service users engage with self help/mutual aid/peer support groups at various stages throughout their own recovery journey or may recover independently from structured treatment.



* It is expected that meaningful service user involvement, in the context of a person-centred approach, would occur throughout this Pathway.

** These may form part of this pathway (at various stages) or may occur independently of statutory or non-statutory structured treatment.

22. Many services across Scotland are developing approaches which seek to maximise the potential for recovery. This involves a conscious decision to move away from a model of service provision which sees service users as passive recipients of interventions organised around the needs of services to manage risk and to meet high levels of demand. Instead they orient themselves around the needs, hopes, wishes and aspirations of service users, embracing a fully person-centred approach.

23. By contrast, an approach which focuses primarily on the service provider's needs, in terms of its being able to utilise its own set of skills, can develop low expectations of the user's ability to overcome problem alcohol use, instead settling for a process which engages individuals in low level contact with treatment services for long periods. This approach is understandable and reflects the fact that problematic alcohol use, such as is found in tiers 3 and 4, can be a long term chronic relapsing condition, which many struggle to overcome. Focusing solely on the user's attendance and ability to work with professionals may, however, limit expectations, foster dependency upon the service provider and can inhibit recovery and re-integration into the community.

24. Efforts from service providers, to engage with hard to reach groups, should be acknowledged. We strongly recommend support for delivery of effective, evidence-based, person-centred treatment and support options, which facilitate a reduction in problematic alcohol use and engage service users in positive lifestyle choices sustained over the long term.

25. Such treatment and support should be co-produced and ultimately managed by the service user, and should be accessible to the service user over a substantial period, not in a way which creates a dependency on services but in a way which underpins a long-term recovery that frees the individual from such dependency. Service providers need to move towards a position in which they are but one useful part of a journey of recovery. According to the *Scottish Care Commission Survey (2005)*, users put a high priority on the following:

- access and availability;
- focus on improving lives;
- choice;
- innovation;
- independence; and
- competent, reliable and trustworthy staff.

Person-centred Approach and Recovery

26. In this report recovery is taken to refer to a style of service user involvement, as described below, rather than any particular treatment type and is used to denote the process through which an individual is enabled to move on from their problematic alcohol use, towards a life free of alcohol related problems, as an active and contributing member of society. There is no right or wrong route through recovery and it will mean different things to different people at different times. It is a function of the interaction between services, service users and the communities in which they live and will therefore be most effective when the aims, needs and aspirations of service users are placed at the centre of their support and treatment, allowing for recovery planning to be a co-production of both services and service users.

27. These plans will evolve over time according to changing circumstance and it is therefore critical that regular review and assessment of recovery capital is made with each individual with a view to informing the way in which their plans change and develop. Recovery plans should include a series of achievable personal goals which will be different for each individual but which act as important and sustainable milestones by which a person's progress can be measured. In this way a person can be supported through the changes in thinking and action that allow them to achieve their full potential in a way that is truly meaningful to them (Wardle, 2009).

28. More recently in the UK the concept of recovery has been driven largely by the mental health service user movement and has demonstrated the clear benefits of involving people as active participants rather than passive recipients of service defined support packages. The ways in which alcohol interventions are progressed in Scotland can learn much from these developments.

29. One of the 3 Quality Ambitions in the Healthcare Quality Strategy is: **Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.**

30. The recovery movement has a long history within the alcohol field, going back at least 150 years. Its nature has changed significantly over this time, responding to shifts in the way that society has conceived and prioritised alcohol problems. It is an evolving concept which in the past has suffered from occasional appropriation by certain treatments as a shorthand way of describing it.

31. Recovery is fundamentally about learning to use personal and social strengths to ‘live well’ in the presence or the absence of problems of all sorts. The shift is therefore towards the individual learning how to manage their issue/s in the context of an empowered self and community rather than being defined by the issue itself and by those services set up to deal with it. The Social Care Institute for Excellence reports common recovery themes as being: the pursuit of health and wellness; shifting from an emphasis on morbidity to health and strength; a belief in positive change and hope; the use of service support as a mentoring rather than a supervisory function; the promotion of social inclusion by basing services in strong communities; and an awareness of the power of using positive language in

describing experience. These themes link closely to the themes of an assets approach, which argues that:

A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses[3]. (Antony Morgan, 2009)

32. From this comes a variety of outcomes which might usefully translate to ADP and community partnership planning. These include:-

- noticeable, measurable and understood improvements in the quality of life;
- an understanding that there will also be beneficial impacts on families and social networks;
- a well developed diversity of options for service users;
- the development of the principle of giving something back to the community that has empowered users; and
- an understanding that the long term goal is to reach a 'tipping point' at which individuals and communities are empowered and strengthened to the point at which future problems are significantly reduced.

33. Alcohol problems can take many forms and may be resolved quickly with minimal support, but the more severe and most destructive forms can be long lived and recurrent.

34. Stigmatisation of those with alcohol related problems is evident at all levels of society: individual, institutional and cultural; general public and service providers. A survey conducted in 2004 (Scottish Social Attitudes Survey) suggested that Scotland is divided over whether problem drinkers can be held 'morally responsible' for their own situation. Thirty four percent of people felt that people with drinking problems had only themselves to blame whilst forty percent disagreed with this point of view. Conversely a third of drinkers and two fifths of non drinkers agreed that their not drinking is something that would be viewed as odd by society. This suggests that not drinking is also stigmatised.

There is little doubt that stigmatisation increases barriers to effective support for those affected by alcohol problems. They may experience feelings of low self worth as a direct result of stigma. People can become reluctant to access services for fear of this reaction which can result in appropriate interventions being delayed. Stigma can have a profound effect on many aspects of recovery such as accessing health and social care services, finding appropriate accommodation and gaining employment. Much stigma can be perpetuated by terminology used to describe people affected by alcohol problems.

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[3] http://www.healthassetsconf.org.uk/index.php?option=com_content&view=article&id=54&Itemid=59

Possible responses to reduce stigma might include :

- Service user, advocacy and mutual aid groups becoming more active in challenging media reporting of alcohol problems
- Education and information campaigns to help improve understanding of alcohol problems
- Improved training for professionals and service providers who come into contact with those with alcohol problems
- Greater use of voluntary work placements to move beyond stereotypes and increase employment opportunities
- Support for those in the public eye to talk openly about their own recovery (six month stigma review, UK Drug Policy Commission, 2010)

Case Study 1

The following case study highlights issues faced by a service user who has multiple and complex needs.

Pam was referred to the alcohol counselling service by her social worker at the Adult Learning Disability Team due to concerns around her escalating alcohol misuse, resulting in increased exposure to risk. Pam was drinking 3-4 days a week to intoxication.

She experiences depression, is a wheelchair user and has a learning disability. Prior to referral she had been arrested for stealing. At the time there was a court case pending for this offence. There had also been other police involvement when she had been reported missing. When located by the police she was intoxicated, in unsafe company and refused to return home. Her local housing association also had concerns due to her level of intoxication when returning home. They were considering taking action on anti-social behaviour grounds.

Shortly after assessment, a meeting was called under Adult Support and Protection procedures in order to address areas of risk.

Initially the worker assessed Pam's understanding of alcohol and looked at all risks and concerns. The focus was on alcohol awareness and harm reduction. Her worker used appropriate language and having her supportive partner present helped to reinforce what had been discussed.

Over the coming weeks her alcohol use remained static, although risk had reduced slightly as she began drinking more at home. She was becoming angry and frustrated with the focus on her alcohol use. Her worker felt at this time it would be of more benefit to redirect her attention by adding structure to her day.

Noted from referral & through on-going assessment, boredom & isolation played a significant part in Pam's behaviour/ alcohol use. This resulted in exploring primary goals and direction, hobbies and interests.

One interest was beauty therapy and a nail course was identified locally. Pam is currently on their waiting list.

The worker also referred her to a local Day Programme. The assessment proved useful as it identified specialist equipment required and opened the door to other services on offer. The workability programme, designed for people with learning disabilities, was suggested and following discussion with Pam, she agreed to be referred. Service users are offered skills training combined with a job placement while working towards a vocational qualification, with the aim of achieving employment.

Since assessment Pam's mood has lifted and her alcohol use has reduced to two evenings per week, mostly within her home, thus exposure to risk has reduced. Her awareness of risk and potential harm has also increased her understanding of other people's motives and needs.

This case will continue to be monitored closely via review. Services will remain involved until it is agreed by all agencies that Pam's risk has reduced.

35. For service users to achieve successful outcomes, well evidenced techniques such as motivational interviewing and relapse management must include the active participation of the person concerned if there is to be a real understanding of the best approach and of what is likely to be successful. The approach needs to be pragmatic and based on an understanding of the physical, psychological and social issues as defined by the user if real change is to occur. This ensures that the process becomes centred upon the person and therefore relevant to their expressed needs.

36. There are at least three key dimensions of change involved in the shift towards the recovery agenda[4]:

1 – Putting People First

The implications of this when constructing service interventions are:

- the service user should be placed at the centre of, and have, considerable influence over the intervention plan negotiated between them and the service;
- the ways in which the services on offer are made available should take into account the full diversity of the community. Every effort needs to be made to ensure that services are fully accessible and acceptable to all members of the community taking into account age, gender, race, religious beliefs, sexual orientation, physical and psychological disabilities and potential barriers such as fear of stigma; and
- services should have strong links and joint working protocols with a wide variety of both non-specialist, non-health related services and community groups.

A service user *Bill of Rights* can be found in annex B.

[4] http://www.scotlandfutureforum.org/assets/files/report.pdf

2 - A shift from an individual and substance based understanding to one that has its base in social networks.

The implications of this when constructing interventions are:

- that interventions should be a function of people's stated need rather than assumptions of need; and
- that families, peer groups or other significant social networks should be an important part of any planned intervention.

3 - A shift from seeing events as discrete to seeing them as part of a whole system.

The implications of this are:

- that the development of the research and evidence base should be encouraged and that this should underpin the development of intervention systems;
- that services should begin to move towards providing earlier interventions; and
- that, although the development of services as part of a systemic approach (including prevention and community development) is beginning to happen with the creation of Community Planning Partnerships and ADPs (and the subsequent inclusion of local outcome planning into broader national planning), this process needs to be encouraged and supported.

Recommendation 3:
Alcohol and Drug Partnerships must ensure service users and people in recovery are represented within the partnership and that services have meaningful service user involvement both in service design and delivery. Services should be underpinned by a recovery ethos which supports and builds on the strengths and assets within individuals, and they should consider adopting the principles contained in the Bill of Rights (see *annex B).*

Case Study 2

This case study showcases the story of a young person affected by problematic alcohol use.

Background
Gillian is a 14 year old female who lives with her mother and 2 younger sisters. She was referred for family counselling by her mother. Her father has an alcohol problem which led to him moving out of the family home and separating from his wife.

Issues
- Poor mental health
- Family breakdown
- No contact with father
- Domestic incident involving police

Assessment
Gillian arrived with her mother and 2 younger sisters for assessment. A young person's counsellor spoke to her mother first to explain the service and the counselling process. The mother was also offered counselling but declined, she seemed to be more concerned about her daughter. During the assessment Gillian discussed her father's drinking and the problems it caused within the family. Gillian was very emotional. She found the situation very difficult to deal with and felt further counselling would help her to cope.

During Counselling
Gillian continued to attend counselling weekly, accompanied by mother and 2 younger sisters (attended 7 sessions in total).

Throughout the counselling process Gillian had many issues to deal with. She was missing her father and at times she felt caught in the middle between her parents. She also felt her father didn't care about the family as he chose to continue drinking. At this point work was done with Gillian to help her understand addiction and the effects it can have on people.

There was an incident when her father turned up at the family home, being verbally abusive towards her mother. Charges were made and Gillian was required to attend court as a witness.

At times Gillian found it difficult to concentrate on her schoolwork. Her teachers at school were aware of the situation and she occasionally spoke to her guidance teacher and friends about her concerns.

Types of Intervention
- Weekly one to one family counselling
- Emotional support
- Alcohol awareness – effects on the body/behaviour, knowledge of units, sensible guidelines and understanding of addiction

Outcome
Due to the Gillian's mother gaining full time employment it proved difficult for her to get to the agency for counselling and due to her age and distance from the office she was unable to travel by public transport. At a later point her mother attended one session with another counsellor and is aware she can call at any time to arrange another appointment for her daughter.

Chapter 3

SERVICE PLANNING, DEVELOPMENT AND DELIVERY

37. There has been a major increase in investment in alcohol services across Scotland in recent years. This much needed investment is finite but has been maintained and protected at a time of significant reductions in public service budgets elsewhere, reinforcing the need to target resources where maximum benefits can be achieved, on the basis of good evidence. Commissioning of services must align with an overarching strategy and be underpinned by the core components of needs assessment; governance and accountability; data exchange; outcome measurement; and compliance with EU Procurement Law.

Recommendation 4:
All alcohol services delivered locally and supported by public funding must be commissioned on the basis of delivering evidence based interventions according to identified need and subject to adequate and appropriate outcome measurements.

Needs Assessment

38. Each Alcohol and Drug Partnership (ADP) should undertake a regular, robust needs assessment that goes beyond simply seeking endorsement for previous decisions to deliver particular services. A snapshot of ADP views on needs assessment is included in annex C.

The needs assessment should explore the prevalence and nature of substance problems in each area. It should explore what arrangements are in place to address local issues and the level of unmet need. The process of identifying need has to include all those who are affected by problematic alcohol use – including families and communities. The needs assessment for each area should include information on local workforce recruitment, retention and development needs, and proposed solutions.

Central to any commissioning process is the ability of a locality/region to understand its population; it is therefore important that ADPs are supported with reliable local intelligence. National and local health and care systems record considerable information about the people who use services both in primary and community settings, as well as secondary care settings such as acute hospitals. ADPs need to establish and support mechanisms for systematic population needs assessment, informed by local knowledge and information gathering.

Recommendation 5:
All Alcohol and Drug Partnerships and commissioned services must have, and review on an ongoing basis, robust needs assessments and Equality Impact Assessments (EqIAs) to ensure the needs of all groups within their community are identified and met, paying particular attention to those most at risk of harm.

Commissioning

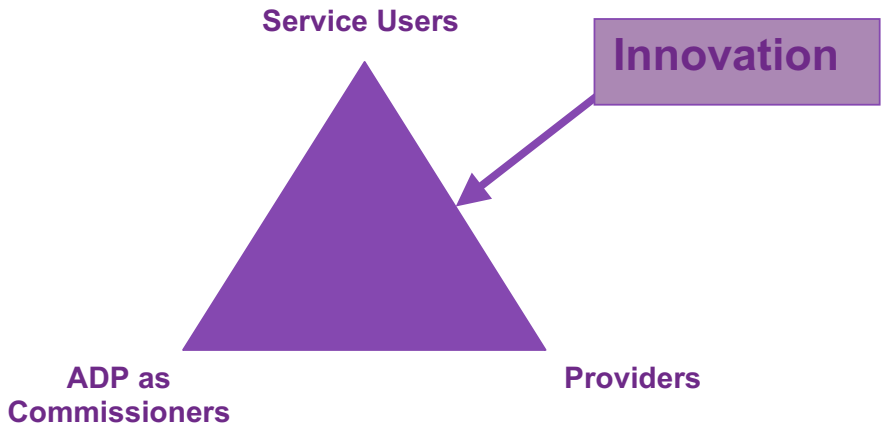
39. When considering the type of care and treatment services provided in a locality, a robust commissioning framework, founded on evidence-informed planning, provision and monitoring, will help ensure that resources are used effectively and creatively to meet the needs of communities. Good commissioning practice levels the playing field for statutory and non-statutory providers (for example by recognising full costs and agreeing longer term commissioning cycles where appropriate), embeds self-evaluation and quality assurance, and promotes creative problem solving.

Commissioning: an outcomes focus

40. The overall aim for effective commissioning of alcohol and drug outcomes should be to move from single-agency and parallel approaches to joint or even integrated approaches anchored in community planning process, across all the activities of outcome commissioning. This means that key commissioners should involve equally Health, Local Authority, Criminal Justice, Police and the Third Sector to work together in activities such as purpose and strategy, needs assessment, resource allocation and management, service monitoring, management and review.

41. Effective outcome commissioning minimises the attention on inputs and the micromanagement of services; instead the focus is on the achievements made by clients at the end of a given programme. Outcome commissioning fosters innovation where it is most likely to occur at the provider/service user interface:

Using commissioning to nurture innovation



Innovation also requires:

- transparency about decisions, money and outcomes; and
- equity for voluntary and statutory providers.

Commissioning: what is needed?

42. Commissioning decisions need:

- a sound evidence base of the needs of those affected by problematic alcohol use;
- a clear assessment of service delivery and gaps in provision; and
- a comprehensive understanding of effective interventions.

43. Regular needs assessment and effective interventions research are essential and provide the foundation for evidence-informed funding decisions. Commitment at the local strategic level is required to channel resources to identified unmet need.

44. Service providers need clear and timely information about the resources available and likely to be available in the system, especially the amount and duration of available funding; transparent decision making; and clearly defined outcomes and monitoring systems. Stable funding that supports continuous improvement is also important; a minimum of 3-year commissioning cycles should be considered.

45. The responsibility of service providers, commissioners and national bodies and the nature of decisions regarding how services are established, who manages services and how they are monitored must be transparent and explicit. Services must also demonstrate the active, on-going involvement of people affected by problematic alcohol use, including meaningful involvement in the management, regulation, inspection and audit of services.

46. Funding directed towards interventions that are evidenced to work will support a return on investment; where there is no evidence base but identified service gaps, pilot schemes with strong evaluation components make sense.

Outcome specifications

47. An outcome specification is different to a service specification, because it identifies the end result to be achieved, rather than the specific inputs and type of service required. It challenges suppliers to generate ideas and solutions, thereby fostering innovation during the procurement process. The premise behind specifying outcomes is that innovation in delivery can only be achieved by service providers engaging with service users and communities. By allowing suppliers freedom to submit innovative bids, compliance with appropriate standards to ensure compatibility can be built into outcome specifications. The general rules for developing outcome specifications are:

- be specific in the outcomes to be achieved;
- specify the groups to be reached;
- specify the effective interventions to be delivered; and
- do **not** specify how this should be done but **do** consult with providers and users about what is meaningful

Outcomes toolkit

48. In April 2009, to support the *New Framework for Local Partnerships on Alcohol and Drugs* (see following section on *Delivery),* the Scottish Government published *An Outcomes Toolkit for Alcohol and Drugs Partnerships* (Version 1). This toolkit provides guidance for ADPs in operating in an outcomes based environment; aims to support working relationships with local partners and service providers; and provides assistance in identifying local priority outcomes relating to alcohol and drugs. This live tool will be updated on an ongoing basis.

Delivery

Accountability

49. Accountability for decisions and actions relevant to alcohol related harm are carried by a range of individuals and organisations. National and local government and their partners carry accountability through democratic structures and the NHS is accountable to government (via a number of mechanisms including HEAT targets). Charities are responsible to their boards and charity regulators. The accountability for corporations, whose decisions have a considerable bearing on alcohol use and misuse, is to their owners and shareholders.

50. On 20 April 2009 the Scottish Government launched a new joint Framework for Alcohol and Drug Partnerships (ADPs, formerly Alcohol and Drug Action Teams (ADATs)), signed jointly by Scottish Government, the NHS and COSLA, for delivering action on alcohol and drugs at local level. This Framework created 30 Alcohol and Drug Partnerships which are anchored in each Community Planning Partnership (CPP) and are responsible for drawing up joint partnership-based strategies for tackling the problematic use of alcohol and drugs in their communities, and making the investment decisions required to deliver on these. The key players in these partnerships are NHS Boards, Local Authorities and the Third Sector, although engagement with other bodies and constituencies such as the Police and the Prison Service, are also vital to their success.

Recommendation 6:
We recommend that the Scottish Government continues to reinforce that Alcohol and Drug Partnerships are responsible for strategic decisions on spend to deliver priority outcomes. We further recommend that ADPs are proactive in taking responsibility for this decision making process. NHS Boards are held accountable to Scottish Government on funding for alcohol services.

51. This Framework for ADPs outlined the joint and individual responsibilities of Boards, Local Authorities and the Scottish Government, and clarified the twin lines of accountability to operate between Government and CPPs on delivery of outcomes for alcohol and drugs misuse, through Single Outcome Agreements and NHS performance management arrangements. The Framework also placed the delivery of action on alcohol and drugs misuse in a clear outcomes context and was accompanied by an outcomes toolkit to help support ADPs in working with an

outcomes approach. National Support Co-ordinators were recruited by Scottish Government to help and assist ADPs in moving towards this new way of working and in using the new arrangements to help deliver on the national drugs strategy (*The Road to Recovery)* and *Changing Scotland's Relationship with Alcohol*. The National Support Co-ordinators continue to work with ADPs to embed the new structures.

This Framework includes the following key features:

- a dedicated partnership on alcohol and drugs operating in each local authority area called an Alcohol and Drugs Partnership;
- an expert local team supporting the operation of every ADP;
- where a particular NHS Board area includes more than one local authority area, appropriate co-ordination arrangements at NHS Board area level;
- under the aegis of each ADP, the development and implementation of a comprehensive and evidence-based local alcohol and drugs strategy based on the identification, pursuit and achievement of agreed local outcomes, and supported by the development of a local outcomes framework;
- a limited set of national core indicators, which each local partnership would be invited to include in its local outcomes framework;
- individual bodies contributing fully and openly to the operation of their local partnership(s), including the development of the local strategy, and commissioning services in line with that local strategy; and
- the Scottish Government supporting local partners and ADPs in achieving agreed local outcomes.

52. For ADPs, which are the key bodies charged with developing and maintaining strategies for local alcohol action, accountability is delivered through existing arrangements between the Scottish Government, local CPPs and NHS Boards. These arrangements are designed to ensure alcohol issues are dealt with through a structure which includes a forum for the wide range of agencies involved, but also that alcohol has the appropriate level of priority within the mainstream work of community planning partnership. Not all relevant bodies have accountability through the NHS and local government although Police Forces, Licensing Boards and Community Justice Authorities should contribute to local partnership arrangements.

Recommendation 7:
The Scottish Government should seek to develop clearer lines of accountability and reporting mechanisms for local Community Planning Partnership outcomes in Alcohol and Drug Partnerships, ensuring alignment to national priorities, Single Outcome Agreements (SOAs) and whole population approach outcomes.

53. Local areas should aim to support local people to envision their communities as places free from alcohol-related harm and then support the change to deliver that vision. In addition, local strategies should work to move services and interventions upstream to prevent the harm caused by alcohol misuse to all groups as well as helping those who need specialist treatment and support. By adopting a whole population approach real impact can be made on reducing the overall consumption

of alcohol and improving quality of life for those who are, either directly or indirectly, affected by the problematic use of alcohol.

Service Delivery

54. The relative responsibility of service providers, Alcohol and Drug Partnerships and national bodies and the nature of decisions regarding how resources are deployed, services are established, who manages services and how they are monitored must be transparent and explicit.

Recommendation 8:
Alcohol & Drug Partnerships and all (statutory, third and private sector) services need to demonstrate effective, published service (outcome) specifications and explicit contract monitoring processes.

55. All services should be able to demonstrate their effectiveness and to this end should maintain and collect data relevant and appropriate to the outcomes generated by the ADP and to the details of their agreed service specification. These data should be standardised both locally and in such a way that readily feeds into national data collecting mechanisms. They should be readily and transparently available to all concerned with service provision.

56. All services should ensure that they comply with the Healthcare Quality Strategy and relevant national service standards and should regularly audit and enhance the competencies of their staff. The relative responsibility of service providers, commissioners and national bodies and the nature of decisions regarding how services are established, who manages services and how they are monitored must be transparent and explicit (Audit Scotland: Drug and Alcohol Services in Scotland, 2009).

57. All services must demonstrate the active, on-going involvement of people with substance misuse problems and their families, including in the management, regulation, inspection and audit of services.

58. All services should establish meaningful contacts with generic agencies in their localities (suitable housing, employment, benefits, education etc.) and with community groups to ensure wraparound care is in place and access to broad based recovery opportunities are available. ADPs and service providers must ensure that the primary requisites of effective care are met both within each service and within the system of services as a whole. This should include provision of needs assessment; appropriate review processes; a named person to coordinate care; a written plan; clear documented care pathways; and published information-sharing protocols among all essential services.

59. Services should also employ good practice by having a more proactive approach to engaging with mutual aid/ peer support/ self-help organisations. If agreed with individual service users, a support worker may request such an organisation contact the service user directly.

60. ADPs should also ensure that they are in a position to support services in developing these requirements, within the context of local and national strategies.

Recommendation 9:
In line with feedback received from service users, services should develop links with peer support, mutual aid and self-help organisations.

Working towards Outcomes

61. A key function of ADPs is to identify the priority outcomes on alcohol and drugs to be achieved locally.

62. Other partnerships, such as community safety partnerships, community health partnerships, and partnerships related to community justice, employability and education, will also have an interest in tackling alcohol and drugs misuse and activity may be undertaken jointly with them, or by them alone, which contributes to shared, high level outcomes. Where there is overlap between partnerships, or joint activity, it should be made clear which partnership is expected to lead on activity and report on progress and achievements.

63. The Scottish Government consulted with ADPs on their use of the Outcomes Toolkit in 2010 which found that a majority of ADPs would welcome the development of a core set of outcomes and indicators for alcohol and drugs that would be common to all areas, and which could be supplemented with further outcomes that reflect locally distinct needs**.** In response, the Scottish Government is working with key stakeholders, including ADPs, to take forward work developing a set of core local outcomes and indicators for ADPs.

Recommendation 10:
The Scottish Government and Alcohol and Drug Partnerships must jointly develop core outcomes.

Measuring, monitoring and evaluating outcomes

64. Demonstrating progress towards achieving outcomes can be challenging. External factors such as economic issues or activity by other partners, can influence progress towards the outcome and identifying the specific impact of these can be difficult. It will, in many cases, be difficult to isolate the particular activity which enabled the outcome to be met (this is an area where logic modelling can be a useful tool, and the Outcomes Toolkit can provide guidance in this area). This does not mean that outcomes should not be measured or evaluated, however. Service delivery outcomes can be achieved and demonstrated and this activity can feed into the achievement of higher level outcomes, over a longer time scale.

65. A wide range of indicators might give objective evidence of the impact of an intervention. In terms of measuring outcomes of treatment interventions, for instance, the ideal is for data to be gathered on each service user passing through

services. The information would be taken at the point of entry to the intervention and then at fixed points thereafter (e.g. 3 monthly care plan review, discharge, 3 months post discharge).

66. Comparison of service users' data over the course of treatment provides information about the changes which have occurred during the time the service user has been receiving the intervention. The service user's view of these changes is critical to guiding the recovery process. This information can be combined with other information (e.g. customer satisfaction, retention, assessment and recovery journey information gathered from Scottish Drugs Misuse Database[5]) to enable monitoring of the effectiveness and performance of the service. It also gives the service and the ADP a clear picture of the needs of the in-treatment population. However, this information is currently only gathered on drug treatment and not alcohol.

Recommendation 11:
The Scottish Government should fund the development of a national outcomes-focused alcohol treatment database. Alcohol and Drug Partnerships should effectively support local services in the delivery of this.

67. Based on the data gathered through this framework, targets in the contracts and SLAs can be set for the service to achieve overall or specific changes through their interventions. In this way, the ADP is able to define the priority outcomes and leave the service provider free to manage the means by which they are achieved.

68. A focus on and ownership of local outcomes for drugs and alcohol will be critical for partnerships. This is because the outcomes approach will help:

- improve the capacity of ADPs and local providers to plan, deliver and manage services for those affected by substance misuse;
- support substance misuse services in making best use of their own outcomes and monitoring information for internal planning, reflection and development purposes;
- identify better ways of designing and delivering services and to provide ideas for future projects;
- demonstrate the effectiveness of projects to funders and other stakeholders;
- shift the assessment of interventions from measuring activity levels to measuring the impacts achieved;
- demonstrate improved performance in terms of recovery from problem alcohol use;
- develop effective structures to enable substance misuse services to report meaningful outcomes and monitoring information to ADPs;
- identify what is effective and thus improve the quality of service provision;
- ensure strategic and management processes are evidence-based; and
- create an environment of shared learning from the best outcome services/areas.

[5] The Scottish Drug Misuse Database (SDMD) holds information on demographic and behavioural characteristics of new clients coming to the attention of medical services (general practice, hospital etc.) and specialist drug services (statutory and non-statutory).

What to measure?

69. It is essential that all interventions have a robust evidence base with clear outcome indicators. Local evidence should be informed by collection of monitoring data agreed through commissioning and contracting processes. The following are some important measures for recording the impact of interventions:

- Reduction/cessation of alcohol use
- Improvements in health
- Improvements in wellbeing
- Improvements in social functioning
- Improvements in relationships.

Depending on local priorities and need, other measures might include:

- Reductions in crime
- Reduction in exposure to violence and abuse
- Improvements in parenting, employment status, and educational attainment
- Increase in perception of personal safety, or reduction in fear of crime.

Why measure?

70. There has been much written and discussed regarding outcomes for the past twenty years but progress has been slow. With the implementation of Single Outcome Agreements for local authorities and Community Planning Partnerships, however, there is renewed impetus to measure outcomes. To date alcohol services have largely failed to communicate successes to the communities in which they work, to potential service users and their families and to government. It is essential that ADPs record and report outcomes to ensure that:

- the positive impact on communities, families and individuals that appropriately commissioned and delivered alcohol services deliver is demonstrated;
- alcohol-related spend and activity is linked to achievement of local and national outcomes. This will be key in dialogue with community planning partners and other strategic budget holders;
- decisions on the mix of prevention, treatment and rehabilitation services are informed by evidence, including how they meet the identified need;
- the impact of activities are communicated to the wider public.

How to collect outcomes?

71. The Framework for Alcohol and Drug Partnerships was accompanied by a simple outcomes toolkit for use by ADPs and services. It is not prescriptive in setting specific outcomes, but rather provides a range of sample intermediate and service delivery outcomes to consider when identifying local priorities.

The toolkit, referred to in paragraph 63, also suggests possible indicators, some of which reflect data already collected locally. Again, these are not exhaustive; they are simply examples to assist in the planning of how to monitor the achievement of

outcomes. ADPs, service commissioners and services will wish to consider which indicators are best suited to their local environment and systems.

There are numerous other recognised outcomes tools for measurement at individual level that can assist the services user and provider to measure outcomes (including; Spider, TOPs, Rickter, Christo, STAR, ASI – see annex D). It is good practice for outcomes to be agreed as part of recovery plans.

Case Study 3

The following case study is an example of an outcome-focused recovery journey.

Background
Patrick is 20 years old. He was referred by his mother who also attends for support. He is unemployed and has not accessed support services before.

Issues
- Drinking high amounts of alcohol daily
- Physical dependence
- Poor physical and mental health
- Poor relationships with family members

Assessment
At time of assessment Patrick was drinking daily and consuming approx 95 units per week. He was also using cannabis daily. He was ambivalent about counselling and was not sure if it was for him. The service and the counselling process were explained to the client. The client was very clear that he did not want to stop drinking but instead chose to cut down his alcohol consumption with a view to achieving controlled drinking.

During Counselling
Patrick was issued with a drink diary to record and monitor his alcohol use and raise awareness of alcohol units. The effects of alcohol and the potential long term problems if the client carried on drinking in the way he did were also discussed. The client continued to attend weekly and managed to record and cut down his drinking using his drink diary.

During the Christmas and New Year period Patrick's drinking increased again. He fell and injured his head and went to sleep without seeking medical attention, the following morning he went into withdrawal and was admitted to hospital. This incident frightened the client and he then decided to abstain from alcohol. He was prescribed benzodiazepines by his GP to help him detox safely and was referred to the local addiction service for an assessment.

Types of Intervention
- 14 one-to-one counselling sessions
- Alcohol awareness – effects on the body/behaviour, knowledge of units, sensible guidelines etc
- Issued with drink diary to monitor alcohol consumption
- Relapse prevention
- Referral to Addiction Service
- Signposted to other agencies

Outcomes

- Abstinent for 6 months prior to end of counselling
- Stopped smoking cannabis
- Completed 3 week STRIVE employability course
- Started Steps to Excellence confidence building course
- Gained part-time employment
- Improved physical and mental health
- Improved relationships

Mutual decision by client and counsellor to end counselling sessions.

Supporting the Development of Scotland's Alcohol and Drug Workforce

72. The Scottish Government and COSLA published, in December 2010, a workforce statement [6]on supporting the development of Scotland's alcohol and drug workforce. This statement is addressed to anyone who has a role in improving outcomes for individuals, families or communities with problematic alcohol and drug use.

The purpose of the statement is to:

- set out why action is required to develop the alcohol and drug workforce and to outline the important roles and contributions of those directly involved in workforce development
- acknowledge the need for strategic leadership and the responsibilities of decision makers at national and local level
- set out learning priorities for all levels of the drug and alcohol workforce.

73. The Scottish Government will be developing a programme of further engagement with stakeholders to progress workforce development in 2011.

74. Scotland's alcohol and drug workforce is drawn from a wide range of sectors, including health, education, social work and the third sector. The aim is for this workforce to be united around a shared vision, focused on the needs of individuals. The workforce will learn from and value the service user, who is an expert by experience – and enable them to lead satisfying, hopeful and contributing lives. In the near future, it is likely that the more traditional 'workforce' will be joined by people in recovery themselves, recruited because of their 'lived experience' of addiction. Contributing as peer mentors and supporters of those in recovery, they must also be skilled and trained to become an effective part of the alcohol and drug 'workforce'.

[6] http://www.healthscotland.com/alcoholanddrug-workforce.aspx

To achieve this, the workforce will work to develop competence, skills and expertise to:

- Effectively assess and respond to the needs of the local population in relation to alcohol and drug misuse;
- Operate within a recovery focused approach that improves outcomes, fuelled by hope and support for the individual;
- Provide timely, sensitive, person-centred, evidence-based treatment and support that is appropriate and empathetic which empowers individuals to set their own recovery objectives, manage their own care and sustain recovery;
- Inform, educate and raise awareness about alcohol and drugs and deliver early stage interventions where appropriate;
- Develop 'whole population' approaches that create environments which discourage alcohol and drug misuse and encourage positive health behaviour change;
- Deliver information and early interventions that support individuals in changing their behaviour and where necessary, refer them on to appropriate services;
- Assess and treat complex cases;
- Protect children from harm caused by drug and alcohol misuse by themselves or others;
- Protect vulnerable adults from harm caused by drug and alcohol misuse by themselves or others;
- Work with individuals with drug and alcohol problems to prevent or minimise harm;
- Deliver care that is appropriate for the needs of our diverse population and respects and protects equality and diversity of individuals; and
- Challenge stigma associated with drug and/or alcohol misuse.

Recommendation 12:
Services should be adequately staffed and all staff working in alcohol services should be adequately qualified, trained, supported and enabled to deliver their agreed roles.

Chapter 4

EFFECTIVE INTERVENTIONS

Systems of care for those affected by problematic alcohol use

A range of issues and services

75. Problematic alcohol use ranges from hazardous use, through harmful use to alcohol dependence. Alcohol dependence itself exists as a continuum of severity from mild to severe.

76. Many people will recover from alcohol use disorders without professional help. Some will reduce their drinking following a change in life circumstances, for example marriage or having children. Others will seek help from friends, peers and various voluntary mutual aid organisations such as Alcoholics Anonymous. Many who continue to drink to excess will, however, require access to specialist treatment due to more severe, complex or chronic alcohol problems (e.g. social isolation, psychiatric co-morbidity or severe alcohol dependence).

77. People affected by problematic alcohol use commonly present to a range of health, social care and criminal justice agencies with the negative consequences of excessive drinking (for example injuries, liver disease, depression, child care problems), but may not necessarily be seeking help for their alcohol misuse. Health and social care professionals are well placed to identify, advise and signpost/refer those experiencing alcohol problems to appropriate specialist services.

78. In some cases health professionals who are not necessarily specialised in the treatment of addictions will need to provide more complex interventions. For example, people who are alcohol dependent and present to an Emergency Department in acute alcohol withdrawal, or who are admitted to hospital for treatment of a physical illness and are at risk of developing alcohol withdrawal, will require the withdrawal to be managed, ideally with the support of specialist services. This should be followed by referral to appropriate specialist alcohol services for follow-up.

79. In view of the range of mental and social issues and/or alcohol related physical damage which problem alcohol users may experience, specialist alcohol services should work in conjunction with other health and social care agencies to deliver a comprehensive package of care. Thus specialist alcohol treatment should engage individuals seeking help in a holistic, person-centred way rather than simply focusing on the drinking.

80. For most people with alcohol dependence the most appropriate goal may be to aim for abstinence from alcohol, at least in the first instance. With an increasing severity of alcohol dependence, a return to “controlled drinking” can become increasingly difficult (Edwards & Gross, 1976; Schuckit, 2009). Hazardous and harmful drinkers and those with a low level of alcohol dependence may be able to achieve a goal of moderate drinking (Raistrick et al., 2006).

Classification of interventions and services

Interventions

81. *Models of Care for Alcohol Misusers* (MOCAM, 2006) describes the range of interventions which should be available to people experiencing alcohol problems. These are organised into tiers that refer to interventions rather than services, since individual services can and should provide a range of interventions that span several tiers.

82. Within MOCAM tier 1 interventions include: screening and brief interventions; provision of information on sensible drinking; and identification and referral of people with alcohol dependence to more specialised services. These interventions should be delivered by a wide range of staff in health and social care and criminal justice that are not necessarily specialised in the treatment of alcohol misuse (e.g. primary care, emergency departments, mental health and criminal justice services, social services, prisons, criminal justice social work). Such early identification and brief intervention should be a key plank of public health strategy in preventing alcohol related harm (NICE 2010a).

83. Tier 2 interventions include open access facilities and outreach that provide: alcohol-specific advice; information and support; extended brief interventions; and assessment and referral of more severe and complex problem alcohol users to "care planned" treatment. "Care planned" treatment refers to the process of planning and reviewing care within the context of structured (i.e. when a recovery support plan is mutually agreed between service user and worker) alcohol treatment, which is a tier 3 intervention.

84. Tier 3 interventions include provision of community based specialist alcohol assessment and treatment that is coordinated and planned. This includes comprehensive assessment, structured psychological interventions (e.g. motivational enhancement therapy or cognitive behavioural therapy), pharmacological interventions aimed at preventing relapse (e.g. acamprosate, naltrexone, disulfiram); community based assisted alcohol withdrawal programmes; day programmes; and specialist alcohol liaison in acute hospitals. These interventions are usually provided by staff working in specialist alcohol treatment agencies, both NHS and non-statutory. In some areas, GPs will be sufficiently trained and competent to deliver several of these interventions, which can be incorporated in an NHS Board's GP Local Enhanced Service[7] guidance for people affected by alcohol problems.

85. Tier 4 interventions include the provision of residential, specialised alcohol treatments which are care planned and coordinated to ensure continuity of care and aftercare. These interventions include comprehensive assessment; inpatient assisted alcohol withdrawal; and structured psychosocial interventions delivered in a residential setting, including residential rehabilitation. Tier 4 interventions are usually provided by staff in specialist alcohol agencies, but inpatient assisted alcohol withdrawal is often provided in acute hospitals, mental health inpatient services, police custody and prisons.

[7] Local Enhanced Service (LES) for 'Patients who are alcohol users'

Services

86. Interventions for problem alcohol users can and should be delivered by a wide range of health, social care and criminal justice services. These can be divided into specialist alcohol treatment services, whose primary role it is to provide interventions, and generic services which are not primarily focused on caring for problem alcohol users. Specialist alcohol treatment services can be provided by NHS Boards, non-statutory agencies and the private sector with considerable overlap in the range of interventions provided across different sectors. Many non-statutory services are funded by the NHS as part of overall local alcohol provision. Some agencies provide both residential and community interventions whereas others are exclusive to one or other setting. In practice, many specialist alcohol services are part of an integrated drug and alcohol treatment service.

87. As part of a national needs assessment undertaken in 2009, a national survey of alcohol treatment services in Scotland mapped specialist alcohol service provision (Drummond et al., 2009). The survey found that amongst 87 community agencies, 38% were primarily alcohol services and 59% were combined drug and alcohol services. Almost half (48%) of community agencies were non-statutory, 47% statutory (NHS) and 5% independent (private). Amongst the 8 out of 10 residential services who responded to the survey, three were non-statutory, 3 statutory and 2 independent. The total estimated whole time equivalent personnel working in these services across Scotland was 632. The NHS24 website also features a list of specialist alcohol treatment services in Scotland.

88. The majority of services provided planned care or group counselling/therapy (66%) and alcohol advice and information (58%). Forty four percent of agencies provided alcohol brief interventions, and 36% provided liaison with the acute medical or psychiatric sector. Approximately a third provided home or clinic based alcohol withdrawal management, 22% shared care alcohol withdrawal, and 28% initiate acamprosate or disulfiram prescribing. A further 22% provided alcohol day programmes.

Co-ordination and organisation of care

89. Several terms have been used to describe the co-ordination of care within specialist alcohol services including case management, key working, care co-ordination, care planning and assertive outreach. There is a growing evidence base to support the effectiveness of case co-ordination (NICE, 2010b). The individual case manager is responsible for assessment of the individual client's needs, development of a care plan, co-ordination of the delivery of interventions and services, and providing support to the client to assist in access to and engagement with services and interventions. In some services this role will be subsumed by the main therapist. The case manager will often use psychological interventions such as motivational interviewing to enhance the client's motivation to engage with treatment. Case co-ordination is a tier 3/4 intervention within MOCAM and usually begins with comprehensive assessment.

Integrated care pathways and stepped care

90. An Integrated Care Pathway (ICP) "describes the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment" (NTA, 2006). ICPs have a function at both an individual and a treatment system level. At the individual level, the care plan should describe the client's personalised care pathway designed to meet the assessed needs, the planned interventions, and the agencies and staff intended to deliver them. The pathway needs to be integrated in that it shows a logical progression of steps, with interventions being provided at the appropriate stages. For example, the pathway for an alcohol dependent client may consist of: initial inpatient assisted alcohol withdrawal, followed by a structured psychosocial intervention in an alcohol day programme, followed by specialised psychotherapy for bereavement, followed by vocational services to support a return to work and help in finding stable accommodation. Each of these elements of care may be delivered by different agencies in different locations; the pathway needs to be integrated to deliver maximum benefit and minimise the client's premature disengagement.

91. Stepped care is a method of organising and providing services in the most cost efficient way to meet individual needs (Sobell & Sobell, 2000). Two defining characteristics are common to all stepped care systems (Davison, 2000). The first concerns the provision of the least restrictive and least costly intervention (including assessments) that will be effective for an individual's presenting problems, and the second is concerned with building in a self-correcting mechanism. Escalating levels of response to the complexity or severity of the disorder are often implicit in the organisation and delivery of many healthcare interventions, but a stepped care system is an explicit attempt to formalise the delivery and monitoring of client flows through the system. In establishing a stepped care approach, consideration should not only be given to the degree of restrictiveness associated with a treatment, and its costs and effectiveness, but also the likelihood of its uptake by a service user and the likely impact that an unsuccessful intervention will have on the probability of the uptake of other interventions.

92. Within this approach service users are initially offered the least intensive intervention that is acceptable and most likely to be effective for them, followed by increasingly intensive interventions for those not responding to the less intensive interventions. A stepped care algorithm effectively describes an integrated care pathway which accommodates individual needs and responses to interventions (Drummond *et al*., 2009). This approach has gained increasing currency in other mental health disorders, including depression (NICE, 2009). A stepped care approach has also been supported by recent guidance from the NICE (NTA, 2006; Raistrick *et al*., 2006).

Alcohol Brief Interventions

93. A brief intervention is typically a short motivational interview, in which the costs and benefits of drinking are discussed, along with information about health risks.

94. Evidence of the effectiveness of brief interventions, show that interventions can lead to a reduction in alcohol consumption among hazardous and harmful drinkers. A Cochrane Review found that brief interventions in primary care lead to a reduction in consumption by an average of four standard drinks. This Review also found that the effect of the brief intervention was clear in men at one year follow up, although less clear for women.

95. In 2008, an NHS HEAT target (HEAT H4) was introduced by the Scottish Government, based on SIGN Guideline 74, requiring Boards to deliver 149,449 alcohol brief interventions, between 2008-09 and 2010-11 within the following settings: Primary Care, A&E and Antenatal with an extension to deliver an additional 61,080 ABIs by March 2012. The aim is that brief interventions will become part of the standard offer of the NHS and wider partners.

96. When hazardous or harmful drinkers are identified, SIGN Guideline 74 recommends that health professionals deliver a 'brief intervention'. In this context, 'hazardous' drinking is defined as more than 5 units per day for men and more than 3 units per day for women; 'harmful' drinking is classified where alcohol consumption is already causing health problems. When patients attending primary care settings with symptoms that may be linked to alcohol, the Guideline states that staff should ask them about alcohol consumption, providing recommendations about the best standardised questions to use for this purpose. The exact timing and content of the brief intervention are not outlined in the SIGN Guideline 74.

97. In addition to the HEAT H4 target, Scottish Government is supporting the expansion of the evidence base for the delivery of alcohol brief interventions through a number of national and local pilots. Currently, national pilots are running in:

- criminal justice settings – in Perth & Kinross and Lanarkshire;
- NHS24 – through the Health Information Service;
- sexual health clinics – in Glasgow and Aberdeen; and
- dentistry – in conjunction with Dundee University and Glasgow Dental Hospital.

All these national pilots will be evaluated.

98. In addition, NHS Boards are undertaking pilots in settings including community pharmacy, occupational health, youth services and in conjunction with Police in custody suites.

Recommendation 13:
To build on the current HEAT H4 target, the Scottish Government, in collaboration with Alcohol and Drug Partnerships, 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.

Self and mutual help

99. People affected by problematic alcohol use may, at various points of their life, engage with self help/ mutual aid organisations. Such organisations can provide easily accessible, low threshold support to those impacted by problematic alcohol use. It is good practice to inform all service users of the availability and potential value of support networks, which can be helpful at the outset and throughout the recovery process. The largest support network is Alcoholics Anonymous (AA) and services should be familiar with their local networks and other relevant organisations.

Self-help manuals based on cognitive-behavioural principles are also an effective and highly cost-effective adjunct or alternative to formal treatment among alcohol users with mild to moderate dependence. (UKATT, 2005)

Web-based screening and support

100. Over the past few years there has been a growing number of computer-based alcohol screening and intervention programmes delivered either through stand-alone computers or via the Internet. Current Internet programmes range from user-generated content applications such as Web logs/blogs, Web-based instant messaging technologies, or discussion boards (e.g. http://www.alcoholhelpcenter.net/), to interactive software applications. Even within interactive applications there is substantial variability, from brief normative feedback interventions to multi-session modularized programmes. Many of these programmes' applications include brief intervention strategies and educational content based on a harm-reduction philosophy and motivational interviewing techniques that are presented in a self-help workbook style. The most recent research published on the Journal of Medical Internet Research[8] would suggest there is some evidence regarding the efficacy of web based interventions. In particular they conclude that web based alcohol intervention might be an attractive first option for women and young people. This is an area of intervention that could work well in Scotland with large rural communities or those reluctant to use face to face services.

Access and engagement

101. Evidence suggests that the longer people with drug and/or alcohol problems have to wait for treatment, the less likely they are to achieve successful outcomes. Recognising this, the Scottish Government has introduced a HEAT target (A11) for specialist drug and alcohol services delivering tier 3 and 4 interventions which will ensure that from March 2013, 90% of clients will wait no longer than 3 weeks to receive appropriate drug or alcohol treatment to support their recovery. This will ensure equal access to treatment across Scotland at the point of need. *A Wait Off Our Shoulders* (2010) guidance has been developed to share good practice and support areas to achieve this target.

102. Every contact has the potential to influence a service user's thoughts and feelings and it is important for all practitioners to work in a supportive, empathetic, respectful and professional way. These qualities have an important influence on

[8] http://www.jmir.org/2010/5/e62/

reducing rates of client drop out at all stages of the care and treatment process. A focus on building a therapeutic alliance is important and likely to be necessary to promote positive change. Research evidence, however, is that a therapeutic alliance is in itself unlikely to be sufficient for those seeking help for their alcohol problem, and practitioners will require additional skills.

103. Structured motivational approaches, using a defined set of techniques and skills, will enhance service users' problem recognition, confidence and motivation to change. Assessment processes should be structured to include motivational interventions. There is a risk that a "tick box" approach can reduce the motivational effect of an assessment interview.

104. Community based alcohol support services need to be inventive in their ability to engage with hard to reach service users. These people are often very vulnerable and most at risk from mental and physical health problems. Some are confused and isolated in their communities. Good practice would suggest that an assertive and persistent out-reach approach works well with engaging these people into service. Creative out-reach does not rely on appointment letters but more on repeated home visiting including out with office hours. Engagement requires patient relationship building often over extended periods of time to gain both trust and credibility.

Families and affected others

105. It is good practice for services to offer information and advice to family members and to gather information, at point of assessment, on children and young people who may be affected by their parent or carer's drinking. It is important, however, to respect the service user's autonomy and rights to confidentiality during contact with families. It is also important to facilitate affected others' access to help in their own right for their own issues, such as depression or domestic violence.

106. There are specific interventions, such as behavioural couples therapy, which involve family members in treatment approaches aimed at helping the problem alcohol user change their drinking behaviour. These should be distinguished from interventions aimed at helping family members, although beneficial changes in drinking behaviour will often benefit both the problem alcohol user and family members.

107. Abundant evidence indicates that parental alcohol misuse can, and does, harm children's health, welfare, and development from the stage of conception onwards. It is therefore essential that child welfare and protection principles be embedded in service design. *Getting it Right for Every Child* (GIRFEC) is the key policy document in Scotland, setting out our national principles for protecting children. Further guidance, published in 2010, *National Guidelines for Child Protection in Scotland*, places renewed focus on protecting children from harm. Development and delivery of essential alcohol services should be informed by and integrated into local collaborative work by Alcohol and Drug Partnerships and other key stakeholders working on the CAPSM (children affected by parental substance misuse) agenda.

Case Study 4

The following case study highlights the potential impact on children affected by parental substance misuse.

Hannah is a 36 year-old mother of two boys, aged seven and five. She started attending the alcohol support service in 2008 at which point she was regularly drinking 50 units of alcohol every weekend and reported having had a problem with alcohol since the age of 12.

Her initial goal was to cut back her alcohol consumption and attended weekly one-to-one counselling for eight months during which time she reduced her alcohol consumption. After two weeks of abstinence, and with the support of her counsellor, she decided to change her goal to one of abstinence and continued to maintain this for the next 18 months while she attended sessions.

During this time she started attending health and well-being clinics and helped set up our client-led gardening group, she also took part in voluntary work and completed the West Highland Way.

After successfully completing treatment she successfully applied for the Intermediate Labour Market Addictions programme and is currently studying for an SVQ Level II in Health and Social Care.

Hannah said: "The kids are seeing me going out to work and are looking forward to my pay day. There is more structure in their lives and in my life, there are timelines, I can plan ahead now whereas before I couldn't see into the next day and now I'm thinking about a summer holiday for the boys which I have never been able to do before. If you were to ask them what their mum does they would say my mum helps people not to drink too much, they are really proud of me and that feels great.

"It's productive for them and for me and I really enjoy what I am doing. Having had personal experience of the support available it is really rewarding and a privilege to be able to put something back.

"I am so glad I have managed to change the cycle and hopefully alcohol won't be an issue for the boys when they grow up as it was for me and my husband – I lost my mum to alcohol and my husband lost his dad, I don't want that for my boys."

108. Moreover, alcohol consumption and violence co-occur in a myriad of places and ways in Scotland. Efforts to reduce harm related to alcohol misuse need links with key cross-cutting issues that affect outcomes for individuals, families and communities. Violence against women (VAW) is one such issue. The Scottish Government's *Safer Lives, Changed Lives: A Shared Approach to Tackling Violence against Women in Scotland* (2009) provides the national framework for addressing VAW. In addition, although much as been written about the relationship between alcohol misuse and violence — particularly alcohol misuse and domestic abuse — there is no evidence of a causal link between the two, and the exact nature of the relationship needs investigation. (Bennett & Williams 2003).

Recommendation 14:
All specialist alcohol services must undertake routine screening for harm against women and children as part of a thorough, ongoing assessment process to ensure provision of a package of support. Staff should be trained to deliver such screening and to provide effective support.

Case Study 5

The following case study is an example of how screening for violence against women (VAW) within specialist alcohol and drug services has assisted service users to seek support and address health issues to improve their quality of life.

Vicki, a young woman with a history of problematic drug and alcohol use since the age of 16 years, attended an initial assessment seeking counselling and support. She was in the process of accessing a substance misuse treatment programme, and was encouraged to seek extra personal support by her key worker within the NHS.

As part of her assessment, Vicki participated in the VAW screening process. It was during this that she disclosed she has previously been sexually assaulted as a teenager. She stated that she had not mentioned this to anyone or spoken about it with anyone, and was clearly visibly shaken by the disclosure.

The worker spent time with the young woman explaining what services and help were available to her. However, at this particular time, she chose not to make contact with any other services. She did, however, take the service information/contacts and agreed to discuss her recent disclosure with her key worker at the NHS.

Vicki felt confident to talk through a number of issues with her NHS key worker. She began to identify a link between the past traumatic event and her use of substances. After a time, the key worker encouraged the woman to engage with a counsellor. Over time she began to make progress with the help of the NHS professional and counsellor, both of whom were aware of her past experience. She commented that the support received helped her achieve the most stable period she had experienced for several years.

Treatment services previously had not asked direct questions regarding violence as part of a routine assessment. In this case, it allowed the client to make key links and, with support, work through a variety of personal issues that had been impacting on her substance misuse. This appeared to enable her to shape a healthier, more productive lifestyle.

As a result Vicki is managing her life much better, and continues to make good progress. She has recently been discharged from local services; however, still has appropriate service contacts, should she need them in the future.

Psychological interventions and changed drinking behaviour

109. The process of recovery from alcohol problems is highly variable for any individual, but generally follows a sequence of problem recognition, self-assessment of the costs and benefits of alcohol use, detoxification, significant drinking behaviour change and maintenance of change.

110. For many people, this recovery process will take place without any external help. For others, interventions aimed at influencing the drinker's thoughts, feelings and behaviours can usefully take place at any stage of the process. These psychological interventions can be complementary to other helping processes. For instance, psychological therapy can increase motivation to participate in a detoxification process or improve confidence and coping skills to enter employment, successfully manage domestic responsibilities and manage relapse. Psychological therapies are also valuable in helping with the range of mental health issues, including mental illness, which often occur along with problematic alcohol use.

111. The most effective ways to provide these interventions have been reviewed by the Health Technology Board for Scotland (now part of NHS Quality Improvement Scotland) (Slattery et al 2003) and the National Institute for Clinical Excellence (NICE). This is an area where there are important differences in the evidence base for alcohol compared to that for other drugs (NICE 2007).

112. The most common approach to measuring outcomes in trials of psychological treatments has been to assess drinking behaviour, rather than outcomes such as happiness, family functioning, employment or life expectancy. There is good evidence, however, of a strong association between reduced alcohol consumption and improvement on a range of wider outcomes (UKATT 2005).

113. In general, reviews of effectiveness of psychological therapies have found the most effective interventions are those using cognitive and behavioural approaches. A cognitive approach emphasises the importance of the drinker's thoughts, including expectations and assumptions, in decisions about drinking. Behavioural approaches focus on the role of learned behaviour and the establishment of habit and routine in maintaining drinking patterns, even when these are harmful. Some specific therapies, often incorporating behavioural and cognitive elements such as Cognitive Behavioural Therapy, Behavioural Couples Therapy and Social Behaviour and Network Therapy have shown good outcomes in well conducted research trials.

114. Directive counselling approaches have been found to be more effective than non-directive counselling approaches, or those based on developing and understanding personal conflicts and how these influence relationships (for example psychodynamic psychotherapy). Most well defined psychological approaches have, however, been shown to be better than no intervention.

115. The delivery of consistently high quality psychological interventions is best achieved through the use of manual guided interventions with regular supervision from an appropriately trained supervisor. As with other interventions, outcomes of

psychological treatments should be monitored, including the view of the service user. (NICE 2011[9]).

Detoxification

116. For people with marked alcohol dependence, safe detoxification is an essential part of the recovery process. All areas should be able to demonstrate that service users have ready access to such services.

Assessment

117. Question 6 of the AUDIT questionnaire (see annex D) is a reliable way to identify those at risk:

> *"How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?"*

Reporting of any alcohol use in these circumstances should lead to further enquiry about experiences after a heavy drinking session, or on stopping or reducing drinking. Anxiety, restlessness, tremors, poor sleep and nausea are indicators that intervention may be required to assist detoxification.

In cases of marked dependence, people can experience severe tremors, sweating or hallucinations (typically hearing or seeing things). People with no previous diagnosis of epilepsy can experience seizures during alcohol withdrawal.

Management

118. Specialist assessment will indicate the level of supervision required for detoxification which may be in a range of settings: hospital inpatient; supported residential setting; at home with staff supervision once or twice per day; at home with support from family members; or unsupervised.

Full details of detoxification practice are in the referenced guidelines. Key principles include:

- a good level of information for the client in the preparation phase;
- assessment of general health;
- assessment of other prescribed or non-prescribed drug use;
- monitoring of the severity of symptoms after stopping drinking;
- safe and effective prescription and administration of benzodiazepines over the risk period (typically 4-7 days);
- confirmation of abstinence from alcohol during detoxification;
- assessment for other risk factors such as vitamin deficiency; and
- co-ordinating relapse prevention support post-detoxification.

Refer to SIGN 74; NICE 2010 [10]

[9] http://guidance.nice.org.uk/CG115
[10] www.nice.org.uk/nicemedia/pdf/AlcoholFullGuidelineForConsultation1.pdf

Pharmacological treatment to prevent relapse in alcohol dependence

119. We recognise these interventions can straddle acute and primary care either in full or with shared care arrangements in place, which should be encouraged.

High quality systematic reviews and meta-analyses are consistent in showing three medications that help to reduce relapse in alcohol dependence (see box showing level of evidence) (Garbutt et al 1999; Slattery et al 2003; Berglund et al 2003; Bouza et al, 2004; Srisurapanont, 2006; Canadian Agency for Drugs and Technologies in Health , 2008)

Medication	Evidence
Acamprosate	grade 1a
Naltrexone	grade 1a
Disulfiram	grade 1b

There are several riders concerning the basis of their effectiveness, and their use in practice.

i. Goal of treatment

For some patients, the goal of treatment is complete abstinence, and for others it is to reduce the frequency of occasions where their drinking is excessive. Both goals can be associated with reduction in social and health harms; studies have used either one, or sometimes both, as outcome measures. Acamprosate and disulfiram studies have chiefly reported cumulative abstinent days, and naltrexone studies have tended to report 'days of heavy drinking' or 'time to first heavy drinking day' (heavy drinking typically being defined as 65g or more ethanol for men and 50g or more for women).

Treatments to help reduce drinking intensity as well as treatments to help sustain abstinence, help reduce harmful drinking.

ii. A chronic disorder

Despite alcohol dependence being a chronic condition, there are few efficacy studies of pharmacotherapies of more than 6 months duration. Although there was no control group in their lengthy follow-up study, Krampe et al (2006), reported a 50% abstinence rate over 7 years, which is impressive.

iii. Adjunct psychosocial therapy

The prescriber should aim to enhance the service user's motivation and compliance with medication.

For disulfiram, some form of supervision (by spouse, family, employer etc.) to ensure compliance, has been used in all trials which showed efficacy.

Enhancing compliance is always important in pharmacotherapy.

iv. Defining responders

Many attempts have been made to delineate the clinical characteristics of those likely to respond to one of the above drugs. So far these attempts have not provided significant results. The studies that showed an effect of acamprosate, however, tended to be those from southern European countries where the patients recruited were often daily heavy drinkers with high intake, requiring medical detoxification, rather than episodic drinkers (as in more northern countries).

A genetic variant has been shown to predict response to naltrexone (Ray and Hutchison, 2007; Anton et al, 2008), although this has not yet entered clinical practice.

v. Mode of use

Disulfiram has only been shown to reduce drinking when the patient is in a programme where its ingestion is supervised (be that by a family member, a clinic, or an occupational health worker). Although this acts to improve compliance, there may be a beneficial effect from the regular encouragement and reinforcement of the abstinence message that the frequent contact with the supervisor entails.

vi. Is detoxification needed before these medications?

For disulfiram, the patient must be free of alcohol when the first dose is taken. In the trials of acamprosate where efficacy was demonstrated, patients had received medical detoxification. Naltrexone has shown efficacy in trials where the patient had been detoxified, and also in studies where drinking was continuing at entry and at the time of the first dose.

Workforce issues

120. Effective Psychological interventions require a high level of Practice Governance. Demonstration of competence requires:

- training;
- supervision; and
- accreditation.

Provision of an effective Psychological Therapies services will require staff with skills in:

- Motivational Interviewing
- Cognitive Behavioural Therapy
- Behavioural Couple Therapy
- Social Behaviour and Network Therapy

CONCLUSION

Although a key pillar of the national Framework for Action on Alcohol, the provision of treatment and support forms only one part of a wider package of measures required to impact the broader alcohol misuse agenda. Partnership working, legislative measures and refreshed emphasis on prevention approaches to effect upstream, cultural and attitudinal shift in communities across Scotland are all key to our success.

The Essential Services working group is fully aware that the provision of quality and effective treatment and support to meet the needs of those affected by problematic alcohol use is a complex and challenging task, particularly in the current economic climate. However, the concerted effort at local level to ensure provision of effective, evidence-based, person-centred support is clearly visible.

Significant progress has been made both nationally and locally in bringing the alcohol agenda to the fore. The working group, in consultation with key stakeholders and service users, has outlined aspects of treatment and support which should be regarded as “essential services”. These should be available in all areas. The group has made clear recommendations which, if implemented, will increase the likelihood that those affected by problematic alcohol use will be able to access the quality services and support they need to recover.

ANNEX A

SMACAP Essential Services Working Group – Membership List

Chair: Dr Charles Lind, Clinical Director of Addictions, NHS Ayrshire and Arran

Ms Hilary Smith, Policy Manager: Essential Services, HEAT A11 Waiting Times Target and Alcohol & Offenders, Alcohol Delivery Unit, Scottish Government

Dr Lesley Graham, Associate Specialist (Public Health), ISD, NHS National Services Scotland

Dr Malcolm McWhirter, Senior Medical Officer, Scottish Government

Dr Andrew Fraser, Director of Health & Care, Scottish Prison Service

Mr Jack Law, Chief Executive, Alcohol Focus Scotland (January – March 2010)

Ms Mary Ellmers, Head of Training, Alcohol Focus Scotland (April 2010 – January 2011)

Ms Laura McFadzen, Project Manager, Alcohol Focus Scotland (February 2011 onwards)

Dr Marsha Scott, Principal Officer: Health, Policy & Planning, West Lothian Council

Prof Jonathan Chick, Consultant Psychiatrist: Alcohol, NHS Lothian

Dr Peter Rice, Consultant Psychiatrist: Alcohol, NHS Tayside

Ms Eunice Reed, Consultant Clinical Psychologist, Substance Misuse Directorate, NHS Lothian

Mr Gregor Urquhart, Communications Director, Young Scot

Prof Colin Drummond, Professor of Addiction Psychiatry, King's College, London

Dr Richard Watson, GP, Greater Glasgow & Clyde and RCGP Scotland Clinical Lead Substance Misuse

Dr Denise Coia, Principal Medical Officer: Mental Health, Scottish Government (January – December 2010)

Ms Geraldine Bienkowski, Associate Director: Psychology, Lead for Psychological Therapies, NHS Education for Scotland

Mr Andrew Horne, Director, Addaction Scotland

Dr Robert Peat, Director of Social Work and Health, Angus Council

Ms Pamela Gowans, Programme Manager, Long Term Conditions Management, NHS Grampian

Mr Sean Doherty, Performance Assessment Manager, QIS (January – August 2010)

Ms Meichelle Walker, General Manager, Edinburgh & Lothian Council on Alcohol

Mr Kevin Hurst, Policy Manager: Mental Health, Scottish Government (August 2010 onwards)

Mr Mike Palmer, Deputy Director, Public Health Division, Scottish Government

Ms Kay Barton, Deputy Director, Health Improvement Division, Scottish Government (February 2011 onwards)

Ms Alison Douglas, Head of Alcohol Delivery Unit, Scottish Government

Dr Donna MacKinnon, Delivery Manager, Alcohol Policy Team, Scottish Government (January – October 2010)

Ms Evie McLaren, Delivery Manager, Alcohol Policy Team, Scottish Government (August 2010 – March 2011)

Mr Alasdair Menzies, Alcohol Delivery Unit (Secretariat), Scottish Government

ANNEX B

Bill of Rights

Adapted from the *Faces and Voices of Recovery* Bill of Rights:
http://www.facesandvoicesofrecovery.org/about/campaigns/bill_of_rights.php

We will improve peoples' lives, their families and their communities if we treat addiction to alcohol and other drugs as a major public health and social care concern.

To overcome these concerns we must accord dignity to people with addiction and recognise that there is no one path to recovery. Individuals who are striving to be responsible citizens can recover on their own or with the help of others.

Effective help can be rendered by mutual support groups, social care, voluntary sector services, health care professionals. Or any combination of these.

Recovery can begin in a doctor's office, A&E Department, treatment centre, church, prison, peer support meeting or in one's own home. Recovery happens every day across our country and there are effective solutions for people still struggling. Whatever the pathway, the journey will be far easier to travel if people seeking recovery are accorded respect for their basic rights.

1. **We have the right to be viewed as capable of changing, growing** and becoming positively connected to our community, no matter what we did in the past because of our addiction.

2. **We have the right, as do our families and friends, to know about the many pathways to recovery, the nature of addiction** and the barriers to long- term recovery, all conveyed in ways that we can understand.

3. **We have the right, whether seeking recovery in the community, a physician's office, treatment centre or while incarcerated, to set our own recovery goals**, working with a personalised recovery plan that we have designed based on accurate and understandable information about our health status, including a comprehensive, holistic assessment.

4. **We have the right to select services that build on our strengths**, armed with full information about the experience, and credentials of the people providing services and programmes from which we are seeking help.

5. **We have the right to be served by organisations or health care and social service providers, that view recovery positively**, meet the highest public health and safety standards, provide rapid access to services, treat us respectfully, understand that our motivation is related to successfully accessing our strengths and will work with us and our families to find a pathway to recovery.

6. **We have the right to be considered as more than a statistic**, stereotype, risk score, diagnosis, label or pathology unit – free from the social stigma that characterises us as weak or morally flawed. If we relapse and begin treatment again we should be treated with the dignity and respect that welcomes our continued effort to achieve long term recovery.

7. **We have the right to a health care and social services system that recognises the strengths and needs of people with addiction** and coordinates its efforts to provide recovery based care that honours and respects our diverse backgrounds and cultural beliefs.

8. **We have the right to be represented by informed policymakers** who remove barriers to educational, housing and employment opportunities once we are no longer misusing alcohol or other drugs and are on the road to recovery.

9. **We have the right to respectful non-discriminatory care from all service providers** and to receive services on the same basis as anyone else who uses health, voluntary or social services. The criteria of 'proper' care should be decided exclusively between our service providers and ourselves. It should reflect the severity, complexity and duration of our problems and provide a reasonable opportunity for recovery maintenance.

10. **We have the right to treatment and recovery support in the criminal justice system** and to regain our place and rights in society once we have served our sentences.

11. **We have the right to speak out publicly about our recovery** to let others know that long term recovery from addiction is a reality.

ANNEX C

Alcohol and Drug Partnership (ADP) Survey Results – Needs Assessment (undertaken June 2010)

Are ADPs applying clear commissioning models including robust needs assessment?

Background

A short survey (9 questions) was sent to a cross-section of ADPs across Scotland (12). Where strategic NHS Board wide structures existed the questionnaire was sent to the key contact there and in other areas directly to the local ADP. The aim of the questionnaire was to attempt to get a flavour of the approaches being taken to needs assessment nationally in Alcohol Services and to identify any areas with particular good practice to share.

12 questionnaires were sent out and a 100% return was achieved. An additional question regarding a national information dataset was asked. Results were as follows:

1. **Do you consider access to needs assessment information an important resource to assist your local ADP decision making processes?**

   100% - yes — 100% response

   Comments

   I think it is important to understand the population demographics and profile in making decisions about what can be provided.

2. **Has your ADP conducted a local needs assessment in relation to alcohol use in the past year?**

   50% - yes
   50% - no — 100% response

   Comments

   Although a local needs assessment document has not been produced in the last 12 months, I have answered 'yes' to this question for the following reasons. The Council did commission a needs assessment document in 2008. A comprehensive re-commissioning of alcohol services then followed. This began in 2009, and was completed in 2010. New commissioned services are currently, or will shortly commence operation. Meetings have also been held, over the last year, involving key stakeholders from partner organisations which have identified needs, including those relating to a group of clients with an alcohol problem who are in regular contact with acute services. The new services will help respond to this identified need.

   We are in the process of tendering for consultants to complete a needs assessment in one if our local authority areas. The assessment will begin as soon as possible.

   Currently ongoing not yet complete.

3. **Was it easy for your ADP to access the appropriate expertise to assist in providing you with a local needs assessment report?**

67% - yes
33% - no

100% response

Comments

Whilst expertise is available through internal staff and on occasions through external consultants, there are issues, such as staff capacity and additional costs which need to be considered. In the current financial climate there will probably be less internal staff capacity or opportunity to access external support.

We commissioned a consultancy firm, but only because we were able to use some of the alcohol funding to do so. If this were not available in the future this would make it difficult to buy in this expertise, particularly with the ADP Support Team funding also being reduced.

We can have some assistance from our Public Health Department but often the capacity is very limited.

Designed Needs Assessment specification and invited groups to apply for work. Had 8 returns.

The ADP National Coordinator has assisted and given advice as well as contacts that could assist in areas that were not her area of expertise.

We have a researcher specifically for alcohol and drugs.

We do not have the resources or expertise for this, we would like the government to provide this.

4. **Please can you give an example of how you have used this information to organise your local services?**

9 replies
3 skipped question

Comments

We have not done a full needs assessment as yet but smaller pieces of work have informed work around the CAPSM agenda.

This information has been used to re-commission services.

It is currently being used to inform the development of a commissioning strategy and in reviewing current allocations/future service development in other ways e.g. the development of an integrated care pathway. It is also being used as a basis for discussion in reviews of individual service contracts (needs assessment incorporated a review of effectiveness of existing services).

We are planning a NA exercise in relation to young people and alcohol and will use the information to re-structure specialist services for young people.

To identify gaps in provision, for example, developing services for people with substance misuse/mental health problems, aspects of current service provision that need to be developed further and services where current provision matches need.

We are currently using local information from locality fora, service users, families and carers and service providers to guide us until the needs assessment is complete.

Will be incorporated into local strategy and inform outcomes being pursued
Will be used to identify gaps and hopefully anticipate future demand.

We are in the process of doing this work.

5. **Has your needs assessment informed you of particular areas to target locally or of any gaps that exist in service provision?**

82% - yes
18% - no

11 answered/1 skipped

Comments

We are aware of the number of children affected by parental substance misuse

It helped commissioners to plan services which aim to provide a spectrum of delivery across identified need. It also helped identify that previous spend on alcohol related hostel respite accommodation was not particularly cost effective. As a result, the Council and NHS did not tender for this service within the commissioning process and amongst others things opted instead for a new community support service.

Once we do the NA, I would expect to be informed in relation to specific areas to target.

Co-occurring mental health/substance misuse problems, aftercare support and alcohol/ services for 16-25 group

The in house assessment that is currently being used.

Yes, about the needs of young people.

6. **Do you have an agreed commissioning framework and does it reflect a particular model for commissioning?**

Yes - I have an agreed commissioning framework, and it reflect a particular model for commissioning
42%

Yes - I have an agreed commissioning framework, but it DOES NOT reflect a particular model for commissioning
8%

No - I do not have an agreed commissioning framework
50%

Comments 100% response

We are working on this and are currently working to restructure our ADP. The new structure will have a commissioning and finance sub group they will be tasked to develop a commissioning strategy.

The ADP approved a paper detailing the ADP Commissioning process in February 2010. This aligns with the Council Commissioning Strategy. The ADP paper is informed by the NTA Commissioning Standards for Drug and Alcohol services.

We are currently working on this.

The local ADP was formed in 2008. Since then we have been developing new policies and procedures. One of the first to be developed was a single SLA.

Locally devised Functional Model of Treatment and Care currently under review to ensure that a recovery focus is adequately captured.

7. **Has your needs assessment informed service commissioning decisions locally?**

55% - yes
45% - no

11 answered/1skipped

Comments

Not yet.

The needs assessment was completed late last year and no new adult services have been commissioned since that time. Previous commissions were based on needs identified through a local consultation process.

Not yet but it will do.

Will be included as an evidence base for new ADP Drug and Alcohol Strategy 2010-13.

It will in the near future.

Still ongoing.

8. **Can you give a local example of a service you commissioned as a result of the information you received via your needs assessment?**

90% - Yes
10% - No

10 answered/2 skipped

Comments

We were aware of the high number of children affected by parental substance misuse and as a result we funded a two year pilot programme to work with families affected by alcohol and drugs

Youth counselling service.

See response to question 5 above.

Family Support Service (that was informed by a previous needs assessment carried out by myself on behalf of the ADP (as it was then) and the local children's services planning partnership.

Not in the past year - but we have commissioned 2 services - a Direct Access service and an Employability service on the basis of a NA information.

We are in the process of establishing a Performance and Commissioning Group which will take the lead role in commissioning new services.

We will be developing youth services as a result of an audit of existing youth services in the local area which has informed us of gaps where services are needed.

Commissioning of vol org partner ongoing at present.

Conducted an ARBD needs assessment two years ago and services for people with ARBD have since been commissioned.

9. **Do you think we should have a national alcohol database, similar to the current Scottish Drug Misuse Database (SDMD) operating for drugs?**

92% - yes
8% - no

100% response

Comments

It would make sense to have similar processes and systems in place for both alcohol and drugs. Data on alcohol is needed.

Would certainly help to provide more robust data on a regular basis, and relieve the issue of having to fund local needs assessments to a degree (although this may still be an issue).

At the moment the lack of SMR-type information for alcohol clients is a real gap for local areas. This also means there is no systematic way to capture data on children and families affected by alcohol misuse.

This should be a combined database. Keeping alcohol separated from other substances as a unique substance of abuse lends to complication and confusion when collecting data.

ANNEX D

Please note that this list is not exhaustive and should be used as a resource guide.

Screening Tools

Alcohol Use Disorders Identification Test (AUDIT) (WHO, 1996)
http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

CAGE
http://counsellingresource.com/quizzes/alcohol-cage/index.html

FAST
http://www.aerc.org.uk/documents/pdfs/FAST_Manual_AERC_VERSION.pdf

Outcome Measurement Tools

Michigan Alcohol Screening Test (MAST) (Selzer 1971, updated 1981)
http://alcoholism.about.com/od/tests/a/mast.htm

Maudsley Addiction Profile (MAP) (Marsden et al, 1998)
www.iop.kcl.ac.uk/iopweb/blob/downloads/locator/l_346_MAP.pdf

Christo Inventory for Substance Misuse Services (Christo et al, 2000)
www.drugslibrary.stir.ac.uk/documents/**christo**.pdf

Treatment Outcome Profile (TOPs) (NTA, 2007)
http://www.nta.nhs.uk/who-healthcare-top.aspx

Alcohol Outcome STAR (formerly Outcome Spider) (Burns, 2005)
http://www.outcomesstar.org.uk/alcohol-star/

Australian Alcohol Treatment Outcome Measure (AATOM) (Simpson et al, 2007)
http://www.med.unsw.edu.au/ndarcweb.nsf/resources/TR+288-292/$file/TR288_TOC_ABSTRACT.pdf

Addiction Severity Index (ASI) (McLennan et al 1980, updated in 1992)
http://www.densonline.org/DENSASI.pdf

Rickter Scale (Hutchinson and Stead, 1993)
http://www.rickterscale.com/

Comprehensive Drinker Profile (Miller and Marlatt, 1987)

Result (Raistrick and Tober, 2003)

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Alcohol Problems Support and Treatment Services Framework (Scottish Executive, 2002)
http://www.scotland.gov.uk/Publications/2002/09/15362/10733

The Healthcare Quality Strategy for Scotland (NHS Scotland, 2010)
http://www.scotland.gov.uk/Publications/2010/05/10102307/8

Alcohol attributable mortality and morbidity: alcohol population attributable fractions for Scotland (NHS National Services Scotland, 2009)
http://www.scotpho.org.uk/alcoholPAFreport/

Scottish Alcohol Needs Assessment (SANA, 2009)
http://www.alcohol-focus-scotland.org.uk/pdfs/SANA%20Report.pdf

Changing Scotland's Relationship with Alcohol: A Discussion Paper (Scottish Government, 2008)
http://www.scotland.gov.uk/Publications/2008/06/16084348/0

Changing Scotland's Relationship with Alcohol: A Framework for Action (Scottish Government, 2009)
http://www.scotland.gov.uk/Publications/2009/03/04144703/0

Drug and Alcohol Services in Scotland (Audit Scotland, 2009)
http://www.audit-scotland.gov.uk/media/article.php?id=103

Scottish Care Commission Stakeholder Survey (Scottish Care Commission, 2005)
http://www.carecommission.com/index.php?option=com_content&task=view&id=266&Itemid=101

Recovery and the UK Drug Treatment System: Key Dimensions of Change (Wardle, 2009)
www.fead.org.uk/docs/IWRecoveryPaper09-web.pdf

Stigma Review (UK Drugs Policy Commission, 2010)
www.ukdpc.org.uk/resources/Stigma_report_media_release_24-08-2010.pdf

Part of The Scottish Way of Life? Attitudes Towards Drinking and Smoking in Scotland – findings from the 2004 Scottish Social Attitudes Survey (Scottish Government, 2004)
http://www.scotland.gov.uk/Publications/2005/07/2992847/28513

Social Care Institute for Excellence
http://www.scie.org.uk/

Putting People First Concordat: a shared vision and commitment to the transformation of adult social care (Department of Health, 2007)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

Approaches to Alcohol and Drugs in Scotland: A Question of Architecture (Scotland's Futures Forum, 2007)
http://www.scotlandfutureforum.org/

World Class Commissioning Model
www.ic.nhs.uk/commissioning

New Framework for Local Partnerships on Alcohol and Drugs (Scottish Government, 2009)
www.scotland.gov.uk/Resource/Doc/270101/0080412.pdf

An Outcomes Toolkit for Alcohol and Drugs Partnerships (Version 1, Scottish Government, 2009)
http://www.scotland.gov.uk/Publications/2009/04/23084349/0

The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem (Scottish Government, 2008)
http://www.scotland.gov.uk/Publications/2008/05/22161610/0

Alcohol dependence: Provisional description of a clinical syndrome. *British Medical Journal, 1,* 1058-61. (Edwards & Gross, 1976)

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Review of the Effectiveness of Treatment for Alcohol Problems. London: National Treatment Agency for Substance Misuse (Raistrick et al., 2006)

Models of Care for Alcohol Misusers (MOCAM) (Department of Health, 2006)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136806

Alcohol Use Disorders – Diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE, 2010)
http://www.nice.org.uk/nicemedia/live/11875/51786/51786.pdf

Alcohol Use Disorders – Diagnosis and clinical management of alcohol-related physical complications (NICE, 2010)
http://guidance.nice.org.uk/nicemedia/live/12995/48993/48993.doc

Heavy Drinking and Changes in Situational Confidence to Avoid Heavy Drinking (Sobell & Sobell, 2000)
http://casaa.unm.edu/posters/Heavy%20Drinking%20and%20Changes%20in%20Situational%20Confidence%20to%20Avoid%20Heavy%20Drinking.pdf

A Wait Off Our Shoulders: A guide to improving access to recovery focused drug and alcohol treatment services in Scotland (Scottish Government, 2010)
http://www.scotland.gov.uk/Publications/2010/06/02115503/0

Cost effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT, 2005)

Getting It Right for Every Child (GIRFEC): An overview of the Getting it right approach showing how the practice model & tools can be used locally to complement practitioners' own materials & processes (Scottish Government, 2008) http://www.scotland.gov.uk/Publications/2008/09/22091734/0

National Guidelines for Child Protection in Scotland (Scottish Government, 2010) http://www.scotland.gov.uk/Publications/2010/12/09134441/21

Safer Lives, Changed Lives: A shared approach to tackling violence against women in Scotland (Scottish Government, 2009) http://www.scotland.gov.uk/Publications/2009/06/02153519/0

Stepped care: Doing more with less? *Journal of Consulting and Clinical Psychology, 68*, 580-585. (Davison, 2000)

Prevention of Relapse in Alcohol Dependence. Health Technology Assessment Report 3. Health Technology Board for Scotland, Glasgow. (Slattery, J., Chick, J., Craig, J. *et al*., 2003)

National Institute for Health and Clinical Excellence. Drug Misuse: Psychosocial Interventions. Clinical Guideline 51. (Nice: London, 2007).

UKATT Research Team: Effectiveness of Treatment for Alcohol Problems: Findings of the Randomised UK Alcohol Treatment Trial (UKATT, 2005) *BMJ* 2005;331;541

Substance Abuse and Men Who Batter : Issues in Theory and Practice, *Violence Against Women* 9: 558 (Larry Bennett and Oliver J. Williams, 2003)

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