SACDM

Scottish Advisory Committee on Drug Misuse

Essential Care:

a report on the approach required to maximise opportunity for recovery from problem substance use in Scotland

SACDM
Integrated Care Project Group:
Essential Care Working Group

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Executive Summary

1. This report was commissioned by the Scottish Advisory Committee on Drug Misuse (SACDM) to address the additional non-medical aspects of service required to ensure that people with substance use problems are given every opportunity to recover from their problems.

2. Scottish services – often in association with methadone prescribing services – have successfully increased the numbers of people in contact with care and treatment and have delivered approaches dominated by 'harm reduction'.

3. Harm reduction and recovery have often been seen by some in the field as opposing philosophies – rather than a continuum of care.

4. As is the case in the management of other chronic relapsing conditions in Scotland – such as the recovery network in mental health – there is an opportunity, in the field of problem substance use, to develop an approach which is more aspirational and places the service user at the centre of care.

5. Such an approach would involve the development of a national philosophy of care with a focus on recovery.

6. Service delivery should reflect key principles, including:

   a. recognition that people with substance use problems have aspirations to have healthy and happy families and to experience fulfilling lives. Disadvantage, poverty and exclusion are closely aligned with problem substance use and plans to improve health must reflect this;

   b. recovery must become a key focus of the care available for problem substance use rather than an ideology which advocates any particular type of treatment;

   c. recovery may not involve abstinence – all services and commissioning partners must put service users at the heart of their activities;

   d. all people should have access to a full range of the essential services described in this document in an accessible location;

   e. care plans must be holistic in approach and address the totality of peoples' lives; and

   f. all people with problem substance use must have access to the same generic services as everyone else – this includes the right to be registered with a General Practitioner (GP) and to access primary health care services.

7. The local commissioning process must become more effective and must involve the 'core components' of needs assessment, governance and accountability, data sharing and outcome measurement.

8. Operational delivery must increase effectiveness of the services participating in the care process. The 'primary requisites of effective care' – assessment, review, named key workers and agreed written plans – are essential elements.

9. Essential services – 'key aspects of service provision' – include services addressing an individual's physical, psychological and social functioning. These must be available in every area and there should be governance processes in place to promote equity of access.

10. Key recommendations are listed for the Scottish Government, local commissioners and services. If delivered, people with problem substance use will have more opportunity to overcome their problems and progress towards more mainstream lives with the impact of improving their health and functioning.

11. **Substance users have the right to the same quality of care as the rest of us**

Section 1 – Background discussion and evidence

1.1 Introduction and context

1.   In 2007 the Scottish Executive published reports on the role of methadone in drug treatment (1,2,3). These concluded that replacement prescribing with methadone should remain a main plank of the Scottish approach to opiate dependency. The reports also highlighted challenges for services if medical treatments were to achieve optimal outcomes. There was a need for Scottish strategy to become more aspirational and for service providers to become more systematic in delivering integrated person-centred services that had the capacity to address a full range of substances as well as the range of psychological and social aspects of life impacted on by problem substance use. Care and treatment needed to become a partnership between service users and agencies with the aim of achieving recovery.

The methadone reports were welcomed at the SACDM meeting on 11 May 2007. SACDM requested that further work be undertaken to advise on the additional services required to improve outcomes. The SACDM Integrated Care Project Group was asked to take this forward and commissioned a time-limited multi-disciplinary working group to: consider the range of services required to maximise effectiveness of care, treatment and recovery; identify the potential challenges faced in delivering comprehensive services in Scotland; and make recommendations aimed at overcoming these challenges. The working group was to report in December 2007.

This paper is the result of this work. It has been prepared by a diverse group of professionals involved in the commissioning and delivery of care, treatment and rehabilitative services for those experiencing problems associated with the use of substances in Scotland. A list of contributors is included in Appendix 1.

The report was commissioned to inform the debate regarding how best to ensure that care and treatment is delivered to the highest quality and achieves the best possible outcomes. This must include the opportunity for all those suffering from problem substance use to access a full range of services that not only effectively reduces harm but also maximises recovery, facilitating a return to mainstream society. The paper aims to be pragmatic and realistic but is also aspirational. It forms a coherent consensus regarding the strengths and weaknesses in current care and treatment in Scotland, clarifying what services should be aiming to achieve and what additional service elements and processes may be required to maximise effectiveness. It concludes with recommendations to Ministers outlining key actions for the Scottish Government, local commissioners and services.

The Challenges

Services to address problem drug use have developed greatly in the last 20 years. In the 1980s developments were driven by concerns regarding blood borne virus (BBV) infection – particularly HIV – in intravenous drug users, resulting in adoption of a national policy of 'harm reduction' (4). This brought concepts such as needle exchange and replacement prescribing with methadone into mainstream policy (5). The 1990s saw harm reduction extended to include social behaviours – in particular

the relationship between treatment and reduced criminal activity. In this context Scotland has seen significant increases in funding of services over the last 10 years with the main aim of policy being to bring more people into treatment and engage them in approaches which reduce harm (6,7,8). The result has been a massive growth in the numbers of people – mainly opiate users – in contact with services (9).

This apparent success is tempered by the lack of detailed information currently available regarding how successful these programmes are at achieving reduction in drug-related harm or promoting recovery. Until now services have seen their main 'outcome' as attracting users into services and retaining them. Despite clear guidance on care planning and review processes, few services record information about outcomes achieved, progress against agreed treatment goals or successful rehabilitation (2). Services may not be emphasising recovery – instead engendering a culture of dependency on the services themselves. Some services may even resist service users' requests to explore other approaches to recovery such as detoxification or residential rehabilitation, reducing opportunities to progress. In some services staff can find themselves dispirited and may lower their expectations of service users (3). Service users may find themselves caught in an environment that is not able or willing to share with them the struggle and risk associated with breaking away from their problem substance use. In this context, our systems of care are not achieving a high degree of engagement. Scottish services saw 13,781 new attenders in 2005-06 but also classified some 8000 cases as 'unplanned discharges'.

Services should be enabling those with problem substance use to live as meaningful and satisfying lives as possible. There are many paths to well-being and recovery and a person's attempt to deal with their substance problem is a unique and personal process. It is important that a full range of high quality services is available for all at the point of need. We must create a continuum of care which balances the undisputed need to reduce the harm associated with problem substance use while maximising the opportunity to return to normal lifestyles and activities whenever this is realistic. Recovery may not mean abstinence. Scottish services must demonstrate that they achieve improved outcomes for people. The complexity of substance users' problems should not be accepted as an excuse not to pursue recovery.

> **In summary: The challenge**
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> 1. A range of services, additional to medical treatment services – *essential services* – are required in any area to promote recovery from problem substance use.
>
> 2. Local systems of care treatment and rehabilitation must meet the identified needs of individuals and recognise that harm reduction and recovery form two aspects on the same continuum. The continuum contains all those aspects of care that will support people who use substances to improve their well-being and minimise harm to others.
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> 3. Recovery may not mean abstinence.
>
> 4. People must have access to a full range of support and care options to meet their assessed needs – whatever the substance they use or the severity and nature of the problem they experience.
>
> 5. Any problems faced by the individual substance user cannot be seen in isolation from their family, local community and society.

1.2   Philosophy of care – a recovery focus

Exclusion, risk and personal aspirations

People who have problems with substance use are some of the most socially excluded and high-risk members of our society. When compared to mainstream society:

- They are more likely to experience significant mental illness

- They are more likely to suffer a premature death

- They are more likely to be homeless

- They are more likely to be unemployed, often having failed to complete their education

- They are more likely to have criminal justice involvement

- Women are more likely to die in childbirth, to have low birth weight babies and to experience family planning problems

- They are more likely to be the subject of concerns regarding the welfare of their children

It is important to recognise, however, that problem substance users share their general life aspirations with other members of society. In response, local commissioners must ensure that everyone has access to essential care, treatment and rehabilitation services

which recognise this. Holistic assessment needs to take cognisance of the person's family, children, education and employment, housing and legal position and their aspirations around these areas. Health care interventions may be an integral part of the care package and access should follow a full clinical assessment covering physical, mental, sexual and reproductive health, diet and dental health. Parental substance use does not always preclude the possibility of effective parenting. However, in order to minimise the potential harm to both the unborn and any children, services and professionals involved with people with problem substance use should pro-actively encourage the discussion of contraceptive needs and plans for children. Medical and social treatments of substance use will increase fertility. All of these aspects of an individual's life must be regarded as essential areas to be addressed in all care packages.

Reducing harm – but limiting recovery? The case for change

In response to the perceived nature of problem substance users, many services have developed approaches which fail to maximise potential. These services can make service users into passive recipients of interventions which are organised, not around their hopes, wishes and aspirations, but around the needs of services to develop systems which meet high levels of demand and manage risk. This approach is rarely person-centred. Services should have higher expectations of the users' ability to overcome problem substance use, rather than settling for a process which engages them in contact with treatment services for long periods. This approach is not wrong in itself. Problem substance use is a long-term chronic relapsing condition and many struggle to ever overcome it. Evidence shows that 'retention' is associated with positive harm reduction outcomes and attempts to remove oneself from problem substance use within existing treatment approaches can be unsuccessful or hazardous (10). However, focusing only on the user's attendance and ability to work with professionals may limit expectations and could prevent recovery and re-integration into the community. It may serve to prolong people's drug using careers, so that being a problem substance user becomes akin to a lifelong identity. This may limit problem substance users from reaching their full potential.

It is inevitable that some professionals in the field will see a move towards recovery as a move away from harm reduction. This is not the case. Introducing recovery into the care of problem substance users does not in any way dilute the need to support efforts to reduce harm. Instead, such an approach could increase the effectiveness of activities focussing on harm reduction. Staff and service users would plan their work together and would alter their focus over time as a partnership based on the user's changing circumstances. Plans would be the product of an active process between service and user that is likely to increase engagement with the process and commitment to the agreed outcome. Recovery and harm reduction are not mutually exclusive but part of the same continuum.

A fresh approach? What is recovery?

Problem substance use is a chronic condition characterised by relapses which users must learn to manage or minimise to maintain their recovery. Evidence for the effectiveness of relapse-prevention approaches can be found in the alcohol literature (11). This reflects the fact that, in the absence of an easily delivered medical

[methadone-like] solution, the approach to alcohol problems has remained a pragmatic attempt to balance medical, psychological and social influences on problem behaviours, with reliance on the development of a person's own abilities at the forefront of their care.

Recently, lessons have been learned in the fields of mental health and learning disability, shifting care from a passive model to one regarding those being helped as active participants with services facilitating their recovery. By using this approach it is possible to change the providers' and service users' beliefs in their ability for self direction. This approach implies that people can develop strengths and skills in the face of the challenges they encounter when dealing with the chronic relapsing nature of their problem. Part of believing in their own recovery is 'believing it can happen for you' – being optimistic that they can recover. It may also help to be in contact with others who believe recovery is possible. Recovery represents a significant paradigm shift in thinking towards different groups throughout Health and Social Care. Why shouldn't individuals with drug problems become part of that change?

Currently, there is little objective evidence to support this approach in the field of problem substance use. In light of the mental health experience, it is, however, reasonable to conclude that similar approaches to recovery may be useful in this area. In some areas of Scotland, specialist nursing teams in problem substance use are being trained and developed in the recovery approach as part of the national recovery programme.

Approaches to Recovery in Mental Health – United Kingdom

In the report *A Common Purpose: Recovery in Future Mental Health Services* written jointly by the Social Care Institute for Excellence, The Royal College of Psychiatrists and The Care Services Improvement Partnership (12), the concept of recovery is described as:

> 'having very broad applicability to many domains of life where people struggle with long-term conditions that may not be particularly responsive to treatment measures. This shifts from an exclusive focus on the problem, to the person struggling with and learning to cope with and manage the problem. Recovery is significantly about recovering an emphasis on the relationship people have with their problem as a counterweight to the endemic tendency to see people defined as and by their problems'.

The report describes common themes in recovery, including:

- the pursuit of health and wellness; a shift of emphasis from pathology and morbidity to health and strengths;

- hope and belief in positive change; service supports reconceived as mentoring not supervisory;

- social inclusion (housing, work, education, leisure);

- empowerment through information; role change; and

- awareness of positive language-use in framing the experience of illness

Approaches to Recovery in Mental Health – United States of America

The report *Transforming Mental Health Care in America, Federal Action Agenda*, identifies the 10 'Components of Recovery' as being: self-direction; individualised and person centred; empowerment; holistic; non-linear; strengths-based; peer support; respect; responsibility; and hope. It states that, crucially, 'at times and places where doctors are more optimistic about the possibility of recovery, recovery rates appear to be higher' (13).

Approaches to Recovery in Mental Health – Scotland

In Scotland the fourth key aim of the Scottish Government's National Programme for Improving Mental Health and Well-being is 'to promote and support recovery' (www.wellscotland.info). The Scottish Recovery Network (SRN) is funded to work towards this aim by the National Programme (www.scottishrecovery.net). The Network is working to raise awareness of the fact that people can and do recover from even the most serious and long-term mental health problems. To support this it is working to learn more about the factors which help and hinder recovery directly from people's lived experience and to consider the implications for people who experience mental health problems and those who support them.

New Scottish research on the recovery experience suggests that 're-finding and re-defining a sense of identity and self-confidence that has potentially been eroded by institutionalisation or ill health was often the first step on a recovery journey' (14). The importance of narrative inquiry as a method of research and support for recovery has been described. People can learn what may help them to recover from a person telling their own story (15).

How can we apply recovery to the field of substance use?

A Common Purpose: Recovery in Future Mental Health Services states that 'new ways of thinking and working will only flourish in a sympathetic policy and funding context. This supports innovators and gives a rationale and resources to others to take up these new ideas and practices. In fact recovery is wholly congruent with the current direction of government Health and Social Care policy'. The Scottish Government supports many policy areas where the ideas inherent in recovery are becoming apparent. The National Quality Standards for Substance Misuse (16) describes the importance of service user involvement. To demonstrate compliance with the Quality Standards, service providers and commissioners must demonstrate that any service provided meets the needs of the intended target group. This is further clarified in the recently published Service User Involvement Manual (17) which defines user involvement as 'The active participation of people who, because they have used services, can bring their knowledge and experience to contribute to the design, planning, delivery and evaluation of services at a local, regional and national level'.

Where could we start? First steps

In Scotland, we have tried to incorporate service user participation and involvement in service design and in giving feedback on policy initiatives. This has only provided isolated pockets of success. Substance users often remain on the margin, at worst passive and increasingly involuntary recipients of treatment, with limited hope of achieving the real change in their situation many are seeking. We need to explore any opportunities there are for changing this picture. We can use lessons learnt from the recovery movement in other fields to refresh our strategy towards working with substance users. Adopting an approach which emphasises the strengths and abilities of people with substance use problems, while harnessing and learning from their lived experience, could go a long way to challenging expectations and promoting better outcomes.

What would this mean for care, treatment and rehabilitation services?

The recovery movement has adopted a set of indicators by which people can assess whether services are moving towards a recovery orientation. These indicators include a leaning towards: less coercive services; increased self management of treatment; and greater participation in their own treatment on the part of individuals (18). Partnership and respect are key features and this should be reflected in the treatment environments and services provided. Services should be coordinated to meet the wide range of issues affecting people with problem substance use. These should be available in a range of settings as required. There should whenever possible be a choice in terms of what services are available and who provides them. Systems should be in place to facilitate coordination and evaluate effectiveness. Further information on what can help and hinder recovery from the mental health recovery field is included in Appendices 5 and 6.

In summary: Philosophy of care – a recovery focus

1. Problem substance users are people with considerable needs and risks.

2. Services have developed a service-led culture to manage demand and risk which promotes a passive response from service users – not a person-centred culture which puts the users' aspirations and recovery at the centre of care.

3. Services for substance users must be designed to engage users in their own process of recovery. This means actively involving them in all aspects of service design, delivery, planning and evaluation.

4. Lessons from mental health/learning disability may facilitate this culture change.

5. Harm reduction is part of the continuum of care. It is not an end goal. Recovery is part of the same continuum.

1.3 Maximising the delivery of essential services

1.3.1 Principles – A consensus – the principles of service delivery

The delivery of comprehensive services that meet the range of needs experienced by problem substance users must be underpinned by the following principles.

1. People with substance use problems, in common with society, have aspirations to have healthy and happy families and to experience fulfilling lives. Disadvantage, poverty and social exclusion are closely aligned with problem substance use. Services to improve health and well-being must reflect this.

2. Services must acknowledge the stigma associated with substance use. It is their duty to challenge it.

3. Recovery must become the focus of the care available for problem substance use rather than an ideology which advocates any particular type of treatment. Recovery encompasses harm reduction and abstinence.

4. All services and commissioning partners must put service users at the heart of their activities. Person-centred approaches must underpin all services.

5. All services provided to people with an alcohol or drug problem should be accessible to individuals regardless of their race, religion, gender, gender identity, sexual orientation, disability or age. Local governance and accountability processes must ensure this national drive is translated into local, effective service design and delivery.

6. Assessment must address the totality of peoples' lives. Recovery plans must therefore address a full range of social issues including housing, education and working aspirations, legal difficulties and health improvement. There should be regular formal review of progress.

7. All people with problem substance use must have access to the same services as everyone else – this includes the right to be registered with a GP and to access primary health and social care services. Services must take cognisance of the full range of substance users' needs.

1.3.2 Commissioning of services

We have described the change of emphasis that would be required to develop a more recovery focused approach to problem substance use in Scotland. Such a paradigm shift would require a systematic approach to the commissioning of services.

'Commissioning' is 'the strategic activity of assessing needs resources and current services and developing a strategy to make best use of available resources to meet identified needs'. Recent guidance to Drug Action Teams (DATs) lists responsibilities which may help define the terms of reference around joint commissioning. This comprehensive list includes: working in partnership; developing and gaining

commitment to strategies; achieving local change; needs assessment; strategic planning; contract setting; contract monitoring; quality assurance; and leadership (19). In the current document, commissioning reflects this broad definition.

Core components of the commissioning process

Commissioning must be underpinned by the core components of *needs assessment; governance and accountability; data exchange; and outcome measurement* and be in keeping with European Union Procurement Law.

Needs Assessment – How do we know what is needed?

Each area (Alcohol and Drug Action Team (ADAT) or otherwise defined) should undertake a regular needs assessment based on a recognised format. Guidance regarding process is available nationally (19). Support, advice and information will also be available from local partners and Information Services Division (ISD). The needs assessment must explore prevalence and nature of substance problems in each area. Ideally this would include surveys of relevant populations. It should look at 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 substance use – including families and communities. This process goes beyond simply seeking endorsement for decisions already made to deliver particular service provision.

Provision of specific interventions in the area should be based on the identified need. The range of possible interventions delivered locally and supported by public funding must be based on the evidence available. Areas will choose from appropriate evidence-based interventions. Exceptions could be made for short-term pilots that are subject to a process of objective evaluation. The needs assessment for each area should also include information on local workforce recruitment, retention and development needs and proposed solutions. The effective provision of any of the interventions detailed below is wholly dependent on having a competent, supported workforce able to deliver all relevant interventions. When appropriate, this should include those who have had substance problems in the past.

Governance and Accountability – How do we know if we are making a difference?

All services in receipt of public funds should have a written, published service specification and explicit contract monitoring process. There is a need to demonstrate effectiveness. 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 demonstrate the active, on-going involvement of people with substance problems, including involvement in the management, regulation, inspection and audit of services.

Data Exchange – How we measure what we do?

There should be a commitment to collection of standardized data for analysis based on a nationally agreed, ideally web-based, core minimum dataset. Reports could be

provided to local commissioners and service providers on a regular basis to inform needs assessment and on-going outcome reporting.

Reporting on Outcomes – What is the result?

High level national outcomes for care, treatment and rehabilitation services are being developed by the Scottish Government. These should be supported by locally relevant detailed outcomes. Reporting should be standardized and available to all stakeholders including service user and carer groups.

Operational delivery – primary requisites of effective care

The core components described above are linked to elements of the care process – primary requisites of effective care.

Where an individual seeks help regarding their substance use the service should undertake to ensure the following elements of care are in place. In order to be effective these elements require active participation and involvement of both the individual service user and those employed by the services. This process is one of facilitation. These elements include: initial assessment of need, with timetable for ongoing review of the individual and family needs; allocation of a named person to coordinate the response – key worker/care manager/care coordinator; agreement of a written plan; agreement of a recorded review process; clear documented care pathways for all essential services; and published information sharing protocols among all essential services.

Essential services – key aspects of service provision

Underpinning both the core components and the primary requisites of effective care are the key aspects of service provision. These key aspects form a description of what should be accessible to those individuals and families who have a problem with substance use problems in each commissioning area of Scotland. In each area it is essential that ADATs and their partners have in place arrangements to access a full range of interventions. In developing this range of services it is also important to reiterate that the process of needs assessment and commissioning must ensure that services are available for the full range of substance use problems encountered locally (not just opiate dependency) and are capable of offering tailored care to those whose problem is at different stages of severity and risk. In such circumstances it is clear that the range of services required or prioritized may vary from area to area. It will be important for ADATs to demonstrate that their service priorities reflect the issues identified in their local needs assessment. The list is not prescriptive regarding delivery. Some key aspects may be delivered by one agency or from shared premises as appropriate. However, it is essential that equity of access to services across Scotland is assured. This list reflects the *minimum* range of service options expected in any ADAT area.

Substance focused services – available locally

Some services should be available in all areas and efforts should be made to make them easily accessible for service users. These will include: direct access

service/street level agency; needle exchange; specialist harm reduction services; structured 1:1 work/counseling and structured group work – to address commonly-occurring issues such as sleep problems, anxiety disorders, understanding relapse and relapse prevention, improving confidence and self-esteem; psychological therapies – including behavioral and cognitive behavior therapy (CBT) approaches; solution focused therapy; specialist psychological and psychiatric care; substitute prescribing; supported self-detoxification; medicated detoxification; community rehabilitation programmes; specialised employability programmes; specialist services for young people with substance problems; and signposting or facilitated pathways to other services.

Substance focused services – available regionally

Some specialist services may be more appropriately commissioned on a regional, national or partnership basis. These would include in-patient detoxification programmes and residential rehabilitation.

Essential Services not specifically substance focused

As well as specifically commissioned services which have their focus on the substance use problem, all areas must be able to facilitate access to a range of 'generic' services. These may be provided within specialist substance misuse services or by generic mainstream services depending on local circumstances. ADATs/partners should monitor these services in terms of their quality, attitudes and accessibility when dealing with those people experiencing problem substance use. These include: primary health care – access to a GP and a dentist; child care support; housing support and advice; employment and training support; financial advice and support; reproductive health information, advice and treatment; family planning; BBV prevention, testing and access to treatment; clinical psychology and mental health services; social work services; and legal services.

In summary: Maximising the delivery of essential services

1. Areas must consider the principles of service delivery when planning services.

2. Commissioning of services involves the assessment of needs resources and current services, and the development of a strategy to make best use of available resources to meet identified needs. The involvement of service users is essential to effective commissioning. Service users can be involved in different ways at different stages.

3. The *core components* of this activity are needs assessment; governance and accountability; agreed data exchange systems; and outcome measurement.

4. The *primary requisites* of effective care include needs assessment; review processes; a named person to coordinate care; a written plan; clear documented care pathways; and published information-sharing protocols among all essential services.

5. The *key aspects of service provision* lists the types of service provision required in each local area.

6. ADAT areas must ensure a full range of services are available – either locally or through regional/national arrangements.

7. 'Generic' service elements should be monitored regarding availability, quality and attitudes.

Section 2 – Essential Services to Maximise Recovery

2.1 Introduction – balancing harm reduction, treatment and rehabilitation

This section describes in detail the key aspects of service provision – care, treatment and rehabilitation – which require to be available in any area with the aim of maximising outcomes for service users through a process of facilitation and partnership. The process of care within which a service user agrees their priorities will ensure that, when appropriate, the service with which they are engaged offers a full range of options to facilitate their progress against agreed goals of treatment. In describing these key aspects no assumptions are made regarding how local systems should address them or whether elements of care should be delivered within any sector (statutory or voluntary) or service (health or local authority). However, it is clear that as ADATs and partners commission services they must address issues of governance and accountability – often through partnership arrangements – and must also demonstrate best value.

2.2 Well-being

2.2.1 Health improvement

Why is health improvement necessary?

'Health is a state of complete physical, mental and social well-being and not merely the absence of disease' (20).

The WHO definition of health illustrates its multi-dimensional nature and confirms that it can be influenced by many factors. Consequently creating care which delivers improved health requires a wide range of actions and activities to address the key influences on health of individuals, communities and populations. These actions can be directed towards preventing ill health, protecting good health and promoting better health. The benefits of improving health are well known: individuals feel better about themselves; communities become more active and involved in health promoting activities and there is positive impact on the population as a whole (21,22). For health improvement to be effective in the context of the problem substance user, effort needs to be directed at the following:

- Addressing lifestyle issues that impact on health (e.g. nutrition and obesity, physical activity, smoking, breastfeeding, addictions, mental health, oral health and safety)

- Addressing life circumstances that impact on health (e.g. worklessness, health differences in deprived areas, income maximisation, community safety, transport and fuel poverty)

- Addressing all forms of inequality that impact on health (e.g. race, gender, disability, sexual orientation, socio-economic status and homelessness)

Health improvement is a key area for development in local planning partnerships. It is essential that substance users are included in these plans. Two key areas of health improvement (nutrition and exercise) are discussed below.

Nutrition

A healthy diet is essential to health and well-being throughout life and has a role to play in maintaining physical and mental health. The benefits of good nutrition are well recognised and may be an important factor in protecting against a wide range of diseases including coronary heart disease, stroke, obesity and diabetes mellitus (23,24). Whilst this risk applies to the population at large, there are additional health and social factors associated with problem substance use that may place such individuals at increased risk of nutritional complications or change their nutritional requirements.

Research on nutritional status and dietary intake in problem substance use suggests that people with problem substance use may be at increased risk of malnutrition, including being under or over-weight or having micronutrient deficiencies (25,26,27,28). Dietary intake may be erratic and of poor quality, with a tendency to high consumption of sugary and refined foods. The presence of conditions such as Hepatitis C may exacerbate these problems, as protein energy malnutrition is common in chronic liver disease (29,30,31). Recent guidelines have emphasised the importance of nutritional care for those in this situation (32). Social factors such as poverty, poor housing or unemployment may further increase nutritional problems and impact on dietary intake, food choices and food availability (33).

Problem alcohol use has a detrimental impact on the gastrointestinal and hepatic systems which may lead to malabsorption and altered metabolism of nutrients (34). In chronic liver disease, basal metabolic rate may be increased, resulting in increased nutrient demands (34,35,37). High alcohol intake has been associated with a range of nutritional problems including poor dietary intake, low bodyweight, obesity and both macronutrient and micronutrient deficiencies (34,35,36). Food intake may be substituted by alcohol and whilst weight may be maintained, protein and micronutrient status may be compromised. Of particular concern is the higher risk of Wernicke-Korsakoff Syndrome, due to acute thiamine deficiency, known to occur more frequently in those with alcohol dependency (37,38).

It is important therefore that nutritional assessment and care provision should be included as an integral part of care planning strategies for such populations. However, availability of nutritional advice or dietician services is often limited and steps should be taken to widen accessibility to such services.

Exercise

People with problem substance use have increased risk of disease. Smoking and often excessive alcohol consumption are identified in national guidelines as risk factors for many conditions including osteoporosis, hypertension, cardiovascular disease, pulmonary disease, stroke, and some cancers (38-50). Conversely it is widely accepted that regular exercise is beneficial for your health. The evidence continues to

grow in support of the importance of physical activity in improving physical function, reducing the risk of disease and improving mental well-being (40-42,44,46,48-52).

Regular exercise has been shown to cut heart disease by one-third, strokes and type II diabetes by one quarter and hip fractures in older people by half (51). Cardiac rehabilitation which involves exercise training, education and counselling can cut cardiac mortality by 27% (51,54). Exercise classes are also used in pulmonary rehabilitation to improve the quality of life of people with respiratory diseases.

Physical activity is associated with a reduction in the overall risk of cancer, particularly cancer of the colon where the most active individuals have a 40-50% lower risk compared with the least active (48). The evidence linking lack of exercise to other cancers including breast, prostate, endometrial and lung continues to strengthen (52).

Exercise is widely understood to be effective as a way of improving the health of those with long term or chronic conditions such as obesity, asthma, hypertension, diabetes and many others (41,50-52,55-57). It has been established to benefit people with schizophrenia, depression, anxiety and intellectual disability, both through improvements in general cardiovascular fitness, but also by reducing anxiety and depression itself (53,58). In combination with other treatments exercise is effective in reducing risk of falls in individuals who are at risk of falling (40,59,60). Arguably, this would be even more important for those with muscle and neurological changes from long term alcohol use.

The challenge is to support people with problem substance use into making the lifestyle changes necessary to increase their levels of physical activity. For some, particularly those who exercised regularly in the past, it may be sufficient to provide information and 'signposting' to available local facilities. Exercise referral schemes should also be used to provide additional encouragement to achieve the recommended 30 minutes of moderate exercise on 5 days (or more) per week (55). However a significant proportion of this population would have difficulty introducing a regular exercise programme into their often chaotic and/or isolated lifestyles. For this group a higher degree of support would be required to introduce an exercise model that would eventually facilitate the person to continue to exercise independently. Accessing local leisure facilities would also have social benefits, assisting the integration of the person into the wider community.

Issues and solutions: Health improvement

1. Health improvement is a broad concept which encompasses positive health and not simply the absence of disease.

2. Health improvement is a key area of local planning – it is essential that problem substance use populations are included in local plans.

3. Nutrition is closely associated with health – substance users often have poor nutritional habits and access to advice and professional support is a need.

4. Exercise habits are closely associated with health – substance users often have poor exercise records and can benefit from increased access to exercise programmes and facilities.

2.2.2 People in crisis

In Scotland, out of hours services are delivered by the NHS and Local Authorities who deal with acute medical emergencies, child protection and psychiatric emergencies. These types of services generally operate as a compliment to the traditional (weekdays 9-5) services offered by statutory service providers, with the exception of pharmacies that can be open at weekends and evenings. Traditionally, services for problem substance users are delivered in line with other weekday services and are generally elective services not designed to manage crisis intervention out of hours. In most areas there are no out of hours services specifically targeted at supporting substance users. There are a few specific crisis intervention services dealing with complex cases (e.g. Glasgow Drug Crisis Centre). There may be a high demand for some crisis provision – but no agreement regarding how it can best be delivered.

Anecdotal information implies that a range of crisis situations or problems in accessing services can disrupt treatment for those on replacement prescription programmes with considerable associated risk. In Glasgow, an audit of referrals to the psychiatric liaison service over a period of one year from July 2006-July 2007 was carried out. A sample of 30 referrals was taken from 320 in which substance use was a factor. Of these, 27 (90%) were known to addiction services demonstrating that most crisis episodes occurred in people already known to addiction services. Most referrals to this service are for people who have multiple needs with substance use being a significant factor along with moderate or enduring mental health problems.

Medical, psychiatric and child protection crisis are currently managed in mainstream services with no specific service targeted at substance users in crisis, their families or carers. This could increase the potential for a person engaged in treatment to relapse and put vulnerable families and children in their care at risk.

What should we be doing?

There are a number of potential solutions:

- Require Community Health Partnerships (CHPs) and Local Authorities to review their arrangements for liaison between out of hours services and services for problem substance use to map out need for an out of hours response to those known to services. It is recommended that capacity should be built into current out of hours services to give information/advice to people in crisis as a result of substance use.

- Develop local pathways for people in crisis who are not known to drug treatment services. Examples might include people whose substance use is identified in acute hospitals. Substance use services have an opportunity to engage with people during an acute admission to initiate substitute prescribing, reducing the risk of overdose.

- NHS 24 and Social Work Standby services should identify people and families who are in crisis as a result of substance use. This should develop the evidence base around need and help decision making around options.

- Local areas should develop their IT capabilities between drug treatment services, community pharmacies and out of hours services to identify development opportunities around key gaps in service provision. Examples might be to consider non-medical prescribing or family support.

2.2.3 General Medical Services

Primary Care

The specific care of problem substance use in primary care has been placed within the Nationally Enhanced Services (NES) contracting arrangement of the General Medical Services (GMS) contract provided by GPs (61). In some areas in Scotland the local NHS boards have adapted this NES to develop Locally Enhanced Service (LES) arrangements to deliver components of the care required for people with problem substance use – mainly replacement prescribing in 'shared care' arrangements. Some GPs have an interest in this field and may have training/experience meaning they will opt in to provide medical assessment and screening. As for all registered patients on their practice list, GPs provide general medical care for problem drug users through the essential services element of the GMS contract. Whether or not the GP delivers enhanced services, it is essential that the provision of general medical care is not compromised. Responsibility for accessing health care must remain with the GP who must be informed of contact with specialist services, and be notified regarding relevant findings, treatment and progress. Primary care services should be central to any care plan.

Receiving services should be holistic, inclusive and philosophically neutral as part of a

continuum between models of problem substance use and treatment services. The following must be seen as a core constituent part of 'essential' problem substance use services:

- Receiving Medical Services (RMS). RMS will include basic care and signposting.

- Basic care must include: holistic medical assessment including relevant physical, mental, sexual and reproductive health, nutrition and diet, family and social history. Social history must include details of existing children, other children to whom they have access and plans for future children.

- Medical examination including height, weight/body mass index (BMI), oral hygiene, physical inspection including (if relevant) injection sites, appropriate organ systems including respiratory, cardiovascular, reproductive (cervical smear and infection screen) and gastrointestinal, as suggested by history.

- Examination of body fluid as appropriate and as required for care governance.

- Provision of substitute prescribing, in accordance within accepted national guidelines, as part of harm reduction, progression towards stability, maintenance or detoxification. During pregnancy or when pregnancy is intended substitute prescribing should be under the guidance of a specialist with expertise in this area. Results of medical history, examination, treatment and referral plans will be communicated to the GP.

- Establishment of care plan within local governance arrangements.

- Clear goals and end points with appropriate timescales, informed and modified by a robust review process.

The nature and quality of general medical services for problems substance and its relationship with specialist provision is clearly articulated within the 2007 national treatment guidelines (62) and the Council Report CR131 *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers* from the Royal Colleges (63). Robust governance arrangements – through monitoring of local GMS provision and enhanced service development must be ensure access to services.

> **Issues and solutions: General Medical Services**
>
> 1. GPs are required to deliver General Medical Services to substance users – but in some areas this provision has been affected by the development of enhanced services to deliver specialist medical interventions.
>
> 2. BBV strategies make it clear that some specific medical services must be closely aligned with substance use services.
>
> 3. Standards of care delivery are well articulated and systems must capitalise on this to ensure access to high quality GMS service.

2.2.4 Blood Borne Viruses

Hepatitis C

The Scottish Government Action Plan for HCV requires that substance use and HCV services should become more integrated. This responsibility affects how these services are located and function. BBV testing should be readily available and be provided for all relevant family members including existing children of an infected mother (64).

Primary care

A survey of GPs as part of a needs assessment showed that the majority of general practices in Scotland are involved (or willing to be) in testing and treatment for HCV. (65). Reporting of HCV testing has occurred in most NHS boards. In the last 12 months less than 6 patients were diagnosed with HCV in primary care.

National considerations and HCV treatments

Cumulative diagnoses of HCV in Scotland to 2006 were 22,073. Only 55% of people living with chronic HCV have attended specialist services. Only 14% of those with HCV have ever initiated therapy. Low completion of assessment is an impediment to treatment. When treated, the response rate is 50-60% with anti-viral therapy. Cost effectiveness studies have shown that treatment lead to gains in quality adjusted life years (QALYs) that justify the expense of treatment. Approximately 225 former injecting drug users access treatment per year. Modeling exercises show that 2000 per year will provide benefits in QALYs, decreases in cirrhosis and Hepatocellular carcinoma (HCC). The challenge is therefore to increase uptake, engagement and retention in treatment (66-68).

Scottish Intercollegiate Guidelines Network (SIGN) Guidelines show that if HCV and substance use services are integrated the uptake, retention and clearance of HCV is the same for injecting drug users, ex-users and non users (32). Other national guidance supports Managed Clinical Networks (MCNs) and robust clinical pathways. Planning services should consider the provision of MCNs involving primary care, needle exchange, health promotion and specialist harm reduction services with HCV mainline services.

Other blood borne viruses

Early introduction of needle exchange in the UK averted an HIV epidemic in the 1980's (69). However HCV was already endemic when needle exchange was further promoted for HCV (70). There is also evidence that HIV incidence and transmission is rising (71). In order to reduce this we need to revisit and revitalise needle exchange, reduce sharing paraphernalia and increase the use of barrier contraception and other strategies to reduce BBV transmission. We must learn the lessons of history. All front line workers must use brief interventions aimed at influencing risk-taking behaviours at every point of contact to reinforce the routes of transmission of BBVs and their primary and secondary prevention. Services should offer HAV and HBV immunisation as routine. Finally, there is also an urgent need to undertake large scale epidemiological study to clarify the extent of the problem.

Issues and solutions: Blood Borne Virus

1. Hepatitis C is recognised as a significant risk – a SIGN guideline, national strategy and associated funding is now in place to progress a response.

2. Key to the plan is integration of HCV and substance use services.

3. Other BBVs need to be recognised and clear national standards regarding testing and treatment developed and adhered to.

3. Local commissioning of BBV services through ADATs/BBVSPGs (Service Providers Groups) may not be effective and robust governance regarding these services is required.

3. Local systems must develop coherent care pathways incorporating prevention, testing, treatment and liaison protocols (e.g. about interactions/treatment changes).

2.2.5 Medical management of problem substance use

The medical management of problem substance use is comprehensively covered within the recently updated national guidelines for drug misuse (62). Regarding Scottish practice, the issues around methadone were addressed within the three reports in 2007 (1,2,3). Medical treatments are less prominent in the management of alcohol problems. However, a recent SIGN guideline addressed alcohol detoxification procedures.

In all areas ADAT partners must ensure that problem substance users have access to high quality prescribing services to deliver replacement prescribing, detoxification and abstinence-focused approaches. Local systems must develop commissioning priorities to reflect local needs. Local governance and accountability procedures should include a requirement that prescribing practice is regularly audited and reported within the local NHS clinical governance frameworks. All areas should have a published prescribing protocol with associated standards against which a regular

audit programme is carried out. There are a number of challenges in delivering medical services.

Accessibility

Accessibility to prescribed treatments may be an issue. Waiting lists for services must be recognised and solutions developed to ensure timely resolution. This may be difficult in NHS Board areas with financial pressures. Organisation of services has the potential to impact on these accessibility issues. Clinical leaders must ensure that GPs are encouraged to share responsibility for their patients' care. 'Shared care' must involve adequate governance requiring training and supervision, quality clinical processes and audit. Use of mechanisms such as non-medical prescribing (nursing and pharmacists) may bring potential for services to increase capacity.

Capacity of community pharmacy daily/supervised dispensing places may be a challenge. This may reflect funding challenges. Local commissioners must ensure pharmacists are encouraged to be involved. Use of approaches which assist pharmacists to manage controlled drugs (e.g. computerised messaging systems dispensing tools and storage facilities) as well as streamlined prescribing arrangements, training and support may ensure that access to adequate pharmacy places is available.

Range of treatment options

Methadone mixture is the most commonly used replacement prescribing substance in the UK. In some areas buprenorphine or a combination buprenorphine/naloxone is available. NICE guidance shows that buprenorphine has not been demonstrated to have clinical advantages over methadone though it is more expensive (72). It does offer choice. These considerations must be addressed and balanced by local commissioners to ensure appropriate treatments are available to meet need. Use of more 'advanced' treatments – such as methadone concentrate, injectable methadone or diamorphine are an option in UK services but bring challenges. Local systems may consider their use within closely governed circumstances – expanding the range of services available locally and having the potential to offer more effective treatments to those who may struggle on oral methadone mixture.

Availability of evidence-based detoxification and abstinence/relapse-prevention interventions is essential in all areas. However, like all prescribed treatments, these should always be delivered as part of comprehensive structured programmes of care.

Issues and solutions: Medical management of problem substance use

Medical treatments must be subject to meaningful local clinical governance systems which must address:

1. *Accessibility* – areas must ensure they have plans in place to give rapid access to appropriate prescribed treatments and should demonstrate that they have considered valid options to address waiting lists.

2. *Range of services* – all areas must ensure they have all appropriate treatments available or clearly articulated plans which explain why treatment decisions are in place to restrict access.

3. *Use of advanced treatments* – should be included in any local prescribing protocol/guidance/standards.

2.2.6 Chronic pain

It is estimated that chronic pain affects some 13% of the UK population (73). There is a close relationship between pain and problem substance use. People with chronic pain may demonstrate aberrant medication-taking behaviours (74) which may reflect co-morbid problem substance use (75) and can lead to escalation in use of prescribed opiate medications (76). Studies of people suffering from chronic pain have found a prevalence rate of problem substance use of up to 40% and a lifetime risk of developing a problem three times that in the general population (77). People with substance use problems are more likely to suffer pain disorders. Studies of methadone patients in the USA have found chronic pain in 37-61% and found that those with pain had more problems and took more medications (78,79). Researchers have shown that chronic pain can contribute to illicit drug use and that people with problem substance use suffer from co-morbid pain require higher methadone doses to attain stability (80).

Doctors find the management of such complex patients time-consuming and challenging (73,74). Studies have shown that those dependent on substances who suffer from pain associated with serious medical illnesses are often treated outside recognised guidance (81-83). Many studies have raised concerns relating to undertreatment of chronic pain in those with substance use problems (79).

In this context, recent UK guidance from the British Pain Society acknowledges the complexity of the relationship between chronic and acute pain and substance use disorders and recommends that the management of these disorders involves both pain and problem substance use specialists working in a coordinated way alongside the patients' own doctor (73). This guidance is re-iterated in the 2007 *Drug Misuse and Dependence UK Guidelines on Clinical Management* (62).

2.2.7 Maternity care

Due to the high rate of co-existing morbidity associated with substance use, pregnant women with problem substance use have potentially high risk pregnancies. As recognised by *Why Mothers Die* (84) they require obstetrically-led multi-disciplinary care embedded in maternity services that attempts to address all their medical and social problems within a single setting.

Those with opiate dependence should be provided with substitute prescribing, usually with methadone although if women are stable on buprenorphine there is no need to change. Those with benzodiazepine or alcohol dependence should be provided with a long acting benzodiazepine short-term to cover withdrawal. Though there is no reliable evidence that opiate detoxification during pregnancy is medically unsafe and some evidence that it is safe (85) it is rarely appropriate. The dose of substitute medication may need to change according to external factors. Blood levels decrease during the third trimester but there is no evidence that this correlates with reduced pharmacological activity and no need to routinely increase the dose. Urine toxicology screening during pregnancy does not influence maternity management. If women use drugs illicitly in addition to prescribed medication they may benefit from an increase in the dose of prescribed medication.

Pregnancy affords an ideal opportunity for opportunistic care including cervical cytology. All pregnant women are routinely offered antenatal screening for HIV infection since interventions are available that will reduce the risk of maternal to child transmission. No such interventions have been identified in the management of

women with HCV infection who are polymerase chain reaction (PCR +ve) so the routine offer of antenatal screening is not indicated. Since treatment during pregnancy is contraindicated, women rarely attend specialist HCV services during pregnancy. The diagnosis can lead to loss of stability so testing out with pregnancy is often more appropriate. Good communication between agencies involved in care is essential throughout pregnancy and after delivery; women should be managed according to national guidelines (86) with antenatal multi-agency planning meetings held as directed.

Women with problem substance use should receive adequate intrapartum analgesia. Opiate dependence does not preclude the use of opiate analgesia during labour and if the standard dose proves inadequate it can be increased. It is important to recognise that methadone as prescribed for opiate dependence will not provide intrapartum analgesia nor will opiate intrapartum analgesia provide adequate opiate substitution. For women on opiate substitute medication, opiate intrapartum analgesia if prescribed, should be given in addition to and not instead of methadone. Breast feeding will reduce the severity of neonatal withdrawal symptoms and consequent need for treatment of the neonate and should be encouraged for all drug using women with the exception of those who are HIV +ve. Having HCV PCR +ve status is not a contraindication to breast feeding.

In common with those from socially disadvantaged backgrounds or with unstable lifestyles, women with problem substance use should be offered effective, appropriate contraception (often using long acting reversible progestagen contraception via implant or intrauterine device) commenced prior to postnatal discharge.

Issues and solutions: Maternity care

1. Substance users have potentially high risk pregnancies and should have access to obstetrically led multi-disciplinary care.

2. Clear guidance exists regarding appropriate care of their substance problem and pregnancy – practice should reflect this.

3. Good practice in multi-disciplinary/multi-agency care is essential in maximising outcomes.

2.2.8 Dental health

Problem substance users often have poor dental health – an issue which can be distressing at any time and can present as a barrier to rehabilitation. They experience dental health problems in association with a number of factors including: poor diet (irregular meal times, increased intake of sugar based foods); irregular lifestyle (poor attendance at dental surgeons); failure to care for dentition (no regular tooth-brushing, flossing or mouth rinses); an inability to find dentists willing to treat them; patient perception that drugs affect teeth; and blaming pregnancy on the decline in dental health.

The aim for services should be to prevent the development of serious dental problems by promoting good dental health at all times. All patients should also be able to access regular dental care: general dental service; salaried dental service; community dental service; and dental hospital referrals for advanced treatment. Few areas have specific arrangements in place to improve access to adequate dental care.

Issues and solutions: Dental health

1. Dental health problems are common for people with problem substance use and have many causes.

2. Preventive practices should be promoted by all services.

3. All areas should have access to a full range of dental interventions.

2.3   Psychological functioning

Background

Psychological care is a fundamental component of the essential services supporting the care, treatment and rehabilitation of those experiencing problem substance use. From initial contact with services through to completion of programmes and beyond, a service's ability to foster psychological well-being has an impact on outcome. In 2006, Scottish Executive Ministers established the Mental Health and Substance Misuse Advisory Group to update guidance on care for people with co-occurring problem substance use and mental health problems making recommendations to improve prevention, care and recovery services. It reported in 2007 (87). This seeks to translate the principles of previous reports (88-91). If we are to assist people to move through harm reduction and recovery, then substance use services require a change in culture and philosophy coherent with the approaches emerging within mental health. Recovery is a central theme in the modernisation of mental health services. The basis is that recovery is possible and service users and their families, friends and carers have the right to access individualized services that promote and foster recovery. The value base and approaches of the workforce support a commitment to anti-discriminatory practice, respect for diversity and the need to challenge inequalities, embracing the Millan Committee Principles (Appendix 4). All of this underpins how psychological care can be delivered in substance use services.

Why is this relevant? What is the evidence base?

There is a body of evidence supporting the effectiveness of a range of psychological interventions in problem substance use. Use of some form of psychological treatment improves outcomes compared to none but no one form of psychological intervention is better for all users than any other. Evidence suggests that some interventions, such as motivational interviewing (MI) and relapse prevention (RP), are effective across a range of substances used. Contingency management approaches are associated with improved outcomes for a number of subsets of users. Involving significant others is

important in engaging and retaining young people in treatment. Variables associated with the person, the therapist and the psychological process contribute to the effectiveness of psychological treatments (92). Recent reviews set out the range of recognized therapies recommended for use in the treatment of problem substance use (72,93).

In Scotland, a recent report noted that people with co-occurring mental health/substance use problems had more severe problems, higher rates of relapse and adverse health and social consequences (94). Service characteristics favourable to recovery were based on the therapeutic interventions and approaches already described above, reinforcing the need to develop an improved range of psychological interventions underpinned by recovery and value based approaches (95). It is recognized that these approaches are not unique to Mental Health Nursing and are recommended across the care sector working in problem substance use.

Issues

Workforce development and staff training issues

Workforce development has not been achieved consistently across services and the emphasis to date has been on medical interventions, with an absence of clear competency frameworks to assist in the development of psychological therapies.

Prioritisation of delivery of psychological therapies

The current evidence is poor in relation to services' abilities to deliver on the mental health/problem substance use co-morbidity agenda. A reason for poor implementation may be that the previous reports had their origins within the problem substance use field. The recognition of the importance of co-occurring problems, and the impact of problem substance use on mental health (87) represents an important step in driving forward service delivery in both mental health and problem substance use services. The psychological approaches required at this level of difficulty need to be captured within a systematic and well supported framework.

Interventions

Psychological intervention starts at the point at which the potential service user presents to the service. The degree to which they are adequately engaged will determine to a large degree the efficacy or not of future interventions. Adequate engagement is made more likely by the presence of a non-judgemental attitude, acceptance of the users definition of what their problem is and the ability to listen reflectively whilst allowing clarification of difficulty.

The National Treatment Agency (NTA) and NICE have both identified and endorsed psychological treatments as effective interventions for problematic substance use (93). Both opiate and stimulant uses respond to psychological treatments and psychologists in particular have been instrumental in developing and training others to utilise evidence-based therapies. These include intervention such as Cue Exposure (96), Relapse Prevention (97), Motivational Enhancement Therapy (98), the Transtheoretical Model of Change (99), Cognitive Behavioural Therapy (100),

Behaviour Modification (101), Dialectical Behaviour Therapy (102), family and marital therapy (103), Community Reinforcement approaches (104), Social, Behaviour and Network Therapy (105) and Contingency Management (106). The establishment of these therapies in practice has allowed clinicians to tailor interventions as new evidence for clinical effectiveness is obtained. The association between psychological treatments and the role played by psychologists in their effective delivery does appear to be overlooked however, and at the present time there are only a few clinical psychologists in the field of problem substance use within the whole of Scotland. This is despite the widespread public and political concern regarding problem substance use and the acknowledged effectiveness of psychological therapies in treating such conditions.

Psychological therapies are practiced by a diverse group of professionals, and, in many areas, given the limitations of the clinical psychology resource, psychologists have been primarily involved in the training and development of other staff to skilfully provide such interventions. The acquisition of new treatment skills requires role adequacy and role competence to be achieved and maintained if patients are to obtain therapeutic benefit from the interventions offered (107). This requires long term specialist support and supervision.

Neuropsychological assessment

A unique area of psychological expertise is in the assessment and care planning for those service users who have neuropsychological problems. These are frequently encountered in substance users, with acquired brain damage – often through the long term effects of alcohol or traumatic injury. Accurate diagnosis is essential if effective treatment is to be provided, particularly in the case of the dementias, where the use of medicines may have financial implications. Psychologists are specialists in neuropsychological examinations and in the care of neurological conditions. They are also trained to deliver other psychometric assessments, which assist in the management of a wide range of conditions, including the Personality Disorders.

Solutions

Psychological therapies should form an essential element of care for people with substance use problems – assisting people to reduce harm to themselves, moving them through a recovery process which seeks to assist them in achieving mental well-being and building resilience as well as empowering them in their own recovery. Thus, a psychological therapies framework for people experiencing problems with substance use and mental health problems should be developed in each NHS Board area, based on the recommendations already set out in key national documents.

A training and support strategy to equip substance use staff with the values, knowledge and skills required to deal with co-occurring problem substance use and mental health problems should be developed by NHS boards and partner agencies, including NHS Education Scotland. The Alcohol and Drugs Workforce Development Strategy Group should include mental health competencies within their remit. Similarly NHS boards should develop a capability framework to equip the mental health workforce with the knowledge and skills required in dealing with problem substance use.

Staff training and continuing development programmes should include a focus on understanding negative staff attitudes and effective approaches to tackle these, including increasing staff knowledge and confidence. Recovery and values-based approaches must underpin the delivery of psychological therapies at all levels.

The key role played by clinical psychologists in the development of and support for the practice of key interventions should be recognised as should their scarcity. If there is to be any expansion of available psychological interventions this must be accompanied by an expansion in the availability of clinical psychology resource.

Issues and solutions: Psychological Functioning

1. Staff awareness, training and development requires to be developed in line with the key national guidance documents.

2. The importance of psychological interventions in substance use must be acknowledged and plans to ensure they are available progressed by all NHS Boards.

3. There is a need to address national workforce issues – in particular to ensure nursing development around recovery in mental health includes nurses in substance use and specialist clinical psychology is developed as a national priority.

2.4   Social functioning

People with substance use problems live in communities with families and friends. They are children, brothers, sisters, and cousins. They are parents and have partners. They are customers and consumers. They are students, employees and employers. They share with their communities many challenges. People with substance use problems can struggle to be good enough parents. They need help to bring up healthy and happy families. They often have pressing financial problems, may struggle with bills, keeping up with rent or ensuring that they and their dependents have light, heat and food. They share these challenges with many in their communities. Some people with substance use problems are involved in crime. Without their substance use many would have no contact with the criminal justice system. They are not a homogeneous group and many would prefer not to be involved in crime. Some become homeless. This may result from arrears in rent, family or relationship breakdown. Being homeless can severely hinder people's recovery and stability. Services must help to overcome these challenges and assist in recovery.

2.4.1 Housing and homelessness

Background

Homelessness is complex and involves many areas, including employment, education and substance use. The number of households applying for assistance to local authorities in Scotland, under homeless legislation, has risen from 29,000 in 1990 to c. 60,000 today. Of these, 40,000 have been assessed as homeless, 75% of whom have been found to be in 'priority need' (108).   More than two-thirds of recent

homeless applicants were single-never married, a quarter were lone-parents and the remainder were couples with and without children (109). The problems faced by homeless people are well known – inadequate housing, relationship breakdown, unemployment, multiple debt, reliance on benefits and low income (110). These problems serve to marginalise homeless people relegating them to ways of life outside mainstream society. Of particular concern is the problem of substance use among homeless people which acts to compound other difficulties (111).

National strategic response

The issuing of government guidance to NHS Boards and the appointment of a Health and Homelessness Coordinator in 2001 highlighted homelessness and problem substance use and demonstrated the governmental commitment to tackling the issue. Health Boards were asked to develop Health and Homelessness Action Plans to link with Local Health Plans and Local Authorities' Homelessness Strategies. Underpinning this would be evidence demonstrating the nature of the homeless problem in each area, integral to which would be a 'comprehensive assessment of homeless people's health and healthcare needs'.

Since 2003, the Health and Homelessness Steering Group has been charged with formally assessing the implementation of local action plans. In 2005, they published six standards against which service providers are judged regarding effectiveness. Tackling problem of substance use amongst homeless people is recognised as a public health issue. In 2005 the Homelessness and Substance Misuse Advisory Group was established with the aim of developing approaches for working with problematic drug and alcohol users, affected by or vulnerable to, homelessness (112). The group will promote implementation of effective practice. Research has been commissioned to identify and review available evidence on approaches that produce positive outcomes for people with substance use problems who are homeless or at risk of homelessness. In March 2005 the Scottish Executive published Health and Homelessness Standards. They are a part of a holistic framework to prevent and alleviate homelessness and to improve the health of homeless people. The Standards are strategic and aimed at NHS Boards, recognising the importance of leadership in tackling health inequalities. Substance use problems extend across a wide range of prevention and support services required by vulnerable and homeless people. Actions within the key strategic documents aim to reduce the impact of substance use on homelessness and to tackle homeless peoples' substance use problems.

Homelessness and problem substance use

Homelessness, poor health and problem substance use are inextricably linked (113). Up to 75% of single homeless people have experienced problem substance use, with rough sleepers more likely to do so (114). Problem substance users are seven times more likely than people in the general population to become homeless (115). The chaotic lifestyles led by the homeless substance using population makes providing services difficult. In common with many substance users, homeless people may not prioritise healthcare. From an agency perspective appointments may not be kept, care plans not followed or regimens ignored. From the homeless person's perspective, structural, policy or attitudinal barriers prevent them from accessing substance use services (116).

Legislative changes and policy initiatives have combined to produce a landscape that is now more favourable to homeless people. Also a raft of public health initiatives in the field of mental health and problem substance use promise a new understanding and joint working. Vigilance is nevertheless required at all levels lest these improvements fail to translate into tangible results for homeless substance users.

Issues and solutions

A number of factors must be taken into account in the planning and delivery of problem substance use services to homeless people. These include:

- *Rationale:* services must be informed by the following principles: *prevention* (i.e. stop people developing problem substance use), *amelioration* (i.e. tackle the effects and lessen their impact); and *resolution* (i.e. take people out of problem substance use).

- *Care:* prejudice and discrimination are faced by this population and in turn shape their experience of healthcare and negative attitudes from staff may limit their engagement with services (117). For services to be used effectively, homeless people must be listened to, treated with respect and offered care as well as treatment.

- *Coverage:* homeless people are not a homogeneous group and services developed for them must reflect this diversity. Notwithstanding the need to target difficult to reach groups of homeless people (e.g. rough sleepers), services should seek to integrate service users within existing mainstream services.

- *Setting:* homeless people make contact in a number of settings. Each point of contact should be a gateway to services. All agencies should provide information and seek to refer people on to relevant substance use services via inter-agency protocols. This requires staff to be trained to carry out initial assessment.

- *Access***:** many factors influence access. Behaviours are influenced by knowledge, skill, motivation and opportunity regarding healthcare services. Good information, positive previous experience and confidence in clinical staff will facilitate engagement, while waiting lists, inflexible appointment systems and negative staff attitudes deter involvement (118).

- *Evaluation:* research has provided convincing evidence of measurable effectiveness with programmes such as 'housing first'.

There is a need to develop the research base to inform policy makers. However, researching these areas prospectively presents difficulties and there may be considerable delays in producing meaningful results. An option could be to retrospectively analyse the effects of policies already in place. Data which may be used in such studies is already being collated on a daily basis in the form of

administrative data and it may be that this could give timely information regarding effectiveness (119).

Issues and solutions: Homelessness and housing issues

1. Homelessness and problem substance use significantly adds to the complexity of care delivery.

2. A national drive to address the health inequalities of this group makes it clear that local systems must respond with effective approaches.

3. Governance and accountability processes must ensure this national drive is translated into local, effective service design and delivery.

2.4.2 Legal advice and representation

People with problem substance use come into contact with the legal system in different ways. At critical times they could have many different types of legal action ongoing. Advice might be required about both criminal and civil law. For example, a criminal case may be ongoing alongside an action for eviction.

Substance use can lead to problems with tenancies such as rent arrears or allegations of anti-social behaviour. The sooner the person receives advice, assistance and representation the better the chance of avoiding a situation spiralling to full-scale eviction. A prerequisite is that the legal advisor will act in partnership with other services to ensure the person receives the support required. Debt management or budgeting skills would be part of a package of measures required. It is also essential that problem substance users have access to free legal representation, especially at critical times. In those circumstances, their solicitor should be able to do the necessary legal fire fighting to get a case back on track. For example, in an eviction action if the person does not appear or is not represented and decree is granted then there is a procedure whereby the decree can be recalled and the action starts again. Legal advice and representation may also be necessary in relation to children – representation at a children's hearing or at the Sheriff Court in context of a referral from the hearing or representation at court in an application for residence or contact. It is when a person is at their lowest ebb in relation to their substance use that different areas of their lives may be at risk. It is crucial that they are given opportunities for recovery and that their efforts towards recovery are taken account of and represented within any legal process. This can be facilitated by access to good quality legal advice.

Domestic Abuse

In police recorded incidents of domestic abuse, 91% of those who experience it are female and 91% of perpetrators are men. It can be perpetrated by partners or ex-partners and can include physical abuse, sexual abuse and mental/emotional abuse (120). A study of hospital records found that women who had experienced domestic

violence were 15 times more likely to develop problem alcohol use and 9 times more likely to develop problem drug use (121). There is also evidence showing that rates of problem drug and alcohol use rose after the first episode of violence and may have been a consequence of the problem use (122). Women in violent situations may turn to substances as a form of self-medication and relief from the pain, fear, isolation and guilt associated with violence (123). Research suggests that up to 70% of men who physically assault their partners do so under the influence of alcohol and up to 20% do so under the influence of other substances (124). In this context, a key thread of this document is that consideration of domestic abuse should be integral to planning for services and service delivery. This includes planning for safety; staff training; substance use services working in partnership with specialist domestic abuse; and sexual abuse projects.

Advocacy

Most existing general advocacy services do not treat problem substance use as a separate category but instead it is subsumed within 'mental health' or 'physical disability' (125). Planning in relation to advocacy should include problem substance use as a separate category, based on the specific needs of those affected by substance use. All the principles referring to legal advocacy above apply to general advocacy services.

Issues and solutions: Legal services

1. Problem substance users often need legal support – to be of use it must be free and readily accessible. Ideally specialist services should be available.

2. Domestic abuse is common in this population.

3. Advocacy services need to be organised to address substance use problems specifically as a separate category.

2.4.3 Education, training and employment

Background

The Scottish Government has developed an employability framework – Workforce Plus – which defines employability as 'The combination of factors and processes which enable people to progress towards or get into employment, to stay in employment and to move on in the workplace' (126). This definition can be expanded to include a person-centred process which leads to meaningful activity assisting an individual in their recovery from problematic substance use.

Scotland boasts an employment rate of 76.7%, higher than the UK figure of 74.4%. Anecdotally, drug services in Scotland estimate that 90% of their service users are unemployed with the majority being in receipt of incapacity benefits. The Effective Intervention Unit (EIU) reported that the majority of treatment-seeking drug users are

unemployed (127). The evidence is overwhelming that work is beneficial to health and well-being. Waddell and Burton in their report to the Department of Work and Pensions (DWP) in 2006 stated that 'When people return to employment their health improves. Returning to work from unemployment improves health by as much as unemployment damages it' and 'Being out of work is bad for both mind and body (128). Unemployment progressively damages health and results in more sickness and mental illness. It increases use of medication and medical services and decreases life expectancy'.

The poverty trap

For all excluded groups it is important not to overlook the issue of benefit entitlement and fear of poverty traps that potentially act as barriers to seeking paid employment. As a result of continued lobbying by pressure groups, several developments in UK welfare policy have sought to improve the financial incentive for individuals to engage in paid employment (such as rolling out of 'return to work credit' payable for twelve months to individuals returning to work and earning less than £15,000 a year. From October 2006, people who return to work from incapacity benefits will be able to return to their previous benefits if they become ill again within two years). Benefit rules are currently changing and people are advised to always seek up-to-date comprehensive advice from a welfare rights specialist to help make the informed choice over whether it is financially viable to work (129).

Methadone and employment

Emerging research findings are adding to the anecdotal evidence that those prescribed methadone are confused about what they can do in the workplace. Therefore clear and consistent messages should be given throughout the treatment and care process that use of methadone is not incompatible with work – support and guidance will be provided on managing methadone and other relevant issues in the workplace.

Moving on services

The EIU published extensive material around employability support for drug users reporting that 'most treatment seeking drug users are unemployed; there is a link between positive physical and mental health and employment; and employment can aid the process of recovery from problem substance use'. In its 2003 *Moving On Update* the EIU also identified employability provision as a key element in the overall treatment, care and support for drug users (130). However, it is clear that problem substance users are not sharing in Scotland's growing economic prosperity and with an estimated unemployment rate of 90%, they are not experiencing the increased employment rates and associated benefits (economic, social and health) as the rest of the community. Staff and service users should view accessing employment as an integral part of their treatment and care and not simply an end point to be considered once rehabilitation has been completed. It is crucial that these employability needs are subject to the same assessment, management and audit arrangements as any other aspect of care.

The beneficial effects of employability are well understood and the failure to implement this effectively may reflect a lack of an over-arching governance

framework. To ensure employability is integral to local care management processes we need to effect a series of structural changes to existing systems.

Promoting awareness – assessment

To increase access to employability services and to support all staff in discussing employability aspirations with their clients, all service users should participate in an assessment which includes the core employability questions: What is your current situation in relation to employment, training, education or volunteering? Would you be interested in finding out more about the options you have for employment, training, education or volunteering either now or in the future? What are the things that are stopping you from getting involved in employment, training, education or volunteering? These questions should be asked at the outset of any assessment process to signal that employment is an integral part of treatment and care.

Currently there is no standard method of recording, measuring and reporting on employability referrals. It would be appropriate for all areas to measure and report on the number of people being asked about employment, training, education or volunteering – expressed as a percentage of the total numbers of service users assessed – the number of clients referred to employability services. Performance management and tracking systems should be required to capture this information.

Role of the care and treatment professional

The provider is responsible for responding to employability needs in the same way as any other aspect of treatment and care. However, it would be inappropriate for health and social care professionals to directly provide employability support. Their role remains that of raising the issue with the service user, giving valid advice and dealing with any barriers as they are presented; referring to an employability professional.

Role of the employability services

As part of the Welfare to Work Agenda, employability agencies are now more focused on working with incapacity benefit recipients. It would represent good practice to organize awareness events to ensure that the non-specialist employability agencies have an overview of the needs of problem substance users. Service Level Agreements (SLAs) should also be considered to define roles and responsibilities between employment and treatment agencies and to underpin a quality referral process. To supplement any single shared assessment process, employability needs should also be added to a care plan and review process. The plan can be amended and updated as the person travels through their recovery. The new futures fund initiatives (NFFI) Final Report 2005 confirms the importance of action planning (131). It states: 'There is a strong correlation between whether or not clients meet or make progress towards their action plan objectives and the likelihood of securing a positive destination on leaving the project.' This action plan process would enable progress to be monitored and tracked. However a balance has to be struck between two potential effects of asking employability questions early in the needs assessment process. Establishing needs and aspirational 'wants' can act as a motivator to assist the individual to believe and take ownership of their recovery; BUT – if these aspirations are pushed too quickly and too forcefully, this can lead to excessive pressure to

succeed which itself can feed into a lack of self-belief and can become damaging to the individual's recovery process. It is therefore crucial that treatment and care services continue to provide ongoing support whilst awaiting a response from employability specialist agencies. National and local ppolicy must also reflect the emerging issues in relation to substance users, Hepatitis C and employability (132,133).

Performance Management

Agreeing national employability performance targets and requiring these to be governed by developing accountability/governance systems will further underpin and reinforce the importance of this area of work. Work should be done to set a realistic but stretching employability referral target. This should rise in future years incrementally to reflect developing aspirations of those in contact with services. It may also be appropriate for senior managers within problem substance use services to take on a lead role for employability performance management. This would increase the likelihood that users have access to a full range of employability services. Their role could involve: supporting staff via training and other resources to implement this approach; putting systems in place to monitor performance; developing a case coordinating approach to ensure that employability needs are a key feature of case load reviews; driving forward performance; and challenging underachievement. To support improvements locally, it may be appropriate to include employability within the problem substance use sector as a key Workforce Plus priority.

Issues and solutions: Education, training and employment

1. A range of structural and personal barriers prevent people accessing employability services.

2. Service users and providers must understand and believe in the beneficial effects of employment. Employability awareness training should be included as part of staff induction with ongoing employability training modules forming a key part of professional development.

3. Employability and care and treatment agencies need to work in partnership to enable service users to move forward. Service Level Agreements should be used to define roles and responsibilities and underpin a quality referral process**.**

4. Employability strategy must become more aspirational. Service providers need to become more objective and systematic in approach to Employability. The assessment process should include structured questions about employment aspirations and staff may require additional training.

5. Management and governance arrangements must be addressed to capture data around referral volumes and employability outcomes.

6. To address stigma a marketing/awareness campaign along the lines of the Mental Health *See Me* initiative could engender a more empathetic attitude to people receiving treatment**.**

2.4.4 Social care services for people with problem substance use

Problem substance use services – background and history

Historically, problem substance use services in Scotland were largely non-medical developing across the country from the mid 1980s in response to the growing drug problem and associated threat of HIV infection. These services generally grew around the large urban conurbations and were delivered through voluntary or statutory sector providers depending on funding streams and local circumstances. This lack of uniformity was reflected in funding. Local Authorities and the NHS funded substance use services, but did not have joint management or monitoring functions. Consequently 'disjointed' funding and planning of services is common associated with variable service quality. In recent years, problem substance use services have become more integrated within statutory social work services in some areas, and latterly – in those areas which have adopted the Joint Future agenda – joint social work/health partnerships have resulted in much closer alignment of services with the potential for improved care. The Association of Directors of Social Work (ADSW) Addictions sub-group is concerned that this has led to the re-medicalisation of services where workers had previously recognised the values of a more holistic 'social model' of health.   Understanding that tackling a substance use problem may involve more than just addressing a persons substance use has traditionally been seen as the main strength of social care services.

Statutory social work services

An independent review of social work services in Scotland was published in 2006 – *Changing Lives – 21st Century Social Work Review* (134). From this review three main conclusions were drawn. These were:

- Doing more of the same won't work. Increasing demand, greater complexity and rising expectations means that the current situation is not sustainable.

- Social work services don't have all the answers. They need to work closely with other universal providers in all sectors to find new ways to design and deliver services across the public sector.

- Social worker's skills are highly valued and increasingly relevant to the changing needs of society. Yet we are far from making the best use of these skills.

These conclusions highlight the key issues for social work services, and indicate the range of challenges that face the social work profession in the 21st century. The review also proposed solutions for these problems:

- Tomorrow's solutions will need to engage people as active participants delivering accessible, responsive services of the highest quality and promoting well-being.

- Tomorrow's solutions will involve professionals, services and agencies from across the public, private and voluntary sectors in a concerted and joined-up effort, building new capacity in individuals, families and communities and focusing on preventing problems before they damage people's life chances.

- Tomorrow's solutions will need to make the best use of skills across the public sector workforce, refocusing on the core values of social work and its mission of enabling all people to develop their full potential, enrich their lives and prevent dysfunction. Social workers will need to make effective use of therapeutic relationships and new ways to manage risk.

These solutions are both consistent with much that has been forwarded by the recently published National Quality Standards for Substance Misuse Services (16) and with much that would follow a recovery approach to substance use problems. Social work services cut across a number of specialist areas, and specific issues can be highlighted within the areas of criminal justice, children and families and community care.

Criminal justice

Over the past decade, the criminal justice system has been used to engage a 'hard to reach' group. Rather than being seen as a coercive intervention, it can be better viewed as opportunistic, engaging with people when they come in contact with the criminal justice system. Given the nature of the criminal justice system in Scotland, different drug treatment interventions have been targeted at different stages of the criminal justice system.

Arrest

At the point of arrest, diversion schemes and arrest referral schemes (135) are effective in targeting users prior to sentencing providing basic harm reduction information, referring onto other agencies and liaising with services they may already be known to.

Sentencing

At the point of sentencing as an alternative to custody, Drug Treatment and Testing Orders (DTTOs), drug courts and (in Forth Valley) the Fast Track Programme have targeted people with a prolific criminal history and extensive substance use problem (136,137). Through an intensive form of intervention, using a multi-disciplinary approach monitored within the criminal justice system, these services impact by reducing substance use and related offending behaviour.

Custody

At the point of custody, the Scottish Prison Service (SPS) and throughcare addiction services provide a range of interventions (138). Historically, the SPS detoxified prisoners on admission and provided for their health needs within custody. Increasingly, methadone is being prescribed in the prison setting and this has been shown to be of benefit for those in receipt of this medication (139). Throughcare addiction services aim to facilitate access to services in the community though

research has detected limited impact in its earliest stages (140). Additional funds have now been provided for this type of provision. Given that we are seeing a steady rise in prison populations and consequently, a larger sector of the drug-using community, this type of care is becoming an increasingly important part of overall provision. It is therefore worthwhile to ensure best value for the investment.

SPS Links Centres

In 1999, the Scottish Prison Service (SPS) in conjunction with Apex Scotland, established their first Throughcare Centre in HMP Edinburgh. The term 'throughcare' is used to denote the provision of a range of services to prisoners and their families from the point of sentence up to and following release into the community. These services are primarily focused on assisting prisoners to prepare for release, and to help them to resettle in the community. At induction and pre-release, prisoners are encouraged to visit the centre – a facility which accommodates a broad range of agencies to assist prisoners to make appropriate links with community-based services on their release. Since 2004 the SPS has promoted this model of delivery of interventions and activities and to ensure consistency across all establishments these areas have been branded 'LINKS Centres'.

Integrated Case Management

Within the LINKS Centre, staff and external partners use the Integrated Case Management (ICM) process, encouraging prisoners to engage in the development of a Community Integration Plan (CIP). Prisoners identified with problem substance use often have a range of issues to address. ICM facilitates an integrated package of treatment and care, whereby the CIP aims to provide purpose to the individuals' time in custody by sequencing interventions appropriately according to risk, need and responsivity. The ICM process adopts a case conference approach to assessment and case management. It brings together SPS, criminal justice social work, service providers (eg. substance use treatment, training, skills and employability and housing providers) and the prisoner to discuss their individual risks and needs at regular intervals. The case conference provides a forum within which an action plan can be developed to help the prisoner address issues and difficulties highlighted, whilst identifying the appropriate support organisations required.

Throughcare Addiction Service (TAS)

A key component of voluntary throughcare for short-term prisoners is the Throughcare Addiction Service (TAS). This service seeks to engage prisoners at least six weeks prior to release from custody, to motivate them to address substance use and associated problems, and link them into community-based resources upon release. The service continues through the six-week period post release. During this period, the TAS worker will attempt to motivate the offender to address their difficulties, provide them with information on how to avoid further problem substance use and offending, and link them into appropriate community based services.

Community Links Centre

The LINKS Centre model has been mirrored in the community with the development of the Community Links Centre (CLC) in Edinburgh. Since 2005, the Scottish Association for the Care and Resettlement of Offenders (SACRO) has been piloting a model of service that assists in the support and management of short-term prisoners, returning to the community from the three main prisons serving the Edinburgh area, namely HMP Edinburgh, HM YOI Polmont and HMP and YOI Cornton Vale. This model is recognised as 'good practice' and it hopes to play an important role in contributing to the reduction of re-conviction rates among the short-term prison population and also the number of drug-related deaths within this vulnerable group.

Key factors within criminal justice drug treatment services

There are aspects of these services which should be highlighted. These services have a unique opportunity to engage with people who may otherwise not be known to drug services and through a multi-disciplinary staff team, often co-located and relatively well funded, criminal justice drug treatment services have the resources to effectively engage with people with complex issues. The delivery of effective enforcement of Courts Orders, whilst also developing a therapeutic relationship, is a challenge to all staff. That does not take away from the fact that the delivery of services must be consistent with core social work values and not driven by a punitive policing response from within the criminal justice system. These services must set realistic (intervention) targets for the completion of drug treatment services and must have a clear exit strategy – linking them to partner agencies involved in delivering the next stage of the person's recovery. Even though we have seen a decade of increased funding for drug treatment services within the criminal justice system, we have also witnessed an ever increasing prison population and more needs to be done to support the ever increasing number of people who are returning to prison on a regular basis (141,142).

Children and families

Harm to the children of people with substance use problems has been a political priority in the UK and Scotland for many years. Since the death of Caleb Ness in Edinburgh in 2001 and other high profile incidents in 2005, concern has risen further with the issue of contracts for drug users being explored following the publication of *Hidden Harm – Next Steps* in 2006 (143). These documents and others discussing how to identify and work with children at risk of harm because of their parents' substance use, (144), or how to encourage agencies/communities to take ownership of the protection of children (145), have contributed greatly to discussions on effective working with children and families.

Hidden Harm identified that adult substance use services often failed to identify that service users had children, or to assess how parental substance use might compromise them. Social workers too, were slow to realise the extent to which children living in chaotic households could be at risk of neglect or violence. It has been suggested that the children of adults with alcohol problems are left at risk longer as alcohol is seen as an 'acceptable' drug by society. *Getting Our Priorities Right* (144) and now *Getting It Right for Every Child* (GIRFEC) (145) provide tools on how to identify children at

risk within individual agencies and across partnerships working jointly to assess the extent of that risk and how to devise intervention packages to help build resilience in children and their families.

Assessing risk

Recent contributors (146-149) advocate a more open approach to assessing risk in a way which actively engages with families, identifies strengths as well as pressures and which promotes timely and proportionate action in line with GIRFEC and also concentrating on building resilience. Concern has been expressed about the increasingly punitive stance being taken by government towards drug using parents in particular but this has given way to a more preventative and early intervention approach to engage and work with families to improve their performance as parents. This recognises that issues around care and protection of children are not only about substance use problems but more about issues of fitness to parent which may be influenced by the provision of parenting instruction and support, building greater resilience in families where substance use is an issue. There is also a continuing need to explore and extend alternatives for those children who cannot be looked after by their parents through family group conferencing, kinship care, respite carers and foster carers.

It is evident that the issues for children and families affected by substance use are now in the open and the way ahead clearer. Better identification and early intervention with families, partnership working, information-sharing and co-location of staff from different disciplines will contribute to protecting children from harm.

Issues and solutions: Social care services

1. Services have grown in an 'ad hoc' fashion, with lack of role clarity amongst professionals. There has also been a division between health and social care professionals which has limited progress in the joint provision of services and in important areas such as identifying children at risk from substance use. Co-location of services, combined with the implementation of a Single Shared Assessment and joint training will promote synergy, efficiency of resources and access to services.

2. Criminal justice services for those with substance use problems have a unique opportunity to engage with people who may otherwise fail to be in contact.

3. Improved guidance and practice in terms of the children of substance using parents – in particular to do with increasing family resilience and cohesion – has the potential to significantly reduce risk.

Section 3 – Recommendations

The following recommendations aim to put in place obligations for national and local strategic bodies to ensure that local providers improve access to services promoting recovery from problem substance use. The response to these recommendations will be led at national or local level.

Clearly all national recommendations will also include local implications for action. These will be particularly relevant to local commissioning partnerships and service providers. It is hoped that the Scottish Government's response to these recommendations will take into account the need for robust governance and accountability processes highlighted in the 2007 ADAT review as well as the national quality standards and other key governance documentation relating to professional practice in this field.

Section 1 – Background discussion and evidence

National recommendations

1.   In its strategic approach to problem substance use, the Scottish Government should develop and introduce governance and accountability processes which scrutinize local performance in terms of both reducing harm and promoting recovery. These processes must ensure that *all* elements of care which may be required to support recovery have in place agreed contractual levels of activity and performance monitoring – including relevant outcome measurement.

These governance and accountability processes could be delivered through a national quality improvement unit working in association with reconstituted ADATs.

2.   In its strategic approach to problem substance use, the Scottish Government should require that all areas demonstrate the local availability of a full range of the essential interventions listed in this document and that service providers are engaging service users in approaches aimed at promoting recovery.

3.   In its national strategy, the Scottish Government should bring forward options for establishing a Scottish Problem Substance Use recovery network.

Local recommendations

4.   All service users have the right to a comprehensive assessment of need which will lead to an inclusive recovery plan that is measurable, achievable, realistic and timeous (SMART) in design. The plan will place the service user – the owner of the plan – at its centre; be agreed and signed by both the assessor and service user; and include a timetable for ongoing formal review of changing needs. The plan will be coordinated by a named professional who will be responsible for assisting the person to achieve their goals; arranging, facilitating and recording reviews and updating the plan; and advocating for the service user when required to ensure that their needs are met.

5.   Local strategic planning partnerships should regularly undertake a comprehensive needs assessment including service user views and review of:

- their current care, treatment and rehabilitation provision; and

- available funding and current spending – with a view to informing the future configuration of services.

This must address ring-fenced substance use funding, other ring-fenced resources of special relevance to substance use and 'generic' funding. Any resulting reconfiguration should integrate specialist care and treatment services and the range of essential interventions described in this report. This will require a plan to address workforce development. Best value principles should apply.

Section 2 – Essential services to maximise recovery

National recommendation

6.   The Scottish Government should ensure that problem substance use is addressed explicitly in its national strategic plans addressing general health improvement, health inequalities and social exclusion/regeneration programmes. In response, local health improvement partnerships must have in place a coherent plan which clearly states the priority given locally to issues associated with problem substance use and lays out the local actions which will be taken to address these.

7.   The Scottish Government should bring forward plans to improve primary care involvement in the full range of GMS interventions relevant to problem substance use. Scottish Government plans should include exploration of and the use of the GMS governance arrangements to improve performance and encouraging synergy between the elements of care addressing problem substance use and substance use/BBV.

8.   The Alcohol and Drugs Workforce Development Action Plan should take due cognisance of the need to develop staff in the full range of competencies to assist recovery. Attention should be given to more skill-based approaches dealing with values, attitudes and the delivery of psychological therapies at all levels of staff engagement with service users.

Psychological health – local recommendation

9.   In all areas, comprehensive packages of care – including a range of recognised psychological treatments – should be available locally. Psychological approaches to address the commonly occurring issues of trauma, abuse, sleep disorders, anxiety, depression and anger in the promotion of recovery are seen as a minimum requirement in all areas.

10.   It must be recognised that medical and social interventions may increase fertility. All women attending services must receive care to help them protect and control their fertility to ensure optimal timing of pregnancies.

Housing and homelessness – national recommendation

11.   Mechanisms should be put in place to consolidate a Scottish strategy for integrating local housing, homelessness and problem substance use services. This must include approaches which assist settlement of individuals and the maintenance of tenancies.

Legal – national recommendation

12.   National and local accountability arrangements should require ADATs to describe the mechanisms in place to ensure access to free independent specialist legal advice and representation which has expertise around the specific issues presented by those with substance use problems.

Education, training and employment – national recommendation

13.   In its strategic approach to address problem substance use the Scottish Government should prioritise the development of a robust strategy to improve prospects for employment or meaningful activity. Employability/meaningful activity issues must be part of assessment. Agreeing and setting a national employability referral target with consideration given to incrementally increasing this target to reflect the developing understanding of client aspirations should be a priority. To increase the employment rate of people with problem substance use, all local areas should agree employability performance measures and outcomes, including:

- percentage of service users asked about employment, training, education or volunteering during assessment;

- number of clients referred to employability services; and

- measures of 'distance travelled'. Exploration of the potential for improving employment opportunities within public bodies should be considered.

Social Care – criminal justice – national recommendation

14.   Community Justice Authorities (CJAs) in association with ADATs must have in place a written strategy which describes clearly how targeted criminal justice resources will be used to increase access to treatment services as an option for the courts and for those sentenced to custody. Priority must be given for them to access services on return to the [non-CJS] community.

Social Care – children and families – national recommendation

15.   The role and approach of all services in relation to children of substance misusing parents needs to be explicitly stated to ensure consistency of approach and support across Scotland. Each area will agree and publish the support it offers substance-using parents. This statement will be designed to ensure consistency of approach within the locality and ensure support is available at the earliest opportunity – even before pregnancy; services must publish their confidentiality policy and

informed consent process. Information-sharing between professionals should be in line with good practice (as articulated in GIRFEC). There must be a recognition that the needs of children at risk are paramount.

In conclusion

The working group has acknowledged that, to date services offering care, treatment and rehabilitation for those experiencing problem substance use in Scotland have focussed their activities on achieving the key goals associated with reducing harm – increasing engagement with treatment services, offering replacement prescribing for those who are opiate dependent and retaining people in treatment. Services delivering these interventions are not available equitably, reflecting issues of funding, demand and strategic planning priorities nationally and locally.

Treatment options which have been associated with 'abstinence' outcomes – detoxification and residential rehabilitation facilities – have not been well integrated with these 'harm reduction' focussed approaches and availability of these is extremely limited. Furthermore, treatment options for those not involved with injecting opiate use are of limited availability across Scotland. This fails to recognise that many Scottish substance users are 'poly-drug users' and often use alcohol in association with drugs.

At the same time, services may be reducing options and aspirations. People with substance use problems are at high risk of poor health and social functioning – but have aspirations, like the rest of society, involving happy, healthy families, a nurturing home environment and opportunity to progress through training or employment. Currently, some services dealing with problem substance use may struggle to share these aspirations with service users.

There is a need to change this situation

In other conditions which are characterised by a chronic relapsing course, services must become more person-centred and focus their activity on the needs of their population. In such a system the person is helped to identify their priorities and services are organised around them in an integrated way to assist them to achieve their goals. This 'recovery' approach does not see harm reduction and abstinence as opposing philosophies – but as aspects on the same continuum. There is no reason to believe that a recovery focus will increase harm.

To make this change we require a national philosophy of care which acknowledges the possibility of recovery and a nationally supported, thriving recovery network with the service user at the centre. Local commissioning practice must change and become a systematic process of identifying local need and targeting resources to achieve the best outcomes. Staff should be trained to carry out their functions professionally and effectively and should be working within well-structured safe systems of care. Local and national governance and accountability processes must be robust to ensure delivery.

The working group has listed those elements of care which are seen as 'essential services'. These should be available in all areas. The group has also made clear recommendations which, if actioned, will increase the likelihood that those suffering substance use problems will be able to access the services, support and guidance they need to recover, at whatever stage of their continuum they find themselves.

Appendix 1 – Membership of group

Dr Brian A Kidd (Chair)	Clinical Senior Lecturer in Addiction Psychiatry, Tayside Substance Misuse Services
Annemargaret Black	Head of Mental Health and Partnerships, East Dunbartonshire Community Health Partnership
Martin Bonnar	Operations Manager, Turning Point, Scotland
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Pamela Gowans	Service Manager, NHS Tayside Substance Misuse Services.
Michael Grassom	Forth Valley Criminal Justice
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Mike Hopley	Department of Clinical Psychology, University of Edinburgh
Andrew Horne	Addaction
Kevin Hurst	West Lothian Council
Dave Liddell	Director, Scottish Drugs Forum
Dr Charles Lind	Consultant Psychiatrist, NHS Ayrshire and Arran
Marion Logan	Operations Manager, Scottish Training on Drugs and Alcohol (STRADA)
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Cameron Stark	Consultant in Public Health Medicine, NHS Highland
Ruth Whatling	Justice Analytical Services, Scottish Government
Carole Ross	Drug Policy Unit, Scottish Government, Secretariat
Stella Fulton	Drug Policy Unit, Scottish Government, Secretariat

Other Contributors

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Andrew Brewer	Associate Specialist in Oral Surgery, Department of Oral and Maxillofacial Surgery, Royal Infirmary, Glasgow (Dental Care)
Dr Alex Baldaccino	CARES, University of Dundee (Homelessness)
Dr John Love	CARES, University of Dundee (Homelessness)
Kathleen McGill	Health Improvement and Inequalities Manager, East Dunbartonshire Community Health Partnership (Health Improvement)
Caroline Horn	Physiotherapy Manager, East Dunbartonshire CHP (Benefits of Exercise)
Helen Bennewith	Senior Dietician, Glasgow Addiction Services (Nutrition)

SCOTTISH ADVISORY COMMITTEE ON DRUG MISUSE: Integrated Care Project Group – Wraparound Services Working Group

TERMS OF REFERENCE AND PROJECT OUTLINE

Background

1.   The Scottish Executive's *Review of Drug Treatment and Rehabilitation Services: Summary and Action Plan* made several recommendations for improving the quality and consistency of services around Scotland. To begin this process, Scottish Ministers published *National Quality Standards for Substance Misuse Services* in September 2006 and we are planning to develop an evaluation framework over the next year which will allow services to monitor improvements in their delivery of support. The standards make clear than all the needs of clients accessing substance misuse services should be addressed and that services need to work with a wide range of partners to make sure those needs are met.

2.   A comprehensive resource already exists in a series of documents previously published by the Effective Interventions Unit (EIU). *Integrated Care for Drug Misusers: Principles and Practice* sets out the evidence base and best practice guidance on service integration, whilst a subsequent series of Integrated Care Pathways Guides provides the beginnings of an operational tool to support the delivery of such principles. The Executive sees adoption of the integrated care pathway approach as an essential element of good practice and a major factor in improving treatment outcomes.

3.   The Executive has also launched major policies promoting the integration of service provision which are of great relevance to the long and complicated treatment journeys of many drug misusers. The primary aim of the Joint Future agenda is to improve partnership working, primarily between health and local authorities to deliver services to all community groups. Community Health Partnerships are the main NHS agent through which the Joint Future agenda is delivered, in partnership with local authorities and the voluntary sector. CHPs provide a focus for service integration for local communities, especially between primary care and specialist services and social care.

4.   While there have been many developments towards improving integrated care for substance misusers across Scotland, the rate of progress is not as great as anticipated The main aim of this working group would be to build on current practice to make recommendations on how to accelerate that progress.

Remit

5.   This project group would aim to:

* summarise arrangements for integrated care of substance misusers across Scotland, including identification of good practice examples;

- review developments in operational practice and methods, such as tools for single shared assessment, since previous work by the EIU;

- identify the main barriers which prevent partnership working in provision of support for substance misusers, with particular emphasis on information sharing; and

- provide practical advice on developing integrated assessment, treatment and support.

Scope and methodology

6.   A wealth of evidence and practical guidance already resides in EIU documents and this working group would be expected to build on this material rather than re-examine or repeat any reviews conducted as part of previous work. There will be a need, however, to gather evidence on practical developments since the beginning of 2003. The group may find it useful to adopt a methodology similar to the EIU work, which looked at three components of the integrated care approach: accessibility of services, assessment practice and the planning and delivery of care.

7.   The group is expected to produce a report and short summary of their findings for Ministers with clear and practical recommendations on how the barriers to integrated care identified in the course of the work can be overcome and on any future work that may need to be carried out.

Key outputs

8.   The group is expected to produce a short report for the Deputy Minister of Justice which includes the following:

- Outlines current practice of integrated care for substance misusers in Scotland, identifying the major barriers to development and including examples of good practice of, for example, planning and assessment.

- Practical recommendations for how service commissioners and service providers can, within existing financial support levels, improve the delivery of integrated care, particularly in relation to sharing of information.

- Recommendations for any future work.

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Appendix 4 – The Ten Millan Principles

There are Ten Millan principles which all areas will adopt to guide our work:

1.   Non-discrimination – People with substance misuse problems should, wherever possible, retain the same rights and entitlements as those with other health needs.

2.   Equality – All interventions will be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion, or national, ethnic or social origin.

3.   Respect for diversity – Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group, and social, cultural and religious background.

4.   Reciprocity – Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

5.   Informal care – Wherever possible, care, treatment and support should be provided to people with substance misuse problems without the use of compulsory powers.

6.   Participation – Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully. Information should be provided in a way which makes it most likely to be understood.

7.   Respect for carers – Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

8.   Least restrictive alternative – Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

9.   Benefit – Any intervention should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.

10.   Child welfare – The welfare of a children affected by substance misuse should be paramount in any interventions imposed on the child under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Appendix 5 – Recovery – Formal programmes and services

HINDERS RECOVERY	FACILITATES RECOVERY
Coercion and forced treatment	Forced treatment avoided
Treatment and/or medication used as a means of social control	Freedom of whether and how to participate in services and meds/self management of medications
Debilitating effects and experiences of long term hospitalization	Inpatient services last resort, but available and small scale/alternatives to hospitalisation/self directed inpatient care
Sub-standard services/poor Quality Assurance	Quality clinical care/consumer-doctor partnership/up to date treatment knowledge/clean and modern programme environments
Limited access to services and supports/not timely/time Limits	No waiting/flexible
Fragmentation of services, eligibility restrictions	Coordinated services across problems, settings and systems/effective case managers with low caseloads and high pay/disengagement or reductions in services based on consumers self directed needs
Lack of individualisation	Tailored to Individual/wide range of choices as to who provides, what and where is provided
Lack of needed range of services, treatments and options	Peer support services/therapy and counselling/'atypical' meds (treatments)/family services/employment support and career development/respite care/integrated dual diagnosis services/jail diversion and community reintegration services
Lack of education for consumers, family members and community	Patient education /illness education/information on meds/effective treatment services and how to secure rights info/family education/public awareness education (anti-stigma and pro-recovery)
Inadequate continuity of care	System navigators/extensive outreach and support (multiple languages, 24hr, minority focused)/homeless outreach /safety net services
	Access to records/can change inaccurate information
	Early intervention and public screenings/outreach to churches, schools, communities

Appendix 6 – Recovery – Organisational culture

HINDERS RECOVERY	FACILITATES RECOVERY
Culture and organisation that is pathology focused, illness focused/dominance of medical model	A recovery orientated system with a vision of recovery/extending support beyond traditional boundaries/consumer driven
Lack of change and innovation	Encourage innovation/de-fund or transform ineffective practice and programmes
Lack of holistic orientation	Holistic approach/pro-active approach supporting preventative measures/positive mental health
Access limited to those in crisis, system promotes dependency/ paternalism, maternalism	Multiple strategies, self responsibility/fostering growth and interdependence/assistance with letting go of dependency on system
Stigma within the system	Fully committed to consumer voice/support risk taking/freedom to fail
Social segregation	More tolerance for diversity and unusual behaviour
Funding problems	Adequate funding and equitable distribution of resources/monies re-invested in community/voucher system
Lack of consumer voice on personal and system levels	Consumers employed within system at all levels/consumers involved in decision making processes such as staff hiring and firing/mandated consumer positions on boards and committees/office of consumer affairs/ombudsman programme