

Outcomes Framework for Problem Drug Use

October 2014

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Introduction

In this section:

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- Outcomes framework for problem drug use and a focus on health inequalities
- Summary of the development process
- How to use the framework

Background and context

Scotland's national drugs strategy, *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*, was launched in May 2008 (Scottish Government 2008) and affirms that it is essential to recognise the impact of action that a wide range of policies will have in tackling the factors associated with problem drug use. The policy clearly states the association between socio-economic disadvantage, deprivation and health inequalities and progression to problem drug use. The strategy focuses on recovery and reinforces the message that services should support people to move on towards a drug-free life, as active and contributing members of society.

A set of Core Outcomes and Indicators¹ for Alcohol and Drug Partnerships (ADPs) have been agreed between ADPs, COSLA and the Scottish Government. These outcomes and indicators support the embedding of outcomes-based planning and reporting at local level, helping ADPs to self-assess their performance (including benchmarking against other ADPs) and to articulate their contribution to their local Single Outcome Agreement(s). They also help provide a national picture of progress in alcohol and drug prevention, support and treatment.

The development of a full outcomes framework for problem drug use was agreed with Scottish Government as part of NHS Health Scotland's support to ADPs. Aligned to *The Road to Recovery*, using an evidence-informed approach the outcomes framework aims to inform effective action and demonstrate progress against the national strategy and partners' collective contribution to achieving common national outcomes.

Drug Misuse Information Scotland, managed by NHS Information Services Division (NHS ISD) on behalf of the Scottish Government, brings together information,

¹ See Appendix A and Scottish Government website for further details:
www.scotland.gov.uk/Resource/0039/00394539.pdf

statistics and research on drugs misuse in Scotland. Available online:
www.drugmisuse.isdscotland.org

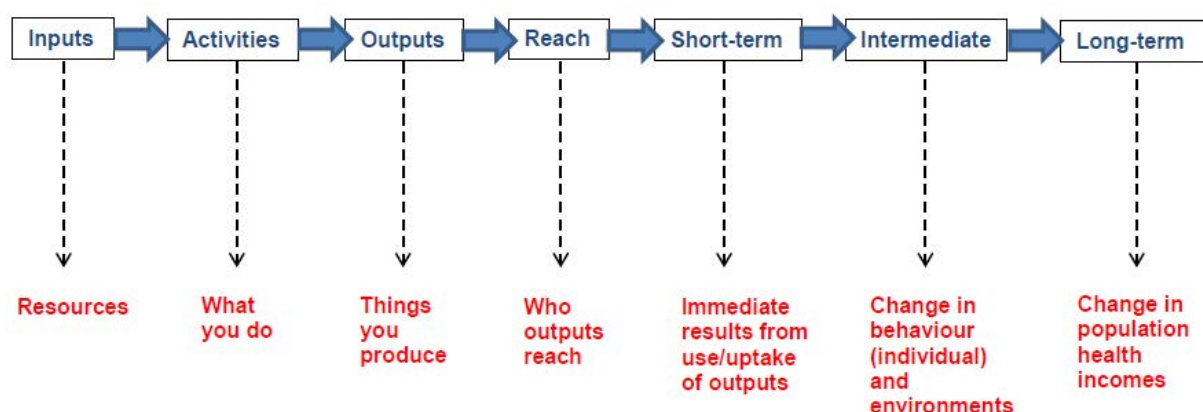
In the context of national estimates, problem drug use is defined by NHS Information Services Division (ISD)² as the problematic use of opiates (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines and implies routine and prolonged use as opposed to recreational and occasional drug use.

Outcomes-focused approaches and resources for health improvement

To support the move towards outcome-focused approaches set out by the Scottish Government in the National Performance Framework,³ NHS Health Scotland with partners are developing a set of resources⁴ to articulate the contribution of stakeholders to delivering health improvement outcomes. The development of an outcomes framework for problem drug use forms part of this wider programme of work and was agreed with the Scottish Government Drugs Policy Unit.

An Outcomes Framework details the logical sequence of expected changes in achieving progress towards improved health and social outcomes, in this case for those affected by problem drug use. Logic models provide a *simplified* illustration of how activities are understood to contribute to a chain of change to achieve the intended outcomes. The outcomes framework can be used and amended to fit local needs. The logic models can also help partners clarify the links between the outcomes of the services they provide and the shared outcomes that they are working with partners to achieve.

The core component is **the simple cause-effect chain** of inputs-outputs-outcomes, sometimes referred to as a 'results chain':



² www.drugmisuse.isdscotland.org/publications/local/prevalence2009_10.pdf

³ www.scotland.gov.uk/About/Performance/scotPerforms

⁴ Resources for tobacco, alcohol, health at work, mental health and healthy weight are available online www.healthscotland.com/OFHI/

Evidence shows how short-term outcomes influence intermediate and long-term outcomes, which can help to identify the most appropriate outcomes to focus on. Multiple, inter-related results chains (illustrated in outcomes frameworks) demonstrate complicated programmes and defined indicators to enable partners to determine progress towards these outcomes and longer-term goals.

Long-term or strategic outcomes are concerned with population health outcomes. Some relate to general health outcomes, such as reduced prevalence of drug use; others relate specifically to people who use drugs such as sustained recovery.

Intermediate outcomes are changes in the determinants of these high level long-term outcomes. These may be individual health behaviours, social economic and physical environments that shape these behaviours; or aspects of the environment with direct health consequences.

Short-term outcomes are the more immediate results of service delivery and reflect the contributions of specific organisations, partnerships, services or programmes.

The Outcomes Framework is designed to help Community Planning Partnerships (CPPs) develop the outcomes-focused approach to planning and performance announced by Scottish Government in the Spending Review (Scottish Budget Spending Review, 2007). It has also been created to support policymakers, planners, evaluators and researchers. Outcomes are the focal point of logic models. Logic models clarify the activities which can be undertaken and which population group can be targeted to achieve a desired outcome. Logic models also map out the time sequence in which the outcomes need to be achieved.

Monitoring and evaluation

Logic models are not intended to be prescriptive about the services and interventions that should be provided locally. Local judgement should be exercised on the range of services that would be most appropriate and affordable in light of local circumstances and needs. Partners need to interpret them for local use and decide whether the arguments are plausible enough. At least if the rationale is explicit, it can be challenged; if the theory of change is explicit, it can be tested. Evidence underpins the models where it is available but is not a limiting factor. Where evidence is lacking or limited, the models present supporting plausible theory.

In this way, the process of developing a logic model can also help identify and prioritise key elements or links in the model that should either be monitored or evaluated. For example, if strong evidence of effectiveness already exists for a particular link then basic monitoring may be all that is required. However, if there is a lack of effectiveness evidence for a particular link (and it is consequently based mainly on plausible theory) this might be an area where further evaluation research

is required. Subsequently, information from monitoring or evaluating the programme should be used as a basis for learning and further adapting the models.⁵

Outcomes framework for problem drug use and a focus on health inequalities

The outcomes framework for problem drug use in Scotland is currently aligned to the priorities in *The Road to Recovery*. Building on the ADP Outcomes Toolkit (2009)⁶ the strategic outcomes logic model has mapped the agreed ADP Core Outcomes in order to demonstrate their role in contributing to the delivery of the national strategy and national high-level outcomes defined in the National Performance Framework.

The premise of the national policy, *The Road to Recovery*, is to tackle problem drug use by fully addressing the needs of people affected. Based on the concept of recovery, the policy sets out a programme of reform in the way that drug services are planned, commissioned and delivered to support people with problem drug use, to help them recover and rebuild their lives.

Informed by the widely accepted association between deprivation and vulnerability to problem drug use the outcomes framework is based on the principle of proportionate universalism. This concept has been defined in a recent briefing by NHS Health Scotland⁷ as:

‘resourcing and delivering universal services at a scale and intensity proportionate to the degree of need. Thus services are universally available and not only for the most disadvantaged, and are able to respond to the level of presenting need’.

The briefing describes that planning for proportionate universalism will:

‘require an assessment of need and understanding of the impact of social inequalities on health outcomes, as well as a judgement as to how much additional resource should be allocated per ‘unit’ of additional need (the weighting)’.

It is intended that the framework provides a planning resource for the design and delivery of services based on local assessments that determine the level and extent of needs of different groups to inform a targeted approach.

⁵ For a full exploration of how outcomes frameworks seek to link evidence, planning and evaluation of complex programmes please see: Craig (2013) Seeing the wood and the trees: using outcomes frameworks to inform planning, monitoring and evaluation in public health. *Journal of Public Health*. 2013; 35(3):467–474. <http://jpubhealth.oxfordjournals.org/content/35/3/467.abstract>

⁶ See Scottish Government website: www.scotland.gov.uk/Publications/2009/04/23084349/1

⁷ Macdonald W. Beeston C. McCullough S. (2014) *Proportionate universalism and health inequalities*. Edinburgh: NHS Health Scotland.

The purpose of the Outcomes Framework is to identify key outcomes for problem drug use and outline which activities can be carried out to achieve them based on evidence or plausible theory. The framework does not try to explain all of the interactions between activities and outcomes. The framework does not depict the true complexity of problem drug use; it only attempts to clarify some of the key paths to achieving intermediate and long-term outcomes in an attempt to illustrate that interactions occur between components of the response as well as between the response and the delivery context of settings and services and for individuals within the system as outcomes and activities are linked. Ultimately, the framework is a resource for policymakers and planners to help them clarify what outcomes they want to achieve and what can be done to achieve those outcomes. The framework presents a snapshot of what is currently known about problem drug use. It will be reviewed and updated to reflect changes.

The high-level outcomes in the outcomes framework define four areas of focus: Prevention, Recovery, Families Affected and Enforcement. It is intended that the related short-term outcomes described in the nested logic models for each area highlight where services can demonstrate their influence and show progress over the next three to five years towards these longer-term outcomes.

The aim of the rationale documents that accompany the nested logic models was to map available evidence that relate to the links and pathways between the stated outcomes, with a view to highlighting effective interventions and initiatives supported by policy and practice guidance. The aim was not to retrospectively set out current delivery but rather to provide a tool for planning in identifying the direction of travel for commissioners and area partnerships to determine service delivery based on local needs assessments.

The evidence review relied on existing sources of evidence and Scottish or UK specific literature and key studies and is not necessarily a comprehensive critical appraisal of all the material. There are gaps in the evidence pathways sometimes supported by plausible theory and emerging practice. Rather than being the definitive account of the evidence on interventions for problem drug use, it is intended that the Outcomes Framework offers an indicative account of where evidence exists and remains a work in progress to be developed and updated from learning through practice and emerging research. Over time we anticipate that further research will enable areas where little evidence is available to be strengthened and the model modified and refined to reflect the changes in our understanding of problem drug use.

Health inequalities impact assessment

Health inequalities are systematic differences in health between different groups within a society, which are avoidable and unfair. All public sector and many private sector agencies have a contribution to make to reducing health inequalities. Health

inequalities impact assessment (HIIA) is a tool⁸ which offers an integrated approach to impact assessment encompassing legally protected characteristics⁹, human rights¹⁰, wider population groups and social determinants of health. The main aim of HIIA is to strengthen the contribution of policies and plans to reducing health inequalities by improving equity of access, ensuring non-discriminatory practice and acting on the social determinants of health.

HIIA encompasses all legal requirements associated with equality impact assessment (EQIA) but additionally seeks to define the likely impacts of a policy in relation to health and human rights and the population groups who will bear them. This provides a means to systematically consider the extent to which the policy can mitigate, prevent or undo inequalities. The assessment should aim to identify unintended consequences of a policy that may increase inequalities as well as to proactively plan to reduce inequalities.

For the purposes of the problem drug use outcomes framework the rationale and validation process of the links in the nested logic models has, where possible, given due consideration to HIIA. Consequently as part of the rationale documents, a summary note on 'HIIA' is included where any characteristic(s) of participants or vulnerable groups have specifically been identified within the evidence that has informed the development of this Outcomes Framework.

In addition, there are a number of rights from the Human Rights Act that may be engaged by the actions taken to deliver in the areas of prevention, recovery, families affected and enforcement. These include the right to Life (Article 2, ECHR); Freedom from ill-treatment (Article 3, ECHR); Liberty (Article 5, ECHR); Fair hearing (Article 6, ECHR); Private and family life (Article 8, ECHR); Freedom of thought, conscience and religion (Article 9, ECHR); Freedom of expression (Article 10, ECHR).

It is intended the HIIA process supports transparent decision-making. NHS Health Scotland encourages policymakers and practitioners to carry out HIAs on strategies and interventions which are developed using the outcomes framework. HIIA helps to raise questions about how proposed policies or activities will impact on the fundamental causes, wider environmental influences and individual experiences of health inequalities. Through adopting a human rights based approach, HIIA can be used to stimulate discussion and action to achieve the highest attainable standard of health for everyone.

⁸ NHS Health Scotland's full impact assessment guidance materials are available online: www.healthscotland.com/equalities/hiaa/index.aspx

⁹ For full details see the Equality Act (2010), available online at: www.legislation.gov.uk/ukpga/2010/15/contents

¹⁰ For full details see the Human Rights Act (1998), available online at: www.legislation.gov.uk/ukpga/1998/42/contents

NHS Health Scotland's Equality Team offers the following practical support:

- Awareness-raising sessions on the HIIA approach, delivered locally
- Support for local teams to carry out a HIIA, including co-facilitating workshops to help staff and key stakeholders consider the impact of a policy, service or decision
- Organisational expertise in the interpretation and use of evidence
- Sharing examples of application of the approach in Scottish Government and NHS Boards.

NHS Health Scotland full impact assessment guidance materials are available online: www.healthscotland.com/equalities/hiia/index.aspx

Summary of the development process

A collaborative approach was adopted in developing the Outcomes Framework. The work was initiated with a national development group comprising NHS Health Scotland, the Scottish Government, Alcohol and Drug Partnerships, Community Justice Authority and third sector national agencies.

A draft strategic logic model was agreed to demonstrate the long-term desired direction of travel. Following a national consultation with stakeholders, a distilled version was produced based on the feedback received. These intermediate and long-term outcomes formed the basis of developing the nested logic models to identify the required short-term outcomes to achieve these aims. The logic models for Prevention, Recovery, Families Affected and Enforcement were developed at a national development event with key stakeholders from across Scotland.

Once the draft models were agreed, a review of the key sources of evidence and plausible theory was undertaken to refine and validate the links between the various components of the models. The Outcomes Framework (the logic models and rationale documents) was revised and finalised following feedback from an external expert review.

How to use the framework

The Outcomes Framework for Problem Drug Use supports the national policy by communicating pathways to achieving the desired outcomes and meet aspirations set out in *The Road to Recovery*. As a common framework for action, using an evidence-informed approach, the logic models identify broad needs. The outcomes framework is not a *fait accompli*; it represents our best understanding of problem drug use at this point in time and involves a process of reflection and continual improvement.

The outcomes frameworks and the logic models that underpin them can be used in various ways by different stakeholders, enabling planning in local areas to be more systematic and evidence informed – with local plans based on local adaptations of the outcomes frameworks. The models may shape a monitoring and evaluation programme assessing a range of health and non-health outcomes identified in local strategies. The Outcomes Framework will need to be reviewed regularly and locally modified to reflect local priorities as we continue to understand more about problem drug use over time.

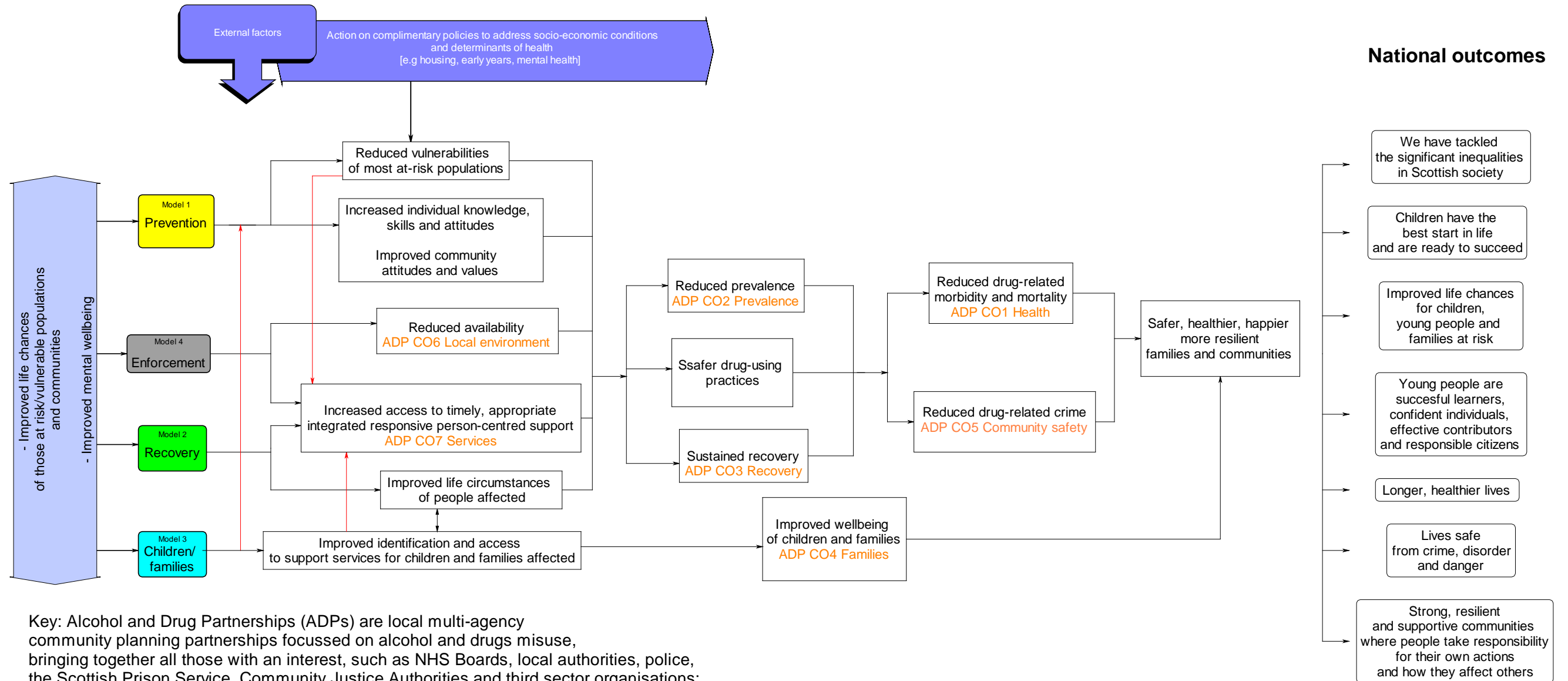
The finalised Outcomes Framework will be disseminated to ADPs via Chairs and Coordinators and the resources published online on NHS Health Scotland's dedicated outcomes framework website: www.healthscotland.com/OFHI/

Additional planning resources are also available here:
www.healthscotland.com/OFHI/Resources/Resources_planning.html

The next steps will be considered based on uptake by stakeholders, for example, it may prove useful to provide links to the indicators with which to measure outcomes and map the indicators agreed for the ADP Core Outcomes and the recovery indicators identified for the new national Alcohol and Drug Information System (DAISy) currently in development by NHS Information Services Division on behalf of the Scottish Government to support monitoring and evaluation.

Strategic outcomes for problem drug use (October 2014)

Please note: coloured arrows only indicate where lines cross



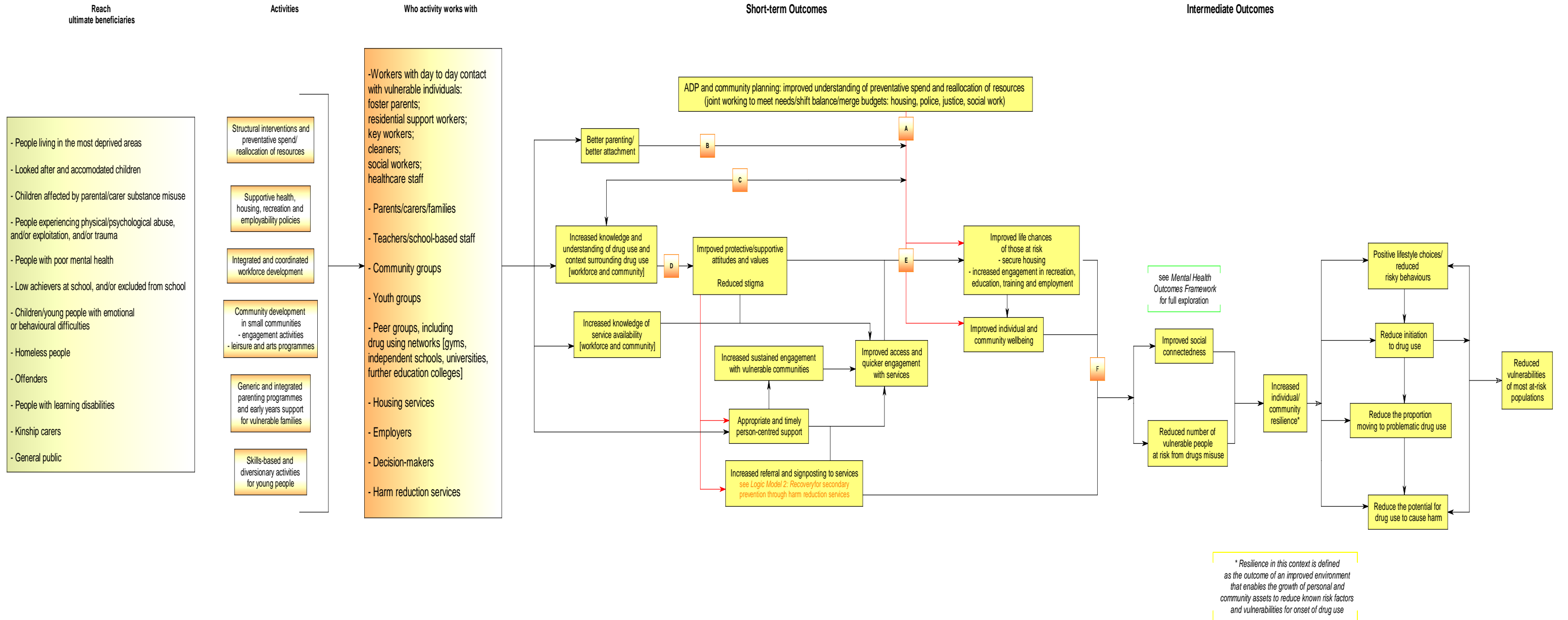
Key: Alcohol and Drug Partnerships (ADPs) are local multi-agency community planning partnerships focussed on alcohol and drugs misuse, bringing together all those with an interest, such as NHS Boards, local authorities, police, the Scottish Prison Service, Community Justice Authorities and third sector organisations;

ADP Core outcomes: A set of core outcomes and indicators for Alcohol and Drug Partnerships has been agreed between ADPs, COSLA and the Scottish Government.

1. Health
2. Prevalence
3. Recovery
4. Families
5. Community safety
6. Local environment
7. Services

**Problem Drug Use Outcomes Framework
MODEL 1: Prevention**

Please note: red coloured arrows only indicate where lines cross



Logic Model 1: Prevention

Introduction

This section should be read in conjunction with the 'Prevention' nested logic model developed for the *Outcomes Framework for Problem Drug Use*. The framework comprises three other nested logic models (for recovery, families and enforcement) brought together by an overarching strategic outcomes logic model. The outcomes were defined by stakeholders in line with national development needs and the Scottish drugs strategy (*The Road to Recovery*).

This rationale document summarises the available evidence to support the desired outcomes described in the model. The relevant links in the chains have been lettered (A to E) and reflected in the model for ease of reference. Where available, evidence has been drawn from key sources: National Institute for Health and Care Excellence (NICE) public health guidance (and relevant NHS Health Scotland Commentaries/ Scottish Perspectives); NICE and Health Development Agency (HDA) public health briefings; Scottish Intercollegiate Guidelines Network (SIGN) clinical guidelines; the Cochrane Collaboration and the University of York Centre for Reviews and Dissemination. We have called this information 'highly processed evidence'.

Additional sources of evidence and theory have been drawn from relevant key systematic reviews and literature reviews and reports commissioned by the Scottish Government, the UK Government and national organisations and collaborators. Further papers were identified in conjunction with lead stakeholders and topic experts. Scottish policy and practice notes from national strategies and guidance documents are also cited. References are provided for further information.

Health inequalities impact assessment: health inequalities are systematic differences in health between different groups within a society, which are potentially avoidable and deemed unacceptable. All public sector and many private sector agencies have a contribution to make to reducing health inequalities. A health inequalities impact assessment (HIIA) is a tool which offers an integrated approach to impact assessment encompassing legally protected characteristics, human rights, wider population groups and social determinants of health. The main aim of an HIIA is to strengthen the contribution of policies and plans to reducing health inequalities by improving equity of access, ensuring non-discriminatory practice and acting on the social determinants of health.

All new public sector policies and programmes must be impact-assessed to meet the requirements of the Equality Act 2010 (Specific Duties) (Scotland) Regulations

2012.¹ As a planning tool, this outcomes framework is intended to guide the development of local and national interventions. Accordingly, for the purposes of the framework, the rationale and validation process of the links in the nested logic models has, where possible, given due consideration to the HIIA. A summary 'HIIA note' highlights where identified protected characteristics or vulnerable groups were featured in the evidence.

Further information is available in the introductory narrative of this outcomes framework and NHS Health Scotland full impact assessment guidance materials are available online: www.healthscotland.com/equalities/hiaa/index.aspx

National Policy Driver – *The Road to Recovery (2008)*

The Scottish Government national drugs strategy, *The Road to Recovery: a new approach to tackling Scotland's drugs problem (2008)*, states that it is essential to recognise the impact of action that a wide range of policies will have in tackling the factors associated with problem drug use. The policy clearly states the association between socio-economic disadvantage, deprivation, health inequalities and progression to problem drug use.

On preventing drug use, the policy outlines a range of complex underlying factors associated with drug use, including recognition that drugs are a symptom and a cause of health inequalities. Action to address these is focused as follows: the Scottish Government's economic strategy for increased and more balanced growth across Scotland to tackle poverty, *The Early Years Framework* to strengthen parenting and family capacity, creating supportive communities, and integrating services to meet holistic needs of children.

Other key areas identified are to address cross-cutting issues such as mental health and homelessness. Information and education, particularly for young people, is also outlined in the policy; for example, the Curriculum for Excellence seeks to develop qualities of resilience and adaptability through values, attitudes, knowledge and understanding to make informed decisions. There is a commitment to drug information and awareness campaigns to provide credible and factual information to increase knowledge of consequences of drug use and promote positive lifestyles, including accurate information for parents/carers to enable them to communicate effectively with their children. In addition, the policy makes specific reference to promoting inclusion at key transitional stages in a young person's life.

¹ Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012: www.legislation.gov.uk/sdsi/2012/9780111016718/contents

Key prevention-related outcomes defined in the strategy at the time of publication:

- Enhance life chances and incentives to those in the most deprived communities.
- Reduce health inequalities.
- Children that are successful, confident learners, effective contributors and responsible citizens and therefore less likely to develop problem drug use.
- More people have access to credible and accurate information about the use of drugs.
- Improved life chances for children, young people and families, especially those at risk.
- People live longer, healthier lives and communities are safer and stronger.

Additional policy contexts include:

- *Achieving our Potential – a framework to tackle poverty and income inequality in Scotland* (2008)
- *Equally Well – the report of the ministerial task force on health inequalities* (2008)
- *The Early Years Framework* (2009)
- *The Mental Health Strategy* (2012–2015)
- *Report of the Ministerial Task Force on Health Inequalities* (Equally Well Review: 2013)

Evidence and supporting rationale for prevention outcomes

A Evidence for joint planning and preventative spend across community planning

In a briefing to the Financial Scrutiny Unit, preventative spend is defined by Scottish Parliament Information Centre as ‘public spending over the longer term that aims to prevent rather than deal with negative social outcomes’ (2010 p. 4).

SPICe. *Preventative spend – literature review*. Edinburgh: Financial Scrutiny Unit Briefing; 2010.

www.scottish.parliament.uk/SPICeResources/Research%20briefings%20and%20fact%20sheets/SB10-57.pdf

An evidence review conducted by David Best and colleagues (2010) following publication of the national drug strategy highlighted the strong link between problem drug use and deprivation, suggesting that tackling deprivation, poverty and widening inequalities (for example in housing and employment) could have a positive impact on prevention and recovery.

Best et al. *Research for Recovery: A Review of the Drugs Evidence Base*. Edinburgh: Scottish Government; 2010.

Based on Sally MacIntyre's framework of guiding principles for effective policies and interventions to address health inequalities for the 2008 Ministerial Task Force, interventions assessed as most likely to have some impact on health inequalities include action on the social determinants of health; structural changes in the environment; legislative and regulatory controls; fiscal policies; income support; reducing price barriers; improving accessibility of services; prioritising disadvantaged; offering intensive support, and starting young.

Macintyre S. *Inequalities in health in Scotland: what are they and what can we do about them?* Glasgow: MRC Social & Public Health Sciences Unit; 2007.

The theory of causation presented in NHS Health Scotland's *Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities* articulates clearly how inequalities arise. Given the established vulnerabilities associated with problematic drug use encountered through the experience of deprivation and poverty, the theory of causation further identifies how wider (economic, physical, learning, services, social and cultural) environmental influences impact on individual experience of disadvantage, creating less of a choice and more a response to these wider factors.

The *Health Inequalities Policy Review* states 'Physical and social environments shape the options available to individuals and choices they take, meaning that even "lifestyle" factors have to be interpreted on the basis of the contexts in which they arise.' (2014, p. 24). Thus, the ability of individuals and families to live in ways that create and sustain health is influenced by factors largely beyond their control. Action so far has largely been to mitigate the consequences of inequalities.

The *Health Inequalities Policy Review* draws on conclusions from the Christie report *Commission on the future delivery of public services* (2011), the Scottish Parliament Finance Committee Report on Preventative Spend (2010) and the Audit Scotland report *Health Inequalities in Scotland* (2012) to emphasise the importance of preventative spend both as a means of reducing the potential future demands on health and social care and as a means of tackling health inequalities.

NHS Health Scotland. *Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities*. Edinburgh: NHS Health Scotland; 2014.

HIIA note: Those experiencing inequalities and disadvantage are the specific focus of the literature.

Scottish policy and practice note:

The Scottish Government national drugs strategy, *The Road to Recovery: a new approach to tackling Scotland's drugs problem* (2008) highlights the Government's economic strategy as a means to increase sustained economic growth, to be achieved through improving learning; skills; wellbeing; creating supportive business environments; developing infrastructure and greater equity through a closer more effective partnership between central and local government.

Drawing from *Equally Well* (2008) this is further highlighted in NHS Health Scotland's *Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities* (2014). The review affirms that achieving better joint working across agencies and services as well as involving local communities and target groups are seen as the cornerstones for successful delivery on health inequalities. The policy review states these principles are embedded in the *Equally Well* report (2008) and the Review of Community Planning in 2012, as well in recommendations from the Christie Commission (2011) – the report on the Future Delivery of Public Services by the Commission. The policy review further articulates a need to shift focus away from meeting the cost of dealing with health and social problems after they have developed to prevention and early intervention.

The *Early Years Framework* (2009) focuses on building parenting and family capacity, creating communities that support the positive development of children, delivering integrated services that meet children's holistic needs and developing a workforce to deliver this. *The Early Years Framework* defines early years as pre-birth to eight years old in recognition of the importance of pregnancy in influencing health, social, emotional and cognitive outcomes for children and families. The framework, which is based on principles of early intervention and the tailored delivery of services, outlines the steps that the Scottish Government, local partners, and practitioners in early years services need to take to maximise positive opportunities for children so that they get the best start in life. Available from: www.scotland.gov.uk/Publications/2009/01/13095148/0

Summary: There is plausible theory from review-level evidence and Scottish specific reports to support the link between preventative spend, tackling poverty and inequality to prevent problem drug use by enhancing life chances.

B Evidence for parenting and the early years interventions

There is highly processed evidence from NICE Public Health Guidance on social and emotional wellbeing in the early years (NICE PH40) that supporting the social, emotional and cognitive development of children can improve long-term outcomes. Although limitations in the evidence were noted, the authors concluded that there is potential for interventions with vulnerable preschool children to be cost effective and cost saving.

NICE PH40 Recommendations include:

- all those responsible for planning and commissioning (including joint commissioning) services for children aged under five in local authorities, the NHS (primary, secondary and tertiary healthcare) and the voluntary, community and private sectors should ensure the social and emotional wellbeing of vulnerable children under-five is assessed as part of the joint strategic needs assessment, with integrated commissioning of universal and targeted services for children aged under five. This includes vulnerable children and their families.
- identifying vulnerable children and assessing their needs (developing a trusting relationship; working with strengths and capabilities of the family; understand and respond to needs and concerns; sensitively discuss risks).
- antenatal and postnatal home visiting for vulnerable children and their families.
- early education and childcare.

NICE. *NICE public health guidance 40 Social and emotional wellbeing: early years*. London: NICE; 2012.

<http://guidance.nice.org.uk/PH40/Guidance/pdf/English>

HIIA note: The guidance is for working with children aged under five years. The term 'vulnerable' is used to describe children who are at risk of, or who are already experiencing, social and emotional problems and who need additional support. In this guidance, vulnerable children include those who are exposed to: parental drug and alcohol problems, parental mental health problems, family relationship problems, including domestic violence, criminality. They may also include those who: are in a single parent family; were born to parents aged under 18 years; were born to parents who have a low educational attainment; were born to parents who are (or were as children) looked after (that is, they have been in the care system); have physical disabilities or have speech, language and communication difficulties.

NHS Health Scotland's Briefing on attachment,² describes attachment as the bond from a child towards their parent or primary caregiver. The briefing cites John Bowlby's theory of attachment (*Attachment and Loss: Vol.1 Attachment, 1982*) that

² Briefing available on NHS Health Scotland's website:
www.healthscotland.com/documents/5755.aspx

defines attached as ‘the disposition of the child to seek proximity to and contact with a specific figure and to do so in certain situations, notably when he is frightened, tired or ill.’

The briefing outlines that there are links between an infant’s attachment style and their later social and emotional outcomes. Secure attachment in infancy is associated with positive outcomes including self-esteem, self-confidence, emotional regulation, resilience and more harmonious relationships in childhood and early adulthood. While attachment style may be a risk or protective factor, this association is not deterministic. Other factors, for example, social support or life stress are likely to mediate this influence (from Sroufe 2006, Prior and Glaser, 2006 cited in *ibid*).

The briefing details evidence on effective strategies for promoting secure attachment in young children:

- The most effective interventions specifically focus on improving sensitive maternal behaviour (as opposed to those which are broader in focus).
- Interventions that are effective in enhancing parental sensitivity are universally effective (including high-risk populations).
- The most successful interventions are brief (fewer than 5, or 5–16 sessions) and behaviourally focused.
- The majority use home visiting as the mechanism for delivery.
- Providing information to new parents on the sensory and perceptual capabilities of their infants appears to enhance maternal responsiveness and parental interaction with their babies.

Scott E. *Briefing on attachment*. Edinburgh: NHS Health Scotland; 2011.

There is review-level evidence that intensive structured support to vulnerable mothers during the first 18 months of a child’s life, delivered by specialist nurses, is effective and cost-effective, in improving social and emotional development of vulnerable children.

NHS Health Scotland. *Evidence summary: Interventions to support parents, their infants and children in the early years (pregnancy to five years)*.

Edinburgh: NHS Health Scotland; 2012.

[www.healthscotland.com/uploads/documents/19955-](http://www.healthscotland.com/uploads/documents/19955-ParentingInterventionsPregnancyTo5Years%20amended%20151112.pdf)

[ParentingInterventionsPregnancyTo5Years%20amended%20151112.pdf](http://www.healthscotland.com/uploads/documents/19955-ParentingInterventionsPregnancyTo5Years%20amended%20151112.pdf)

HIIA note: Parents, their infants and children in the early years – pregnancy to five years

There is limited highly processed evidence from *NICE public health guidance 4: Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people*. A good deal of the evidence reviewed was insufficient or inconsistent in its findings to enable firm conclusions in relation to

the effectiveness of programmes in preventing drug use among vulnerable and disadvantaged young people. However:

- Among young people with multiple risk factors, evidence suggests that multi-component community-based approaches and family-based interventions are effective in improving substance misuse behavioural outcomes.
- Among black and minority ethnic populations, most evidence is insufficient or inconsistent. However, evidence from one review does suggest that incorporating refusal skills training in drug prevention programmes improves effectiveness in reducing substance use.
- Parenting interventions in combination with drug treatment are effective in improving parenting skills and reducing parental drug use in families with drug use problems. However evidence suggests that home visitation makes no difference on a number of child and parental outcomes among families with substance using members.
- Among young substance users, there is strong evidence that family therapy following treatment is effective in reducing substance use and improving social behaviours. Skills training for parents is effective in reducing cannabis use among young substance users and in improving parental coping.
- Among young people with behavioural and aggressive problems, multi-component parent and child programmes have been found to be effective on a range of child outcomes.
- For young offenders, multi-systemic therapy can be effective at reducing soft drug use and reducing reoffending.

Recommendations in the guidance³ include:

- the need for local-area based strategies to be developed and implemented to reduce substance misuse among vulnerable and disadvantaged young people aged under 25
- the use of screening and assessment tools to improve the identification of this target population
- offering a family-based programme of structured support and offering the children group-based behavioural therapy before and during the transition to secondary school.

National Institute for Health and Care Excellence (NICE) Public Health Guidance Intervention 4: Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. <http://guidance.nice.org.uk/PH4>

HIIA note: The guidance defined vulnerable and disadvantaged children and young people aged under 25 who are at risk of misusing substances

³ See also: NHS Health Scotland. *Commentary on NICE Public Health Guidance Intervention 4: Community based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people*. Edinburgh: NHS Health Scotland; 2007. www.healthscotland.com/scotlands-health/evidence/NICE.aspx

as those whose family members misuse substances; those with behavioural, mental health or social problems; those excluded from school and truants; young offenders; looked after children; those who are homeless; those involved in commercial sex work; those from some black and minority ethnic groups.

There is review-level evidence of the effectiveness of parenting programmes with pre-teen and early adolescent children, notably in the transition from primary to secondary school, to reduce substance misuse in children. Parental engagement and commitment are important to the success of interventions and the focus should not solely be on the issue of substance use, rather on the whole family (relationships, social skills and personal responsibility).

Petrie J, Bunn F and Byrne G. Parenting programmes for preventing tobacco, alcohol or drugs misuse in children <18: a systematic review. *Health Education Research*. 2007;22(2).

<http://her.oxfordjournals.org/content/22/2/177.full.pdf+html>

HIIA note: Participants in included studies were parents with children under the age of 18 years.

Scottish policy and practice note:

NHS Health Scotland's (2014) ***Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities*** cites a Scottish Evaluation of Family Nurse Partnerships⁴ demonstrating initial learning of the potential to strengthen a range of personal assets, practical skills of young mothers as well as supporting emotional health and wellbeing.

Summary: There is highly processed and review-level evidence of effectiveness that parenting support and intervention in the early years can improve long-term health and social outcomes for children (at-risk). Attachment theory and effective interventions further demonstrate the importance of early years support for parents and children. There is highly processed evidence that interventions targeted at vulnerable groups can be effective in reducing substance misuse and improving other positive behavioural outcomes.

⁴ Ormston R, McConville S. *Evaluation of the Family Nurse Partnership Programme in NHS Lothian, Scotland: 3rd Report – Infancy*. ScotCen Social Research 2012; and an English randomised control trial to assess the impact of FNP on pregnancy outcomes and both child development and parental outcomes is currently underway (reporting April 2014). See Sanders J, Owen-Jones E, Robling M. Evaluating the family nurse partnership in England: the Building Blocks trial. *The practising midwife*. 2011;14(7):13-5.

C**Evidence for educational and youth work interventions**

Although some study quality limitations were noted there is highly processed evidence from a Cochrane review that showed consistent results from skills-based interventions (programmes developing drug knowledge, decision-making skills, peer resistance and self-esteem) as the most effective of school-based interventions in reducing drug use (compared to usual curricula).

Faggiano F, Vigna-Taglianti F, Versino E, Zambon A, Borraccino A, Lemma P. School-based prevention for illicit drugs' use. *Cochrane Database of Systematic Reviews*. 2005. www.thecochranelibrary.com

HIIA note: Target populations were primary and secondary school pupils.

In their review of the evidence for a Lancet Addiction Series, Strang et al (2012) suggest that economic analyses of psychosocial developmental interventions (personality targeted coping skills programmes) among school- aged adolescents are cost-effective even with the small to medium effects due to substantial lifetime benefits of even slightly lower rates of early drug or alcohol use.

Strang J, Babor T, Caulkins J, Fischer D, Humphreys K. Drug policy and the public good: evidence for effective interventions. *Addiction 2 Series. The Lancet*. 2012; 379.

Scottish policy and practice note:

NHS Health Scotland's (2014) ***Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities*** highlights that education and learning are a key area for intervention to address health inequalities. Good-quality education provides core life skills to increase employability, mental health and wellbeing, resilience and social inclusion.

Reversing the Trend is a joint project involving six voluntary youth work organisations, Lloyds TSB Foundation for Scotland's Partnership Drugs Initiative, and Evaluation Support Scotland about the role the youth sector plays in preventing problem substance use by young people.

The purpose is to offer an insight into what outcomes can be achieved by providing preventative approaches from universal help through to more specialist support for young people – and how to evaluate them. The resource focuses on substance use but recognises youth work also contributes to other cross-cutting issues facing young people.

www.itsbfoundationforscotland.org.uk/index.asp?cat=Publications

Summary: There is highly processed and review-level evidence that school-based interventions which focus on psychosocial and developmental skills can be effective in reducing drug use.

D**Evidence for interventions to reduce stigma associated with substance misuse**

There is evidence that communicating positive stories of people with substance-use disorders reduced stigmatising attitudes among the general public towards heroin and alcohol dependence. However, information factsheets did not achieve meaningful change in stigmatising attitudes among the general public.

In relation to professional groups, the available evidence suggests that educational interventions targeting medical students achieve enhanced results when contact-based approaches facilitating interaction with people with substance misuse problems are included in training and curricular. There was evidence of improving attitudes and comfort levels towards working with this population, notably significant increases in comfort were found from specialist prenatal clinic placements working with pregnant women with substance use disorders.

Finally, skills training working with police officers and interventions targeting substance use counsellors have also demonstrated positive effects on stigma-related outcomes.

Livingston JD, Milne T, Fang ML, Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*. 2011;107:39–50.

HIIA note: The evidence identified pregnant women who use substances as one of the target groups.

Summary: There is evidence from one systematic review that a range of interventions may influence positive outcomes in reducing social and structural stigma associated with substance misuse.

E**Evidence for interventions to improve life chances and individual and community wellbeing**

As part of the Mental Health Outcomes Framework (NHS Health Scotland 2012b) a chain of change 'Increasing social inclusion and decreasing inequality and discrimination' is outlined in logic model 4 of the framework. The evidence summary below supports the rationale for social inclusion activities in the following logic model link:

Having access to education, culture, leisure and the arts as well as basic needs will increase social inclusion.

Evidence summary on social exclusion:

- There is no highly processed evidence in the health sector about which are the most effective strategies for increasing access to education,

culture, leisure and the arts and how this might impact on mental health outcomes. Drawing on a review of literature and research, as well as consultations and field studies, *Mental Health and Social Exclusion: A report by the Social Exclusion Unit* report identifies a number of actions to address social exclusion including actions relating to supporting families and community participation (enabling people to lead fulfilling lives the way they chose) and getting the basics right (access to decent housing, financial advice and transport).⁵

- Models of learning indicate, for example, that engagement in learning results in wider benefits to health and wellbeing through the development of skills and competencies (e.g. cognitive skills, technical/vocational skills, resilience, beliefs about self and social and communication skills), social networks and qualification.⁶
- Rowling and Taylor (2005) argue that community-based arts programmes can contribute to community health through collaborative and inclusive processes, social cohesion and a sense of belonging.⁷

Logic Model 4 of the Mental Health Outcomes Framework is available online:
www.healthscotland.com/OFHI/MentalHealth/logicmodels/MH_LM4.html

The full outcomes framework, tools and resources, for mental health are available here: www.healthscotland.com/OFHI/MentalHealth/content/MHtools.html

Provision of housing to improve health

There is review-level evidence that support with housing, particularly for the most vulnerable groups (homeless people with mental health or substance misuse problems), benefits health.

Evidence suggests housing provision should optimally be combined with other support services.

Fitzpatrick-Lewis D, Gannan R, Krishnatatne S, Ciliska D, Kouyoumdjian F, Hwang SW. Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. *BMC Public Health*. 2011;11(683):1–14.

HIIA note: Interventions for homeless people with substance misuse, mental health problems.

⁵ Social Inclusion Report Mental Health and Social Exclusion: Social Exclusion Unit Report. London: HMSO; 2004.

⁶ Foresight Mental Capital and Wellbeing Project. Final Report. London: The Government Office for Science; 2008.

⁷ Rowling L, Taylor A. Intersectoral approaches to promoting mental health. In Herman H, Saxena S, Moodie R (Eds). *Promoting mental health: Concepts, emerging evidence, practice*. Geneva: World Health Organization; 2005.

Scottish policy and practice note:

Commission on the Future Delivery of Public Services (2011) outlines key elements of a programme of reform to improve Scotland's public services to improve the quality of life and outcomes for the people of Scotland. The key objectives of the reform programme are to ensure that:

- public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience
- public service organisations work together effectively to achieve outcomes – specifically, by delivering integrated services which help to secure improvements in the quality of life, and the social and economic wellbeing, of the people and communities of Scotland
- public service organisations prioritise prevention, reduce inequalities and promote equality
- all public services constantly seek to improve performance and reduce costs, and are open, transparent and accountable.

www.scotland.gov.uk/About/Review/publicservicescommission

In describing the challenges ahead in addressing the social determinants of health and tackling inequalities, NHS Health Scotland's **Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities** highlights the key role and contribution of Community Planning Partnerships (CPPs) at the local level.

The policy review report states that the CPP role is to bring together partners to agree priorities and shared outcomes, and to pool resources around these shared outcomes. There is a need for CPPs to be explicit about the roles and contributions of the partnerships that sit within the umbrella context of community planning, for example Health and Social Care Partnerships, Alcohol and Drug Partnerships, Integrated Children's Services Partnerships.

There are opportunities for CPPs to take on board the following:

- Clear leadership, understanding and shared values for changing power money and resource inequalities in their area through a thorough understanding of need and allocating budgets and resources proportionately to that need.
- Creating the social culture for communities to re-engage; a civic society in which there is increased democratic engagement.
- Ensuring the approaches that work to reduce health inequalities become reality in their CPP area.
- Ensuring measurement of indicators and evaluation is in place to understand impact and demonstrate progress over time to ensure that approaches are not inadvertently widening health inequalities.

The policy review report concludes by stating that closing the inequalities gap and lessening the inequalities gradient would bring greater cohesion, economic progress and better health in Scotland, lowering the burden on individuals, communities and public services and contributing to social equity.

Summary: Limited highly processed evidence and limited review-level evidence and Scottish policy directives support early years interventions, access to community resources, including good-quality housing, education and training to enhance social capital and improve health and social outcomes to reduce inequalities and associated acknowledged vulnerabilities for onset of (problem) drug use.

F Evidence for interventions to improve social connectedness

As part of the Mental Health Outcomes Framework (NHS Health Scotland 2012b), limited highly processed evidence was identified from NICE public health guidance to suggest direct and indirect community engagement activities may impact on social capital. A chain of change 'Increasing social connectedness, relationships and trust in families and communities' is outlined in logic model 3 of the Mental Health Outcomes Framework. The evidence summary below supports the rationale for community engagement activities in the following logic model link:

Community engagement activities, individual and community-based arts programmes and social prescribing will contribute to individuals and communities having increased knowledge and awareness of services and promote motivation and access to services and programmes for all. This, in turn, will increase attendance, participation and engagement, therefore contributing to increased trust in the community, increased social support and social networks.

Evidence summary on community engagement:

- There is limited highly processed evidence in the mental health sector about effective interventions to promote community engagement and participation, build social capital and increase trust. There is some review level evidence that direct and indirect community engagement activities may impact on social capital. (*Community engagement to improve health*. Edinburgh: NHS Health Scotland; 2008.)
- Informed by reviews of effectiveness evidence, NICE public health guidance 09 Community engagement to improve health, made 12 action recommendations which together are intended to present 'the ideal scenario for effective community engagement'. These include prerequisites for community engagement, infrastructure, approaches and evaluation of community engagement programmes. The NHS Health Scotland commentary on this guidance supported these action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements. (NHS Health Scotland. *Health Scotland Commentary on NICE Public Health Guidance: Community engagement to improve health*. Edinburgh: NHS Health Scotland; 2008.)

- Evaluations of other community-based projects such as Communities that Care (CtC) suggest that they can result in improvements in family and community relations as well as other behavioural impacts. (Hosman C and Jané-Llopis E. The Evidence of Effective Interventions for Mental Health Promotion. In Herman H, Saxena S, Moodie R (Eds). *Promoting mental health: Concepts, emerging evidence and practice*. Geneva: WHO; 2005.) www.who.int/mental_health/evidence/en/promoting_mhh.pdf
Long-term evaluations in the UK have not been undertaken to date.

Logic Model 3 of the Mental Health Outcomes Framework is available here: www.healthscotland.com/OFHI/MentalHealth/logicmodels/MH_LM3.html

The full outcomes framework, tools and resources, for mental health are available here: www.healthscotland.com/OFHI/MentalHealth/content/MHtools.html

NHS Health Scotland's *Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities* states that area-based initiatives may improve their effectiveness by including communities and individuals in designing interventions that draw on community strengths, and address social isolation through co-production.

NHS Health Scotland. *Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities*. Edinburgh: NHS Health Scotland; 2014.

Scottish policy and practice note:

The ***Report of the Ministerial Task Force on Health Inequalities*** (2013) (the second review of Equally Well) looked at how communities are being engaged in the decisions that affect them and also the importance that 'place' has on health inequalities. Two priority areas identified in the review were:

- development of social capital
- support for the implementation of a Place Standard

In support of the creation of health the report includes the following definition of social capital:

Social capital describes the pattern of networks among people and the shared values which arise from those networks. Greater interaction between people generates a greater sense of community spirit. The definition used by the Office for National Statistics, taken from the Office for Economic Cooperation and Development (OECD), is 'networks with shared norms,

values and understandings that facilitate cooperation within or among groups’.

Higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes, and lower crime rates. There are a number of different aspects to social capital:

- levels of trust (for example, whether individuals trust their neighbours)
- membership (for example, to how many clubs, societies or social groups individuals belong)
- networks and social contacts (for example, how often individuals see family and friends).

Shared norms, values and understandings relate to shared attitudes towards behaviour that are accepted by most individuals and groups as a ‘good thing’.

The Task Force report highlights the growing recognition of a need to shape places which are nurturing of positive health, wellbeing and resilience. The report cites the Single Outcome Agreement (SOA)⁸ guidance published in 2012 that highlighted the importance of tackling place as a key determinant of health, followed by the recent policy statement *Creating Places*⁹ that recognised that the quality of the built environment affects everyone, and that it is the purpose of architecture and urban design not only to meet our practical needs, but also to improve the quality of life for the people of Scotland and to that end the Scottish Government has committed to developing a Place Standard.

www.scotland.gov.uk/Publications/2014/03/2561

Summary: There is limited highly processed evidence and plausible theory to suggest a link between community cohesion and improved social outcomes.

⁸ Scottish Government and COSLA. *Single Outcome Agreements: Guidance to Community Planning Partnerships*. Edinburgh: Scottish Government and COSLA; 2012.

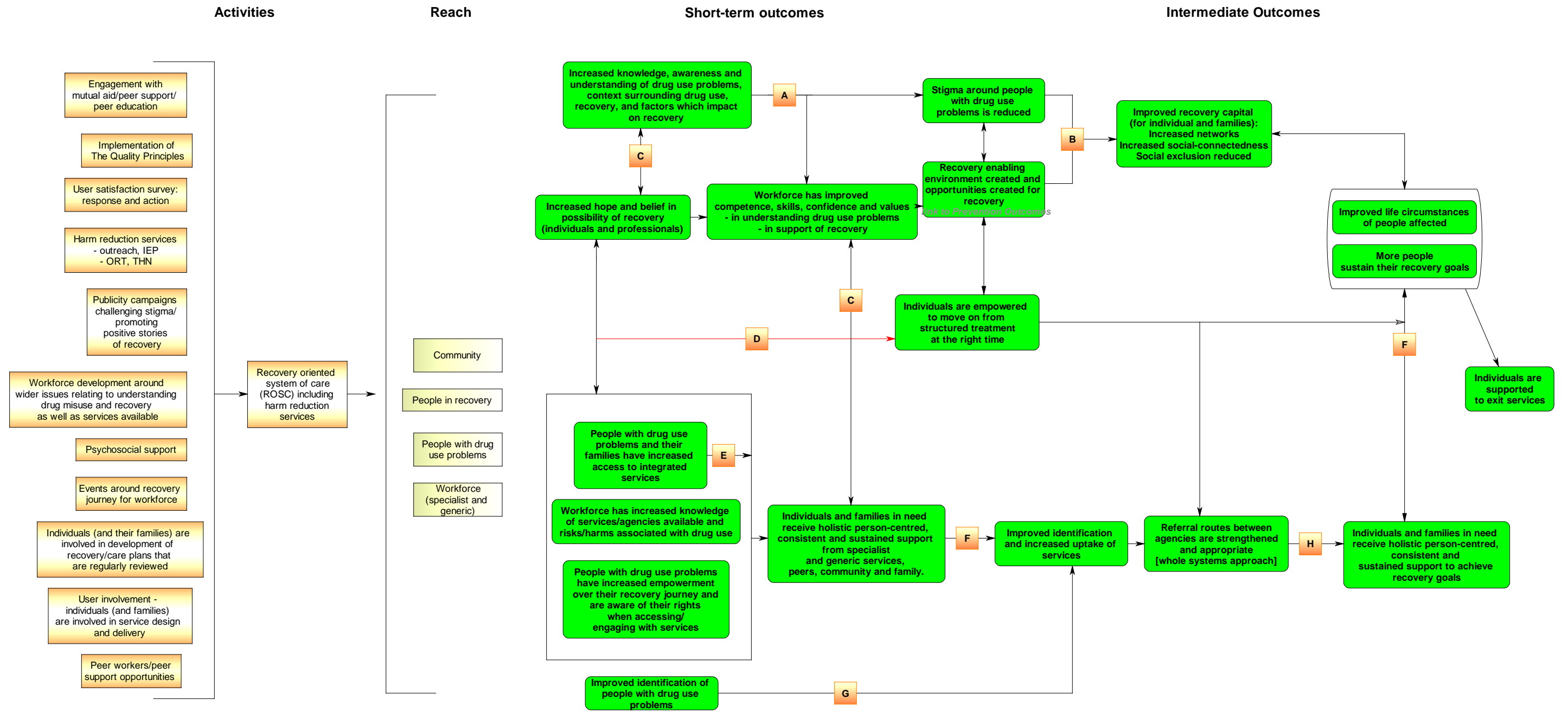
www.scotland.gov.uk/Topics/Government/local-government/CP/SOA2012/SOA2012

⁹ Scottish Government. *Creating Places – A policy statement on architecture and place for Scotland*. Edinburgh: Scottish Government; 2013.

www.scotland.gov.uk/Publications/2013/06/9811/downloads#res-1

Problem Drug Use Outcomes Framework MODEL 2: Recovery

Please note: red coloured arrows only indicate where lines cross



Logic Model 2: Recovery

Introduction

This section should be read in conjunction with the 'Recovery' nested logic model developed for the *Outcomes Framework for Problem Drug Use*. The framework comprises three other nested logic models (for prevention, families and enforcement) brought together by an overarching strategic outcomes logic model. The outcomes were defined by stakeholders in line with national development needs and the Scottish drugs strategy (*The Road to Recovery*).

This rationale document summarises the evidence available to support the desired outcomes described in the logic model. The relevant links in the chains have been lettered (A to G) and reflected in the model for ease of reference. Where available, evidence has been drawn from key sources: National Institute for Health and Care Excellence (NICE) public health and clinical guidance (and relevant NHS Health Scotland Commentaries/Scottish Perspectives); NICE and Health Development Agency (HDA) public health briefings; Scottish Intercollegiate Guidelines Network (SIGN) clinical guidelines; the Cochrane Collaboration and the University of York Centre for Reviews and Dissemination. We have called this information 'highly processed evidence'.

Additional sources of evidence and theory have been drawn from relevant key systematic reviews and, reviews and reports commissioned by the Scottish Government, the UK Government and national organisations and collaborators. Further papers were identified in conjunction with lead stakeholders and topic experts. Scottish policy and practice notes from national strategies and guidance documents are also cited. References are provided for further information.

This nested logic model and rationale within the *Outcomes Framework for Problem Drug Use* outlines what is needed to make a difference as part of the recovery agenda. It is a simplification of a complex world, but allows an explanation of delivery needs based on evidence of effectiveness to address problems and harms related to drugs misuse and the factors that may contribute to recovery from drug dependence.

Health inequalities impact assessment: health inequalities are systematic differences in health between different groups within a society, which are potentially avoidable and deemed unacceptable. All public sector and many private sector agencies have a contribution to make to reducing health inequalities. A health inequalities impact assessment (HIIA) is a tool which offers an integrated approach to impact assessment encompassing legally protected characteristics, human rights, wider population groups and social determinants of health. The main aim of an HIIA is to

strengthen the contribution of policies and plans to reducing health inequalities by improving equity of access, ensuring non-discriminatory practice and acting on the social determinants of health.

All new public sector policies and programmes must be impact assessed to meet the requirements of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012¹. As a planning tool, this outcomes framework is intended to guide the development of local and national interventions. Accordingly, for the purposes of the problem drug use outcomes framework, the rationale and validation process of the links in the nested logic models has, where possible, given due consideration to HIIA. A summary 'HIIA note' highlights where identified protected characteristics or vulnerable groups were featured in the evidence.

Further information is available in the introductory narrative of this outcomes framework and NHS Health Scotland full impact assessment guidance materials are available online: www.healthscotland.com/equalities/hiia/index.aspx

National policy driver – *The Road to Recovery* (2008)

The Scottish Government national drugs strategy, *The Road to Recovery: a new approach to tackling Scotland's drugs problem* (2008), states that it is essential to recognise the impact of action that a wide range of policies will have in tackling the factors associated with problem drug use. The policy clearly states the association between socio-economic disadvantage, deprivation and health inequalities and progression to problem drug use.

Recovery from drug addiction and dependence is acknowledged to be a highly individual and rarely linear process. In the Scottish Government national drugs strategy recovery is defined as 'a process through which an individual is enabled to move from their problem drug use, towards a drug-free lifestyle as an active and contributing member of society' and states that 'recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment... an aspirational and person-centred process'.

On promoting recovery, the policy outlines a reform of service delivery to deliver a recovery focus approach with the needs of carers and families integrated. An emphasis on person-centred care and planning is described to improve aspirations and quality of life among dependent drug users. The policy emphasises reducing harm and promoting recovery with blood-borne viruses and drug-related deaths identified as the most serious harms.

¹ Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012:
www.legislation.gov.uk/sdsi/2012/9780111016718/contents

Partnership working is highlighted to enhance and integrate the range of services to meet service user needs (including psychosocial support). Factors associated with success are identified as rapid access to intensive ongoing support (with multiple needs addressed); retention in treatment of at least three months; client characteristics (such as severity of the problem and their motivation); the responsiveness of services; a shared belief in recovery (staff and individual); and structured aftercare. The availability of employability services is noted as important, and the role of primary care (GPs and pharmacists) is highlighted in access to treatment and support as part of a network of local services.

Key recovery-related outcomes defined in the strategy at the time of publication:

- To effect culture change among those working with, or affected by problem drug use.
- To see more people recover from problem drug use to live longer, healthier lives making a positive contribution to society and the economy.
- More joined-up approach which sees more people recover from problem drug use.
- To facilitate more people moving on and recovering from problem drug use
- Stronger more resilient families and communities.
- Action to help reduce the number of drug-related deaths so people live longer, healthier lives.
- Strengthened evidence base which improves policy and practice at national and local level.

Evidence and supporting rationale for recovery outcomes

Based on Sally Macintyre's framework of guiding principles for effective policies and interventions to address health inequalities for the 2008 Ministerial Task Force, interventions for problem drug users are assessed as most likely to have some impact on health inequalities, as they target a disadvantaged group and provide intensive support.

Macintyre S. *Inequalities in health in Scotland: what are they and what can we do about them?* Glasgow: MRC Social & Public Health Sciences Unit; 2007.

An evidence review conducted by David Best and colleagues (2010) following publication of the national drug strategy highlighted the strong link between problem drug use and deprivation, suggesting that tackling deprivation, poverty and widening inequalities (for example, in housing and employment) could have a positive impact on prevention and recovery.

Best et al. *Research for Recovery: A Review of the Drugs Evidence Base.* Edinburgh: Scottish Government; 2010.

A**Evidence for interventions to reduce stigma associated with substance misuse**

The limited evidence among people with substance use disorders supports the broader research literature regarding self-stigma interventions and suggests that therapeutic interventions such as group-based ACT and vocational counselling are likely to produce positive effects (decreasing shame and improving feelings of social alienation). There is also some evidence that communicating positive stories of people with substance use disorders reduced stigmatising attitudes among the general public towards heroin and alcohol dependence. However, information factsheets did not achieve meaningful change in stigmatising attitudes among the general public.

In relation to professional groups, the available evidence suggests that educational interventions targeting medical students achieve enhanced results when contact-based approaches facilitating interaction with people with substance misuse problems are included in training and curricular. There was evidence of improving attitudes and comfort levels towards working with this population, notably significant increases in comfort were found from specialist prenatal clinic placements working with pregnant women with substance use disorders.

Finally, skills training working with police officers and interventions targeting substance use counsellors have also demonstrated positive effects on stigma-related outcomes.

Livingston JD, Milne T, Fang ML, Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*. 2011;107:39–50.

HIIA note: The evidence identified pregnant women who use substances as one of the target groups.

Summary: There is evidence from one systematic review that a range of interventions may influence positive outcomes in reducing self, social and structural stigma associated with substance misuse.

B**Evidence for improved recovery capital**

The Advisory Council on the Misuse of Drugs (ACMD, 2012) refers to Granfield and Cloud's (2001) definition of recovery capital as the 'breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery' from substance misuse (dependency). The ACMD cite Granfield and Cloud's (2009) four components of recovery capital as follows:

- **Social capital** is defined as the sum of resources that each person has as a result of their relationships, and includes both support from and obligations to

groups to which they belong; thus, family membership provides supports but will also entail commitments and obligations to the other family members.

- **Physical capital** is defined in terms of tangible assets such as property and money that may increase recovery options (e.g. being able to move away from existing friends/networks or to fund an expensive detox service).
- **Human capital** includes skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital, and will help with some of the problem-solving that is required on a recovery journey.
- **Cultural capital** includes the values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours.

Advisory Council on the Misuse of Drugs. *Recovery from drug and alcohol dependence: an overview of the evidence*. London: ACMD; 2012.

NICE Clinical Guidelines for Drugs Misuse: Psychosocial Interventions (CG51) recommendations for implementation include the following:

- Staff should routinely provide people who misuse drugs with information about self-help groups.

NICE. *Clinical Guidelines 51: Drugs Misuse: Psychosocial Interventions*. London: NICE; 2011.

HIA note: This guideline covers psychosocial interventions for adults and young people who misuse opioids, cannabis or stimulants (for example, cocaine or amphetamine). It does not specifically cover people with dual diagnosis; people who misuse alcohol, prescription drugs or solvents; diagnosis or primary prevention; people younger than 16 years.

An evidence review conducted by Best et al (2010) following publication of the national drug strategy concluded that recovery capital (an individual's assets) is the best predictor of sustained recovery.

Best et al. *Research for Recovery: A Review of the Drugs Evidence Base*. Edinburgh: Scottish Government; 2010.

There is limited evidence from small-scale studies that a community reinforcement approach (CRA) with abstinent-contingent incentives is effective for cocaine addiction and limited evidence from one study that this approach is effective in opioid detoxification. For methadone maintenance, there is also evidence from one study that single CRA (i.e. without incentives) is more effective than usual care.

Roozen HG, Boulogne JJ, van Tulder MW, van den Brink W, De Jong CAJ, Kerhof AJFM. A systematic review of the effectiveness of community reinforcement approach in alcohol, cocaine and opioid addiction. *Drug and Alcohol Dependence*. 2004;74.

HIA note: participants in included studies had alcohol, cocaine and opiate abuse or dependence, and were aged between 18–65 years.

Summary: There is review-level evidence that recovery capital (social, physical, human and cultural resources) assists enables and supports positive outcomes for individuals seeking to overcome drug dependence.

C

Evidence for interventions for improved knowledge of recovery across the workforce for integrated service delivery

NICE Clinical Guidelines for Drugs Misuse: Psychosocial Interventions (CG51) general considerations state:

- In order to reduce loss of contact when people who misuse drugs transfer between services, staff should ensure that there are clear and agreed plans to facilitate effective transfer.
- All interventions for people who misuse drugs should be delivered by staff who are competent in delivering the intervention and who receive appropriate supervision.
- People who misuse drugs should be given the same care, respect and privacy as any other person.
- Routine screening for recent drug use should be offered in mental health and criminal justice settings and staff in primary care and hospitals (including A&E) should consider raising the issue of substance misuse with people who present with suspected drugs-misuse injuries or symptoms.

NICE. *Clinical Guidelines 51: Drugs Misuse: Psychosocial Interventions*. London: NICE; 2011.

Best et al (2010) (Scottish-Government-commissioned review) concludes that the key ingredients of effective treatment include qualified and supported staff in a service with a clear treatment philosophy, delivering packages of evidence-based care that addresses clinical needs, that provides appropriate psychosocial interventions and that provides appropriate links to 'wraparound' care in the community and to ancillary needs specific to the individual.

Best et al. *Research for Recovery: A Review of the Drugs Evidence Base*. Edinburgh: Scottish Government; 2010.

Scottish policy and practice note:

Supporting the Development of Scotland's Alcohol and Drug Workforce sets out the aim of identifying all actions required to deliver the alcohol and drug workforce and to outline the important roles and contributions of those directly involved in workforce development. See Scottish Government website: www.scotland.gov.uk/Topics/Justice/law/Drugs-Strategy/recovery/deliverystrategy/Workforce/workforce

Scottish Government's ***Developing Recovery-Orientated Systems of Care (ROSC) through Service Redesign: Driver Diagram*** is a tool to assist local areas with service planning and redesign to work towards the implementation of a recovery-orientated system of care (ROSC). The tool includes links to guidance and advice which will hopefully be of use when undertaking system redesign work locally. Interactive version: www.ssk.org.uk/topics/drugs-and-alcohol/developing-recovery-orientated-systems-of-care-driver-diagram.aspx
PDF version: www.ssk.org.uk/media/88060/driver_diagram_feb_2013.pdf

NHS Scotland's ***Strategy for Workforce Education and Development related to BBV Service Delivery*** (2014), developed by NHS Education for Scotland (NES) in partnership with stakeholders at the request of the Scottish Government, is to support implementation of the Scottish Government *Sexual Health and Blood Borne Virus Framework 2011–2015* within NHS Boards through cohesive workforce education and development activity.

It specifically focuses on the blood-borne virus (BBV) HIV, hepatitis C and hepatitis B elements of the national framework, reflecting sexual health issues only as they relate to BBVs. Available online at:
www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/public-health/health-protection/blood-borne-viruses/bbv-workforce-education-and-development.aspx

Summary: There is review-level evidence and policy directives supporting a joined-up approach from services to support individuals in addressing problem drug use.

D Evidence for empowerment of individuals and rights-based approach for access to services

Scottish policy and practice note:

In the Scottish Government commissioned evidence review, Best et al (2010) describe a **recovery oriented system of care (ROSC)** as a network of formal and informal services developed and mobilised to sustain long-term recovery for individuals and families impacted by severe substance use disorders; and that overall treatment systems (such as ADPs) will be restructured over time to be recovery oriented in the sense that the ethos of the system will be around client empowerment and choice, and the distillation of hope for individual, family and community recovery.

The Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Services (2014) is supported by a Recovery Philosophy. This is a

statement of the principle that all people have a right to recover from addiction to alcohol and other drugs. It exists to support recovery journeys ensuring that individuals are treated with dignity and respect when they choose to access drug and alcohol treatment and support services; and that with these rights come responsibilities. Available from:
www.scotland.gov.uk/Publications/2014/08/1726/downloads

Summary: The Scottish Government Quality Improvement Framework for Drug and Alcohol Services is supportive of empowerment for individuals and a rights-based approach in access to services.

For person in recovery and to meet needs of (adult) family members

E Evidence for family support interventions and integrated service provision

NICE Clinical Guidance 51: Drugs Misuse: Psychosocial Interventions general considerations include:

- If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.
- Staff should ask families and carers about, and discuss concerns regarding, the impact of drug misuse on themselves and other family members, including children.

Staff should also:

- Offer family members and carers an assessment of their personal, social and mental health needs
- Provide verbal and written information and advice on the impact of drug misuse on service users, families and carers.

Where the needs of families and carers of people who misuse drugs have been identified, staff should:

- offer guided self-help or support groups
- provide information about and facilitate contact with, support groups, specifically focused on addressing families' and carers' needs or, alternatively
- offer individual family meetings.

NICE. *Clinical Guidelines 51: Drugs Misuse: Psychosocial Interventions*. London: NICE; 2011.

HIA note: This guideline covers psychosocial interventions for adults and young people who misuse opioids, cannabis or stimulants (for example, cocaine or amphetamine). It does not specifically cover people with dual diagnosis; people who misuse alcohol, prescription drugs or solvents; diagnosis or primary prevention; people younger than 16 years.

There is review-level evidence that community reinforcement and family training (CRAFT) is effective in engaging treatment resistance substance-abusing individuals. Included studies were small scale but assessed as good quality with high programme fidelity. Evidence also suggests that irrespective of treatment engagement by the affected individual these programmes are beneficial to families and significant others.

Roozen HG, Waart, van der Kroft P. Community reinforcement and family training: an effective option to engage treatment resistant substance-abusing individuals. *Addiction*. 2010;105.

HIIA note: Included studies targeted individuals with substance use disorders from 18 years and older.

In their Scottish Government-commissioned review for the Scottish Child Care and Protection Network, Mitchell and Burgess (2009) identify evidence from one US-based-study (Gregoire and Schulz 2001) examining drug treatment outcomes that found support from significant others emerged as having a strong, positive relationship with assessment completion and treatment outcomes, and custody outcomes. It is worth noting that this support was more commonly received by males as women in the study sample were more likely to have significant relationships with men who were themselves misusing substances.

There is review-level evidence from UK-based qualitative studies to suggest that targeted family support interventions where drugs (and/or alcohol) use exists have a positive influence on the lives of parents and children, including remaining together as a family despite previous child protection concerns at referral, although evidence of effect on child welfare outcomes is not known. Projects were characterised as child-focused with a strength-based approach to assist families (individuals and as a whole) to identify their issues and how to address them. Interventions were community-based with substantial contact time.

There is review-level evidence that integrated substance treatment and family support services may be successful in assisting women to reduce their drug and alcohol use, and to bring about changes that support their parenting and family life. Both programme completion and length of stay within treatment appear to be key factors in influencing positive outcomes for women.

Mitchell F, Burgess C. *Working with families affected by parental substance misuse: a research review*. Edinburgh: Scottish Child Care and Protection Network, Scottish Government; 2009.

HIIA note: The review aimed to identify studies that explicitly considered the circumstances of children, young people or families exposed to parental substance misuse.

There is review evidence to suggest that interventions based on the stress-strain-coping-support theoretical model: the 5-Step Intervention is effective in reducing stress symptoms and improving family member coping responses.

Copello A, Templeton L, Powell J. *Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses*. London: UK Drug Policy Consortium; 2009.

Scottish policy and practice note:

Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Services 2014

The underlying philosophy of a ROSC is that treatment and aftercare are integrated, and priority is given within the system to sustaining individuals in their recovery journey. The distinguishing features of a ROSC include being person-centred, inclusive of family and significant others; provision of individualised and comprehensive services across the lifespan with systems anchored in the community. At its core it has strength-based assessments and interventions that are responsive to personal belief systems, a commitment to peer recovery support services, is inclusive of the voices and experiences of people and their families in recovery and provides integrated services. It also provides for system-wide education and training, ongoing monitoring and outreach, is outcomes driven and evidence based. Available from:

www.scotland.gov.uk/Publications/2014/08/1726/downloads

The Adult Support and Protection (Scotland) Act 2007 seeks to protect and benefit adults at risk of being harmed. The Act requires councils and a range of public bodies to work together to support and protect adults who are unable to safeguard themselves, their property and their rights.

It provides a range of measures which they can use. The public bodies are required to work together to take steps to decide whether someone is an adult at risk of harm, balancing the need to intervene with an adult's right to live as independently as possible.

www.scotland.gov.uk/Topics/Health/Support-Social-Care/Adult-Support-Protection

Summary: There is highly processed and review-level evidence that involving families in recovery care plans for affected individuals and providing support for family members themselves is beneficial to improve outcomes for both parties.

F

Evidence for holistic support from services for people with drug use problems

NICE Clinical Guideline 51: Drugs Misuse: Psychosocial Interventions' general considerations state:

- Best practice for the treatment and care of people who misuse drugs should have the opportunity to make informed decisions about their care and treatment, in partnership with healthcare professionals. Good communication between staff and service users is essential. Treatment and care, and the information service users are given about it, should be culturally appropriate. It should also be accessible to people with additional needs, such as physical, sensory or learning disabilities, and to people who do not speak or read English.
- If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.
- Assessment should have a holistic approach to care planning with the service user, with consideration given to specific needs, history of drug use and previous experience of treatment, goals and preferences.
- Staff should support service users in fulfilling their care plan with a supportive relationship, developing coping strategies, access to wider range of services and maintaining engagement as well as ensuring successful collaboration with other care providers.
- Residential treatment may be considered for people who are seeking abstinence and who have significant comorbid physical, mental health or social (for example housing) problems. Urgent assessment should be offered to people who have relapsed.

NICE. *Clinical Guidelines 51: Drugs Misuse: Psychosocial Interventions*. London: NICE; 2011.

Housing support

There is review-level evidence that support with housing, particularly for people with mental health or substance misuse problems benefits health. Evidence suggests housing provision should optimally be combined with other support services.

Fitzpatrick-Lewis D, Gannan R, Krishnatatne S, Ciliska D, Kouyoumdjian F, Hwang SW. Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. *BMC Public Health*. 2011;11(683):1–14.

HIIA note: Interventions for homeless people with substance misuse, mental health problems.

Evidence of effectiveness of psychosocial interventions to improve drug-related outcomes

There is highly processed evidence of effectiveness from a Cochrane Review of standard psychosocial support (routine counselling) delivered with methadone maintenance treatment (MMT), when compared to any other structured psychosocial intervention delivered with agonist maintenance treatments.

Amato L, Minozzi S, Davoli M, Vecchi S. Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. *Cochrane Database of Systematic Reviews*. 2011;(10).

HIIA note: The above evidence is taken from interventions targeting opiate addicts, the client group was 73% male, with an average age of 35 (range 27 to 45 years).

Case management for people with drug use problems

There is highly processed evidence from a Cochrane Review that suggests case management is effective as a strategy for linking community and treatment services for persons with substance use disorders in need of a variety of support. However, effects differ depending on availability, access and model of case management (with the most promising effect found for strengths-based approaches and the use of a manual to guide and standardise delivery).

Findings related to drug use outcomes varied but overall did not provide convincing support that case management is effective to reduce illicit drug use, although a small effect was found when compared with other specific treatment such as motivational interviewing or drug counselling. A small number of studies found evidence of a moderate significant effect for improvements in housing and small (yet non-significant) but consistent effect on legal outcomes (e.g. number of days incarcerated, charges for drug-related offences). This evidence is drawn from studies that concerned patients who were out of treatment when assigned to case management or control.

Hesse M, Vanderplasschen W, Rapp R, Broekaert E, Fridell M. Case Management for persons with substance use disorders. *Cochrane Database of Systematic Reviews*. 2007.

HIIA note: Interventions targeted substance misusers (including alcohol, opiate dependent and cocaine), in treatment and non-responders; homeless; veterans; (ex-) offenders; dual diagnosis patients; all but one of the studies reported male participants with age range 29 to 45 years.

Scottish policy and practice note:

Scottish Government's **Developing Recovery-Orientated Systems of Care (ROSC) through Service Redesign: Driver Diagram**. The driver diagram is a tool to assist local areas with service planning and redesign to work towards the implementation of a recovery-orientated system of care (ROSC). The tool includes

links to guidance and advice which will hopefully be of use when undertaking system redesign work locally.

Interactive version: www.ssks.org.uk/topics/drugs-and-alcohol/developing-recovery-orientated-systems-of-care-driver-diagram.aspx

PDF version: www.ssks.org.uk/media/88060/driver_diagram_feb_2013.pdf

Alcohol and Drug Quality Improvement Framework

The underlying philosophy of a ROSC is that treatment and aftercare are integrated, and priority is given within the system to sustaining individuals in their recovery journey. The distinguishing features of a ROSC include being person-centred, inclusive of family and significant others; provision of individualised and comprehensive services across the lifespan with systems anchored in the community. At its core it has strength-based assessments and interventions that are responsive to personal belief systems, a commitment to peer recovery support services, is inclusive of the voices and experiences of people and their families in recovery and provides integrated services. It also provides for system-wide education and training, ongoing monitoring and outreach, is outcomes-driven and evidence-based. (Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Services 2014) Available from:

www.scotland.gov.uk/Publications/2014/08/1726/downloads

Summary: There is highly processed and review-level evidence as well as policy directives that support the effectiveness of a person-centred sustained and holistic approach for improving health and treatment outcomes of people who use drugs.

Review-level evidence demonstrates the benefit of psychosocial interventions and suggests case management is effective as a strategy for linking community and treatment services for persons with substance use disorders in need of a variety of support.

G Evidence for effectiveness of harm-reduction services and improved uptake of treatment and support services

Injecting equipment provision (IEP)

There is highly processed evidence from NICE public health guidance on needle and syringe programmes (2014) that states:

The main aim of needle and syringe programmes is to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment, such as HIV, hepatitis B and C. In turn, this will reduce the prevalence of blood-borne viruses and bacterial infections, so benefiting wider society. Many needle and syringe programmes also aim to reduce the other harms caused by drug use and include:

- advice on minimising the harms caused by drugs
- help to stop using drugs by providing access to drug treatment (for example, opioid substitution therapy)
- access to other health and welfare services.

NICE public health guidance PH52² (2014) has 10 recommendations:

- consult with and involve users, practitioners and the local community
- collate and analyse data on injecting drug use
- commission both generic and targeted services to meet local need
- monitor services
- develop a policy for young people who inject drugs³
- provide a mix of services
- provide people with the right type of equipment and advice
- provide community pharmacy-based needle and syringe programmes
- provide specialist (level 3) needle and syringe programmes
- provide equipment and advice to people who inject image- and performance-enhancing drugs.

The guidance outlines a number of factors and issues it took into account when developing the recommendations and updating the guidance:

- Needle and syringe programmes (NSPs) need to be considered as part of a comprehensive substance-misuse strategy that covers prevention, treatment and harm reduction.
- The remit of this guidance was to consider the optimal provision of NSPs, not whether or not these programmes should be provided. Evidence from systematic reviews shows that NSPs are an effective way to reduce many of the risks associated with injecting drugs.
- Public Health Intervention Advisory Committee (PHAC) emphasised the important 'gateway' function that NSPs may perform in bringing people who inject drugs into contact with a range of services. In particular, NSPs may bring them into contact with services that may help by:
 - emphasising the dangers of overdosing (about 1% of people who inject drugs die of an overdose each year)
 - encouraging people to switch to less harmful forms of drug taking
 - encouraging people to opt for opioid substitution therapy
 - encouraging people to stop using drugs
 - encouraging people to be tested and treated for hepatitis C and HIV
 - encouraging people to address their other health needs.

² This guidance updates and replaces NICE public health guideline 18 (published February 2009). www.nice.org.uk/guidance/ph18

³ Under-16s are not currently included in Scottish Injecting Equipment Guidelines

PHAC considered a summary of the findings from the health economic modelling undertaken for the original guidance. This showed that providing people who inject opioid drugs with sterile injecting equipment is estimated to be cost-effective from an NHS/personal social services (PSS) perspective (that is, excluding the costs of crime). It is similarly cost-effective from a societal perspective. If the indirect 'gateway' effects of needle and syringe programmes – of increasing the proportion of people who inject drugs who take up opioid substitution therapy, or take part in other drug treatment – are included, a fall in the number who inject drugs is likely. This would, in turn, lead to a reduction in crime. If that is the case, modelling shows that these programmes are likely to be cost-effective in the longer term. However, the figures in relation to the size of the 'gateway effect' are subject to considerable uncertainty, as are figures relating to any effect that an increase in needle and syringe programmes will have on the number of people injecting drugs.

NICE public health guidance 52: needle and syringe programmes.
London: NICE; 2014.

HIIA note: The guidance targets people who inject drugs and has been extended to include young people aged under 18 (including those under 16) and users of image- and performance-enhancing drugs. The equality impact assessment is available here:

www.nice.org.uk/nicemedia/live/14492/67221/67221.pdf

Take-home naloxone (THN)

Naloxone is an opioid antagonist, which temporarily reverses the effects of heroin and other opioids, it has no intoxication effects and no abuse potential. Naloxone is recommended as an intervention to prevent overdose by the World Health Organization as an essential medicine and is already used by the emergency services. In their review of UK and international evidence on the effectiveness of naloxone provision the ACMD (2012) recommends that naloxone should be made more widely available to tackle the high numbers of fatal opioid overdoses in the UK. The report highlights the educational and public health benefits in that the provision of naloxone will widen awareness of the risks opioid overdose and emphasises the importance of basic life support training as part of the package of interventions to prevent opioid overdose.

The ACMD (2012) report on the consideration of naloxone notes that risks and concerns regarding the provision of naloxone programmes potentially increasing drug using risk(s) are not supported by evidence. The report cites literature (see Gaston et al 2009) that participants in naloxone programmes have been found to have an 'increase in self efficacy and more insight in relation to personal safety and health'.

Advisory Council on the Misuse of Drugs. *Consideration of naloxone*.
London: ACMD; 2012.

Opioid replacement therapy (ORT)

In their commissioned independent expert review of the place of ORT for the Chief Medical Officer for Scotland⁴, the Drug Strategy Delivery Commission (DSDC) (2013) cite consistent conclusions from systematic reviews that ORT is effective treatment for opioid dependency and is associated with improved retention in treatment, reduced illicit heroin use and reduced risk of harm related to injecting and transmission of BBVs. Less consensus from the systematic reviews is noted in relation to positive effects on criminal activity and mortality. Factors identified with positive outcomes are treatment dose and quality of therapeutic relationships. The DSDC authors conclude that despite the limitations noted in the quality of research the benefits to physical health and reduction in BBVs is strongly supported by the evidence. The final report of the independent review makes 12 recommendations, including the following:

- Opioid replacement is an essential treatment with a strong evidence base. Its use remains a central component of the treatment of opiate dependency and should be retained in Scottish services.
- In all settings, ORT should be delivered as part of a coherent person-centred recovery plan with SMART goals and based upon an assessment of individual recovery capital.
- The quality of ORT should be governed and delivery should be in line with national standards and guidance. NHS Medical Directors should hold this responsibility on behalf of local partnerships.
- Fit-for-purpose information systems should be able to identify individuals on this care pathway and objectively demonstrate what progress is being made.

Scottish Drugs Strategy Delivery Commission (DSDC) (2013) *Independent Expert Review of Opioid Replacement Therapies in Scotland*. Scottish Government

The provision of foil

The provision of foil for the purposes of smoking controlled substances, generally heroin and crack cocaine, is currently illegal in the UK under section 9A of the Misuse of Drugs Act 1971. In their report considering the provision of foil as a harm reduction intervention, the ACMD (2010) concluded the balance of benefit favours exempting foil from Section 9A of the Misuse of Drugs Act 1971⁵. The following was provided as rationale:

- There is no evidence of harmful effect of the provision of foil; previous studies indicate that the intervention does not encourage the use of illegal drugs.

⁴ See Scottish Government website: www.scotland.gov.uk/Publications/2013/08/9760

⁵ Reference to the ACMD's previous recommendations on drug paraphernalia are also included in the report – namely to amend the misuse of drugs legislation to permit the supply of swabs, bowls, spoons, stericups, citric acid and water for injecting (May 2001) and filters (May 2003) – these recommendations were accepted by government and changes made by secondary legislation (Regulation 6A of the 2001 Regulations).

- Potential benefits include:
 - Potential for decrease in BBV transmission.
 - Increased contact and engagement with drug services.
 - Reduced systemic infections.
 - Reduced soft tissue and venal damage.
 - Lower risk of overdose.
 - Reduced litter.
 - The ACMD noted the provision of foil is specifically designed to move individuals away from injecting.

Advisory Council on the Misuse of Drugs. *Consideration of the use of foil, as an intervention, to reduce the harms of injecting heroin*. London: ACMD; 2010.

In July 2013, the Home Secretary accepted the ACMD recommendations for the lawful provision of foil confined to the drug treatment context. However, legislative changes are pending for exemption from the Misuse of Drugs Act 1971. The legislation to be introduced will set strict conditions to ensure that foil is only given by drug treatment providers as part of structured efforts to get individuals off drugs. This is regardless of whether the purpose is getting them into treatment in the first place or into the initial stages for their treatment and recovery plan. Mechanisms will also be put in place to carefully monitor the take-up, implementation and adherence to the conditionality over the next year.

The Home Secretary's letter to the ACMD is available on the UK Government website: www.gov.uk/government/publications/lawful-provision-of-foil-home-secretarys-letter-to-acmd

NICE Clinical Guidelines for Drugs Misuse: Psychosocial Interventions (CG51) key priority for implementation:

- Opportunistic brief interventions focused on motivation should be offered to people in limited contact with drug services (for example, those attending a needle and syringe exchange or primary care settings) if concerns about drug misuse are identified by the service user or staff member.
- Drug services should introduce contingency management programmes to reduce illicit drug use and/or promote engagement with services for people receiving methadone maintenance treatment, with incentives offered based on regular screening and concordance with or completion of interventions to improve physical health (e.g. hepatitis B/C and HIV testing; hepatitis B immunisation; tuberculosis testing)

NICE CG51: *Drugs Misuse: Psychosocial Interventions*. London: NICE; 2011.

There is review-level evidence of the effectiveness of screening and brief interventions for secondary prevention of drug use in multiple settings. Results from one study found brief interventions in a clinical setting can reduce cocaine and

heroin use (even without meaningful contact with the treatment system). There is evidence from single studies that motivational interviewing is effective in students to reduce cannabis, alcohol and tobacco use and to reduce consumption among regular amphetamine users. Limited evidence of effectiveness of impact of GP and primary-care-based brief interventions to reduce excessive benzodiazepine use and other illicit drugs.

Evidence of effectiveness of brief interventions with adolescent school-aged children is less conclusive, with limited studies finding mixed results in reducing drug use.

Strang J, Babor T, Caulkins J, Fischer D, Humphreys K. Drug policy and the public good: evidence for effective interventions. *Addiction* 2 Series. *The Lancet*. 2012;379.

Scottish policy and practice note:

The Sexual Health and Blood Borne Virus Framework (2011–2015) combines areas of work surrounding sexual health, HIV, hepatitis C and hepatitis B. It is a multi-agency, cross-agenda approach based on five high-level outcomes:

Outcome 1: Fewer newly acquired blood borne virus and sexually transmitted infections

Outcome 2: A reduction in the health inequalities gap in sexual health and blood-borne viruses.

Outcome 3: People affected by blood-borne viruses lead longer, healthier lives

Outcome 4: Sexual relationships are free from coercion and harm

Outcome 5: A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and blood-borne viruses are positive, non-stigmatising and supportive.

See: www.scotland.gov.uk/Publications/2011/08/24085708/0

Guidelines for services providing injecting equipment: Best practice recommendations for commissioners and injecting equipment provision (IEP) services in Scotland (2010)

These guidelines aim to provide a consistent framework which can be used across Scotland to support the delivery of IEP services. The objectives of the guidelines are:

1. To promote good practice in relation to the planning and development of IEP services
2. To improve the accessibility of sterile needles, syringes and other injecting equipment to injecting drug users who are at risk of acquiring HCV and other BBVs
3. To improve the quality and consistency of IEP services
4. To promote integration between IEP services and other services for injecting drug users, including primary, secondary and social care services

5. To ensure that local areas are taking active steps to protect the health and safety of IEP service staff and clients, and the community in relation to the disposal of used injecting equipment. See: www.scotland.gov.uk/Publications/2010/03/29165055/0

A **National Take Home Naloxone Programme** has been centrally funded by the Scottish Government since June 2011. Local programmes have been developed in 29 out of 30 Alcohol and Drug Partnerships in Scotland.

Scottish Government investment in the programme provides:

- A national coordinator and training and development officer based at the Scottish Drugs Forum (SDF)
- Continued support to Alcohol and Drug Partnerships and Health Boards in the development of their local programmes
- Training, information and awareness materials
- Reimbursement to Health Boards for kits issued
- A national monitoring and evaluation programme based at NHS ISD Scotland.

See: www.scotland.gov.uk/Topics/Justice/law/Drugs-Strategy/drugrelateddeaths/NationalNaloxone

Further information can be found here:

www.sdf.org.uk/index.php/drug-related-deaths/take-home-naloxone-thn-overdose-intervention-training/ or www.naloxone.org.uk

NHS Scotland Strategy for workforce education and development related to BBV service delivery (2014) The strategy, developed by NHS Education for Scotland (NES) in partnership with stakeholders at the request of the Scottish Government, is to support implementation of the Scottish Government *Sexual Health and Blood Borne Virus Framework 2011–2015* within NHS Boards through cohesive workforce education and development activity.

It specifically focuses on the blood-borne virus (BBV) (HIV, hepatitis C and hepatitis B) elements of the national framework, reflecting sexual health issues only as they relate to BBVs. Available online at:

www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/public-health/health-protection/blood-borne-viruses/bbv-workforce-education-and-development.aspx

Summary: There is highly processed and review-level evidence of the effectiveness of harm reduction services such as IEP, THN and ORT, to prevent or reduce the significant harms associated with problem drug use, including blood-borne viruses and drug-related deaths. Harm reduction services have immediate public health benefits and are widely acknowledged to contribute to engaging and promoting recovery programmes.

H**Evidence for a person-centred approach and consistent support from service providers**

Best et al. (2010), a Scottish-Government-commissioned review reported that a range of different interventions are required to effectively treat drug dependence, providing evidence of a need for individualised person-centred care as described by White's Recovery Management Model (2008). The review concludes that structured treatment results in improvement in substance use, reduced offending, improved social functioning, physical and psychological health and reduced risk taking. These beneficial treatment effects are demonstrated both immediately and in the long term. Findings from multiple longitudinal outcome studies at two to five years follow-up suggest a minimum three month treatment duration is critical to contributing to successful outcomes.

Best et al. *Research for Recovery: A Review of the Drugs Evidence Base*.
Edinburgh: Scottish Government; 2010.

Evidence of the effectiveness of treatment for drug dependence

There is evidence from seminal large-scale treatment outcome studies in the US (DATOS), the UK (NTORS and DTORS) and Scotland only (DORIS) [studies of what works in practice] that good-quality therapeutic relationships, retention in treatment and self-help/mutual aid groups are predictors of positive recovery-related outcomes.

For a summary of individual study findings see Best et al. (2010) or DSDC (2013).
HIIA note: Individual studies reported that the client samples, i.e. the target group for the intervention, was deemed to be similar to the demographic and drug-using profiles of the overall treatment seeking populations.
Predominantly white males with long-term heroin dependence.

Scottish policy and practice note:***Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Services 2014***

The underlying philosophy of a ROSC is that treatment and aftercare are integrated, and priority is given within the system to sustaining individuals in their recovery journey. The distinguishing features of a ROSC include being person-centred, inclusive of family and significant others; provision of individualised and comprehensive services across the lifespan with systems anchored in the community. At its core it has strength-based assessments and interventions that are responsive to personal belief systems, a commitment to peer recovery support services, is inclusive of the voices and experiences of people and their families in recovery and provides integrated services. It also provides for system-wide education and training, ongoing monitoring and outreach, is outcomes-driven and evidence-based.

Available from: www.scotland.gov.uk/Publications/2014/08/1726/downloads

In their commissioned **independent expert review of the place of Opioid Replacement Therapy (ORT) for the Chief Medical Officer for Scotland**, the Drug Strategy Delivery Commission's (DSDC) final report makes 12 recommendations, including the following in relation to progressing recovery in Scotland:

Recovery-orientated systems of care (ROSCs) are well described in many guidance documents. All local systems should immediately publish prioritised SMART plans to ensure they can demonstrate a process towards delivery of ROSCs. Elements expected in such plans include:

- All service users should be offered and actively encouraged to use Essential Care⁶ services. This offer should be recorded and repeated at regular intervals. This should become the norm in Scotland's services.
- In all settings staff should be trained in the delivery of ROSC.
- A full range of Essential Care services should be available in every locality – this should include a full range of identifiable community rehabilitation services – including those using people with lived experience; access to detoxification and residential rehabilitation; access to a full range of psychological and psychiatric services; services addressing employability and accommodation issues.
- Within the medical and other caring professions, it is everyone's responsibility to manage drug users and their problems which extend into every clinical speciality. All practitioners can effect change and have opportunities to address drug-related problems within their professional arena. Local systems should have plans in place to ensure substance users are not excluded from generic services.

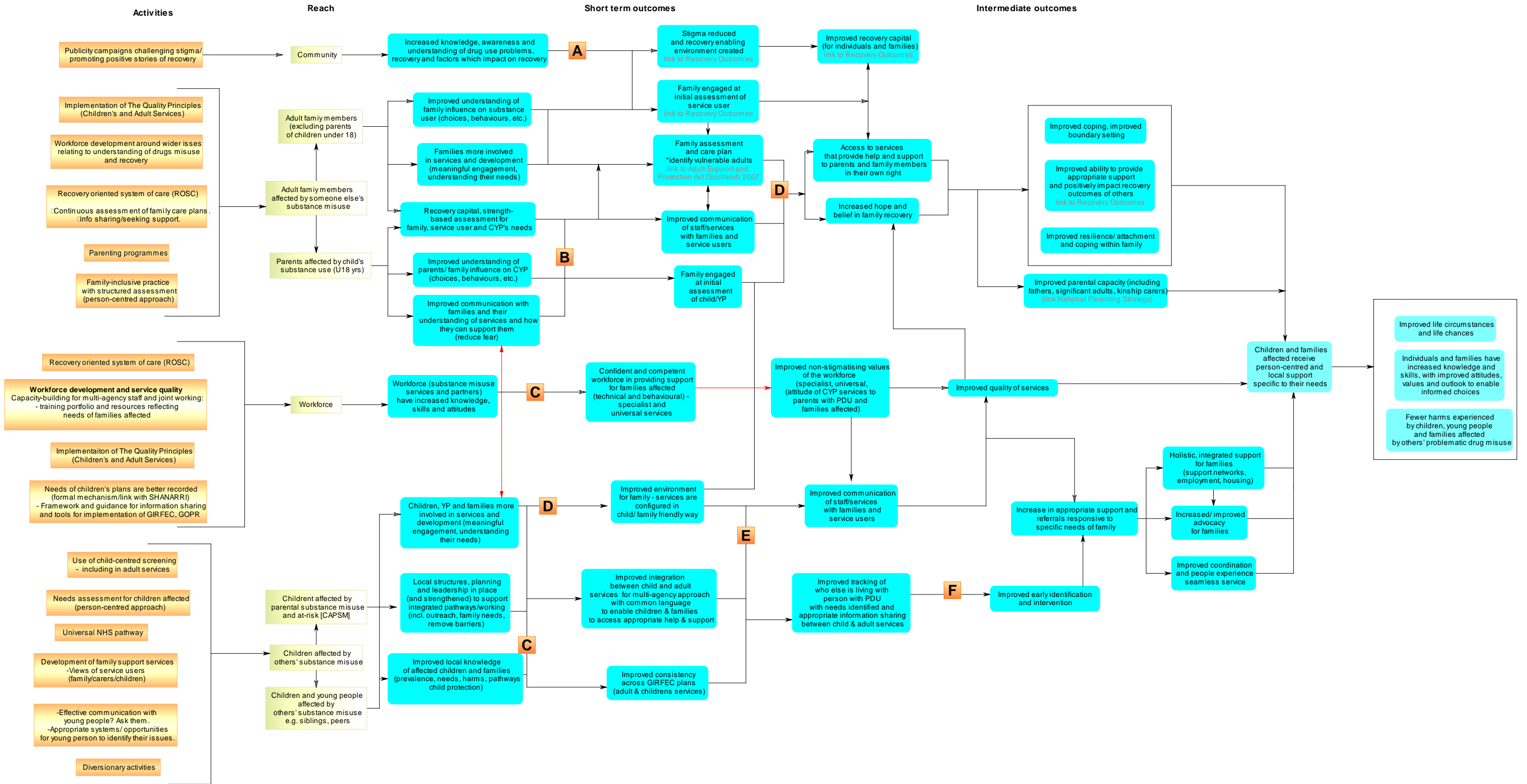
See: www.scotland.gov.uk/Publications/2013/08/9760

Summary: There is review-level evidence and policy directives for a recovery-oriented system of care to provide effective personalised, sustained treatment support and address multiple and complex needs associated with problem drug use.

⁶ 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*. Edinburgh: SACDM; 2008. www.scotland.gov.uk/Resource/Doc/217018/0058174.pdf

Problem Drug Use Outcomes Framework MODEL 3: Families

Please note:
the term 'family' is interpreted to include concerned significant others
red arrows only indicate where lines cross



Logic Model 3: Families

Introduction

This section should be read in conjunction with the 'Families' nested logic model developed for the *Outcomes Framework for Problem Drug Use*. The framework comprises three other nested logic models (for prevention, recovery and enforcement) brought together by an overarching strategic outcomes logic model. The outcomes were defined by stakeholders in line with national development needs and the Scottish drugs strategy (*The Road to Recovery*).

This rationale document summarises the available evidence to support the desired outcomes described in the model. The relevant links in the chains have been lettered (A to E) and reflected in the model for ease of reference. Where available, evidence has been drawn from key sources: National Institute for Health and Care Excellence (NICE) public health guidance (and relevant NHS Health Scotland Commentaries/ Scottish Perspectives); NICE and Health Development Agency (HDA) public health briefings; Scottish Intercollegiate Guidelines Network (SIGN) clinical guidelines; the Cochrane Collaboration and the University of York Centre for Reviews and Dissemination. We have called this information 'highly processed evidence'.

Additional sources of evidence and theory have been drawn from relevant key systematic reviews and literature reviews and reports commissioned by the Scottish Government, the UK Government and national organisations and collaborators. Further papers were identified in conjunction with lead stakeholders and topic experts. Scottish policy and practice notes from national strategies and guidance documents are also cited. References are provided for further information.

Health inequalities impact assessment: health inequalities are systematic differences in health between different groups within a society, which are potentially avoidable and deemed unacceptable. All public sector and many private sector agencies have a contribution to make to reducing health inequalities. A health inequalities impact assessment (HIIA) is a tool which offers an integrated approach to impact assessment encompassing legally protected characteristics, human rights, wider population groups and social determinants of health. The main aim of an HIIA is to strengthen the contribution of policies and plans to reducing health inequalities by improving equity of access, ensuring non-discriminatory practice and acting on the social determinants of health.

All new public sector policies and programmes must be impact-assessed to meet the requirements of the Equality Act 2010 (Specific Duties) (Scotland) Regulations

2012.¹ As a planning tool, this outcomes framework is intended to guide the development of local and national interventions. Accordingly, for the purposes of the framework, the rationale and validation process of the links in the nested logic models has, where possible, given due consideration to the HIIA. A summary 'HIIA note' highlights where identified protected characteristics or vulnerable groups were featured in the evidence.

Further information is available in the introductory narrative of this outcomes framework and NHS Health Scotland full impact assessment guidance materials are available online: www.healthscotland.com/equalities/hiiia/index.aspx

National policy driver – *The Road to Recovery* (2008)

The Scottish Government national drugs strategy, *The Road to Recovery: a new approach to tackling Scotland's drugs problem* (2008), states that it is essential to recognise the impact of action that a wide range of policies will have in tackling the factors associated with problem drug use. The policy clearly states the association between socio-economic disadvantage, deprivation and health inequalities and progression to problem drug use. The policy states children and families affected by substance misuse are high priority inequality group, and among the most vulnerable in society. Current best estimates indicate that 40–60,000 children may be affected.

The 'Getting it right for every child' policy and *The Early Years Framework* have been established to improve outcomes for children, with the central tenet of building capacity and resilience of families and children. *The Road to Recovery* sets out an action plan to improve identification assessment, recording, planning and information-sharing; build the capacity, availability and quality of support services (including support for young carers and strengthening adult services focus on needs of children and families); and strengthen the consistency and effectiveness of the management of immediate risk.

Key children and families-related outcomes defined in the strategy at the time of publication:

- Improved life chances for children, young people and families, especially those at risk.

¹ Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012: www.legislation.gov.uk/sdsi/2012/9780111016718/contents

Guiding principles

The 'Getting it right for every child' (GIRFEC)² approach is about how practitioners across all services for children and adults meet the needs of children and young people, working together where necessary to ensure they reach their full potential. It promotes a shared approach and accountability that:

- builds solutions with and around children, young people and families
- enables children and young people to get the help they need when they need it
- supports a positive shift in culture, systems and practice
- involves working better together to improve life chances for children, young people and families.

Children, young people and their families should always know where they can find help, what support might be available and whether that help is right for them. The GIRFEC approach ensures that **anyone** providing that support puts the child or young person – and their family – at the centre.

The Children and Young People Bill will put this definition and other key elements of the GIRFEC approach on a statutory basis. This shared understanding by services of a child's wellbeing is critical. The approach uses eight areas and indicators of wellbeing in which children and young people need to progress in order to do well now and in the future: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included (SHANARRI).

These eight areas are set in the context of the 'four capacities', which are at the heart of the Curriculum for Excellence. The four capacities aim to enable every child and young person to be a successful learner, a confident individual, a responsible citizen and an effective contributor.

It's a consistent way for people to work with all children and young people. It's the bedrock for all children's services and can also be used by practitioners in adult services who work with parents or carers. The approach helps practitioners focus on what makes a positive difference for children and young people – and how they can act to deliver these improvements. 'Getting it right for every child' is being threaded through all existing policy, practice, strategy and legislation affecting children, young people and their families.

At practice level to support implementation of this approach the *Getting Our Priorities Rights* (GOPR)³ good practice guidance offers child and adult services working with

² See Scottish Government website: www.scotland.gov.uk/Topics/People/Young-People/gettingitright

³ See Scottish Government website: www.scotland.gov.uk/Publications/2013/04/2305

vulnerable families advice and considerations for action to assess risk and improve outcomes.

In this regard, as part of the recovery agenda services should focus on a ‘whole-family’ approach when assessing need and aiming to achieve overall recovery. ‘Family recovery’ is conceptualised by White (2008) in Best et al’s (2010) Scottish-Government-commissioned evidence review and described as involving repair of family rules, roles and relationships across three family subsystems (adult intimate relationships, parent–child relationships, sibling relationships) and altering (increasing or decreasing) the family’s interactions with the outside world.

Evidence and supporting rationale for families logic model

A

Evidence for interventions to reduce stigma associated with substance misuse

There is evidence that communicating positive stories of people with substance use disorders reduced stigmatising attitudes among the general public towards heroin and alcohol dependence. However, information factsheets did not achieve meaningful change in stigmatising attitudes among the general public.

In relation to professional groups, the available evidence suggests educational interventions targeting medical students achieve enhanced results when contact-based approaches facilitating interaction with people with substance misuse problems are included in training and curricular. There was evidence of improving attitudes and comfort levels towards working with this population, with significant increases in comfort found from specialist prenatal clinic placements working with pregnant women with substance use disorders. Finally, skills training working with police officers and interventions targeting substance use counsellors have also demonstrated positive effects on stigma-related outcomes.

Livingston JD, Milne T, Fang ML, Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*. 2011;107:39–50.

HIIA note: The evidence identified pregnant women who use substances as one of the target groups.

Summary: There is evidence from one systematic review that a range of interventions may influence positive outcomes in reducing social and structural stigma associated with substance misuse.

B**Evidence for parenting interventions**

There is review-level evidence of the effectiveness of parenting programmes with pre-teen and early adolescent children, notably in the transition from primary to secondary school, to reduce substance misuse in children. Parental engagement and commitment are important to the success of interventions and the focus should not solely be on the issue of substance use rather on the whole family (relationships, social skills and personal responsibility).

Petrie J, Bunn F, Byrne G. (2007) Parenting programmes for preventing tobacco, alcohol or drugs misuse in children <18: a systematic review. *Health Education Research*. 22(2).

<http://her.oxfordjournals.org/content/22/2/177.full.pdf+html>

HIIA note: Participants in included studies were parents with children under the age of 18 years.

Scottish policy and practice note:

The **National Parenting Strategy**⁴ (2012) champions the importance of parenting, by strengthening the support on offer to parents and by making it easier for them to access this support.

The **GOPR guidance** further highlights the need to keep parents at the forefront of a coordinated response if services are to be effective in achieving overall recovery for the whole family. The guidance describes good practice of working in partnership with parents and, where possible, including parents in any multi-agency meetings, in assessments and in developing care plans.

Summary: There is review-level evidence and policy to support the effectiveness of parenting interventions as a strategy to improve outcomes for children and reduce risk of misusing substances.

For the workforce**C****Evidence for workforce development, building capacity, availability and quality of services****Scottish policy and practice note:**

Building capacity, availability and quality of support services for those affected by parental substance misuse is highlighted in the drugs strategy, **The Road to Recovery (2008)**. The drugs strategy outlines actions to improve identification,

⁴ See Scottish Government website: www.scotland.gov.uk/Resource/0040/00403769.pdf

assessment, recording and planning, and information sharing; to build the capacity, availability and quality of support services; and to strengthen the consistency and effectiveness of immediate risk management.

The **GOPR guidance**⁵ highlights key elements of effective partnership working in strategic planning and leadership, as well as operational service design and management. The guidance states that ultimately, ADPs are anchored in CPPs and are responsible for drawing up joint partnership-based strategies to tackle alcohol and/or drugs in their communities. They should ensure that community planning takes a coherent response to adult problem alcohol and/or drug use and the impacts on children.

The ***Supporting the development of Scotland's Alcohol and Drug Workforce statement***⁶ sets out the aim of identifying all actions required to deliver the alcohol and drug workforce and to outline the important roles and contributions of those directly involved in workforce development.

Staff in adult services should be trained to a level that matches what is expected of their role. This may include raising the issue of children and pregnancy with service users, ongoing assessment, identification of risks and unmet needs of children, liaison and referral with other agencies and services.

The workforce involved with children and/or adults where problem drug use is a factor includes a broad range of practitioners: universal services, specialist and targeted services, clinical, residential and in-patient services. GOPR sets out a number of principles as the basis for joint CPP and ADP workforce training programmes.

The ***National Framework for Child Protection Learning and Development in Scotland***⁷ sets out a common set of skills and standards for workers to ensure the delivery of a consistently high standard of support to children and young people across the country.

The ***Common Core of Skills, Knowledge and Understanding and Values for the 'Children's Workforce' In Scotland*** (2012)⁸, describes the skills, knowledge, understanding and values that everyone (paid or unpaid) working with children, young people and other family members should have, and the 'basics' needed to build positive relationships and promote children's rights. The skills, knowledge and

⁵ See Scottish Government website: www.scotland.gov.uk/Publications/2013/04/2305

⁶ See Scottish Government website: www.scotland.gov.uk/Topics/Justice/law/Drugs-Strategy/recovery/deliverystrategy/Workforce/workforce

⁷ See Scottish Government website: www.scotland.gov.uk/Topics/People/Young-People/protecting/child-protection/national-framework-cp-learning-2012

⁸ See Scottish Government website: www.scotland.gov.uk/Publications/2012/06/5565

understanding ('essential characteristics') are set out in two contexts: relationships with children, young people and families; and relationships between workers. They are cross-referenced to the guiding principles of the *United Nations Convention on the Rights of the Child* (UNCRC), and the values are taken from GIRFEC.

Learning and development in the area of problematic alcohol and/or drug use is not an isolated activity and has to link to other learning and development strategies, for example local implementation of GIRFEC, child protection, *The Sexual Health and Blood-Borne Virus Framework 2011–15*, domestic abuse and mental health.

The Children and Young People's Act (2014) makes provision about the rights of children and young people; to make provision about investigations by the Commissioner for Children and Young People in Scotland; to make provision for and about the provision of services and support for or in relation to children and young people; to make provision for an adoption register; to make provision about children's hearings, detention in secure accommodation and consultation on certain proposals in relation to schools; and for connected purposes.

www.legislation.gov.uk/asp/2014/8/introduction/enacted

Summary: Scottish policy and guidance support specialist and generic workforce development to foster appropriate knowledge, skills and values related to substance misuse, needs and services.

For all family members affected by someone else's substance misuse

D Evidence for family support interventions and integrated service provision

For the person in recovery and to meet needs of (adult) family members

NICE Clinical Guidance 51: Drugs Misuse: Psychosocial Interventions general considerations include the following:

- If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.
- Staff should ask families and carers about, and discuss concerns regarding, the impact of drug misuse on themselves and other family members, including children.
- Staff should also:
 - Offer family members and carers an assessment of their personal, social and mental health needs
 - Provide verbal and written information and advice on the impact of drug misuse on service users, families and carers.

Where the needs of families and carers of people who misuse drugs have been identified, staff should:

- offer guided self-help or support groups
- provide information about, and facilitate contact with, support groups that are specifically focused on addressing families and carers needs or, alternatively
- offer individual family meetings.

NICE. *Clinical Guidelines 51: Drugs Misuse: Psychosocial Interventions*. London: NICE; 2011.

HIA note: This guideline covers psychosocial interventions for adults and young people who misuse opioids, cannabis or stimulants (for example, cocaine or amphetamine). It does not specifically cover people with dual diagnosis; people who misuse alcohol, prescription drugs or solvents; diagnosis or primary prevention; people younger than 16 years.

There is review level evidence that community reinforcement and family training (CRAFT) is effective in engaging treatment resistant substance-abusing individuals. Included studies were small scale but assessed as good quality with high programme fidelity. Evidence also suggests that irrespective of treatment engagement by the affected individual these programmes are beneficial to families and significant others.

Roozen HG, Waart, van der Kroft P. Community reinforcement and family training: an effective option to engage treatment resistant substance-abusing individuals. *Addiction*. 2010;105.

HIA note: Included studies targeted individuals with substance use disorders from 18 years and older.

In their Scottish-Government-commissioned review for the Scottish Child Care and Protection Network, Mitchell and Burgess (2009) identify evidence from one US-based-study (Gregoire and Schulz 2001) examining drug treatment outcomes that found support from significant others emerged as having a strong, positive relationship with assessment completion and treatment outcomes, and custody outcomes. It is worth noting that this support was more commonly received by males as women in the study sample were more likely to have significant relationships with men who were themselves misusing substances.

There is review-level evidence from UK-based qualitative studies to suggest that where drugs (and/or alcohol) use exists, targeted family support interventions have a positive influence on the lives of parents and children. These include remaining together as a family despite previous child protection concerns at referral, although evidence of effect on child welfare outcomes is not known. Projects were characterised as child-focused with a strength-based approach to assist families (individuals and as a whole) to identify their issues and how to address them. Interventions were community-based with substantial contact time.

There is review-level evidence that integrated substance treatment and family support services may be successful in assisting women to reduce their drug and alcohol use, and to bring about changes that support their parenting and family life. Both programme completion and length of stay within treatment appear to be key factors in influencing positive outcomes for women.

Mitchell F, Burgess C. *Working with families affected by parental substance misuse: a research review*. Edinburgh: Scottish Child Care and Protection Network, Scottish Government; 2009.

HIIA note: The review aimed to identify studies that explicitly considered the circumstances of children, young people or families exposed to parental substance misuse.

There is review evidence to suggest that interventions based on the stress-strain-coping-support theoretical model: the 5-Step Intervention is effective in reducing stress symptoms and improving family member coping responses.

Copello A, Templeton L, Powell J. *Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses*. London: UK Drug Policy Consortium; 2009.

Scottish policy and practice note:

Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Services (2014) The underlying philosophy of a ROSC is that treatment and aftercare are integrated, and priority is given within the system to sustaining individuals in their recovery journey. The distinguishing features of a ROSC include being person-centred, inclusive of family and significant others; provision of individualised and comprehensive services across the lifespan with systems anchored in the community. At its core it has strength-based assessments and interventions that are responsive to personal belief systems, a commitment to peer recovery support services, is inclusive of the voices and experiences of people and their families in recovery and provides integrated services. It also provides for system-wide education and training, ongoing monitoring and outreach, is outcomes driven and evidence based.

Available on the Scottish Government website:

www.scotland.gov.uk/Publications/2014/08/1726/downloads

The Adult Support and Protection (Scotland) Act 2007 seeks to protect and benefit adults at risk of being harmed. The Act requires councils and a range of public bodies to work together to support and protect adults who are unable to safeguard themselves, their property and their rights.

It provides a range of measures which they can use. The public bodies are required to work together to take steps to decide whether someone is an adult at risk of harm,

balancing the need to intervene with an adult's right to live as independently as possible.

www.scotland.gov.uk/Topics/Health/Support-Social-Care/Adult-Support-Protection

Summary: There is highly processed and review-level evidence that involving families in recovery care plans for affected individuals and providing support for family members themselves is beneficial to improve outcomes for both parties.

For children affected by parental substance misuse and at-risk

E

Evidence for multi-agency response and direct support to children and young people

For child or young person affected/at risk

There is highly processed evidence from NICE Public Health Guidance that supporting the social, emotional and cognitive development of children can improve long-term outcomes (NICE PH40)*; and limited highly processed evidence (NICE PH4)* that community-based interventions targeted at vulnerable groups can be effective in reducing substance misuse and improving other positive behavioural outcomes.

NICE. Public health guidance 40 Social and emotional wellbeing: early years. London: NICE; 2012. Available from:

<http://guidance.nice.org.uk/PH40/Guidance/pdf/English>

The National Institute for Health and Care Excellence (NICE) Public Health Guidance Intervention 4: Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. Available at: <http://guidance.nice.org.uk/PH4>

* For details see Prevention Logic Model 1, Link B: Evidence for parenting and early years interventions.

There is evidence of effectiveness of improvements in coping strategies and social behaviours among adolescents where drug use exists in their family, across a range of targeted prevention interventions (family-oriented and school/community-based programmes). School-based programmes showed improved levels of knowledge about alcohol, drugs, addiction and their effects on families. Evidence in relation to self-worth and substance use was however inconsistent.

Broning S, Kumpfer K, Kruse K, Sack P-M, Schaunig-Busch I, Ruths S, Moesgen D, Pflug E, Klein M, Thomasius R. Selective prevention programs

for children from substance-affected families: a comprehensive systematic review. *Substance Abuse Treatment, Prevention, and Policy*. 2012;7(23).
HIIA note: Studies describing or investigating effects of preventive interventions on children and adolescents with substance-abusing parents (or on affected families as a whole entity) were included in the review. The age of the target population ranged from 0–17 years.

There is limited evidence of effectiveness interventions to support children to develop knowledge and skills in dealing with issues in their lives related to others' substance misuse (usually a parent's). Group-based approaches were identified by Mitchell and Burgess (2009) in their Scottish-Government-commissioned review for the Scottish Child Care and Protection Network – reported positive effects are limited to understanding the impact of addiction, communication skills, coping strategies and improved resilience.

Mitchell F, Burgess C. *Working with families affected by parental substance misuse: a research review*. Edinburgh: Scottish Child Care and Protection Network, Scottish Government; 2009.

Scottish policy and practice note:

The Children and Young People's Act (2014) makes provision about the rights of children and young people; to make provision about investigations by the Commissioner for Children and Young People in Scotland; to make provision for and about the provision of services and support for or in relation to children and young people; to make provision for an adoption register; to make provision about children's hearings, detention in secure accommodation and consultation on certain proposals in relation to schools; and for connected purposes.

www.legislation.gov.uk/asp/2014/8/introduction/enacted

Effective partnership working is an underpinning principle of GIRFEC which has a focus on early, proactive intervention in order to create a supportive environment and identify any additional supports for a family that may be required. To help ensure effective working, all agencies should embed the **GIRFEC National Practice Model** (in particular the shared understanding of a child's wellbeing, the role of the Named Person and also the Lead Professional) into local protocols for tackling substance use. Strengths and challenges of multi-agency working are outlined in the guidance, together with practice point for joint working, including enablers and barriers. One key aspect defined in the guidance in making effective decisions in determining the degree of risk to the child is good inter-agency communication and collaboration at all stages – i.e. in assessment, planning and intervention.

www.scotland.gov.uk/Topics/People/Young-People/gettingitright/national-practice-model

Reversing the Trend is a joint project involving six voluntary youth work organisations, Lloyds TSB Foundation for Scotland's Partnership Drugs Initiative and

Evaluation Support Scotland about the role the youth sector plays in preventing problem substance use by young people.

The purpose is to offer an insight into what outcomes can be achieved by providing preventative approaches from universal help through to more specialist support for young people – and how to evaluate them. The resource focuses on substance use but recognises youth work also contributes to other cross-cutting issues facing young people. www.itsbfoundationforscotland.org.uk/index.asp?cat=Publications

Summary: There is highly processed and review level evidence to suggest that direct support to children affected by others' substance misuse, and those at-risk, can improve health, behavioural, development and social outcomes.

F Evidence for a coordinated response and appropriate information sharing for improved identification and assessment of children affected by parental substance

NICE Public Health Guidance 4 recommendations on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people:⁹

- Use of existing screening and assessment tools to identify vulnerable and disadvantaged children and young people aged under 25 who are misusing, or at risk of misusing, substances.
- Work with parents or carers, education welfare services, children's trusts, child and adolescent mental health services, school drug advisers or other specialists to provide support and referral for children and young people to other services based on a mutually agreed plan.

NICE Public Health Guidance Intervention 4: Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. London: NICE; 2007.

<http://guidance.nice.org.uk/PH4>

HIIA note: The guidance defined vulnerable and disadvantaged children and young people aged under 25 who are at-risk of misusing substances as those whose family members misuse substances; those with behavioural, mental health or social problems; those excluded from school and truants; young offenders; looked after children; those who are homeless; those involved in commercial sex work; those from some black and minority ethnic groups.

⁹ See also: NHS Health Scotland (2007) *Commentary on NICEPHG004 Community based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people*. www.healthscotland.com/scotlands-health/evidence/NICE.aspx

In their Scottish-Government-commissioned review for the Scottish Child Care and Protection Network, Mitchell and Burgess (2009) identify evidence from one good quality small-scale UK-based study identifying that early referrals, at or around birth in particular, were associated with good outcomes for children. The study authors, Forrester and Harwin (2008) advocate for early identification and effective inter-agency working encompassing screening and referral for either alcohol or drugs misuse during pregnancy and infancy.

Mitchell F, Burgess C. *Working with families affected by parental substance misuse: a research review*. Edinburgh: Scottish Child Care and Protection Network, Scottish Government; 2009.

NHS Health Scotland's *Briefing on attachment* (Scott 2011)¹⁰ describes attachment as the bond from a child towards their parent or primary caregiver. The briefing cites John Bowlby's theory of attachment (*Attachment and Loss: Vol. 1 Attachment*, 1982) that defines attached as 'the disposition of the child to seek proximity to and contact with a specific figure and to do so in certain situations, notably when he is frightened, tired or ill.'

The briefing outlines that there are links between an infant's attachment style and their later social and emotional outcomes. Secure attachment in infancy is associated with positive outcomes including self-esteem, self-confidence, emotional regulation, resilience and more harmonious relationships in childhood and early adulthood. While attachment style may be a risk or protective factor, this association is not deterministic. Other factors, for example social support or life stress are likely to mediate this influence (from Sroufe 2006, Prior and Glaser, 2006 cited in *ibid*).

The briefing details evidence on effective strategies for promoting secure attachment in young children:

- the most effective interventions specifically focus on improving sensitive maternal behaviour (as opposed to those which are broader in focus)
- interventions that are effective in enhancing parental sensitivity are universally effective (including high risk populations)
- the most successful interventions are brief (less than 5 or 5-16 sessions) and behaviourally focused
- the majority use home visiting as the mechanism for delivery
- providing information to new parents on the sensory and perceptual capabilities of their infants appears to enhance maternal responsiveness and parental interaction with their babies.

Scott E. *Briefing on attachment*. Edinburgh: NHS Health Scotland; 2011.

¹⁰ Briefing available on NHS Health Scotland's website:
www.healthscotland.com/documents/5755.aspx

Scottish policy and practice note

Children affected by parental substance misuse have been specifically cited as a priority area in the drugs strategy, *The Road to Recovery*¹¹ (2008). The drugs strategy cites the role of adult services and outlines actions to improve identification, assessment, recording and planning, and information sharing; to build the capacity, availability and quality of support services; and to strengthen the consistency and effectiveness of immediate risk management.

The **GIRFEC approach** provides a series of common tools, language and planning processes that can improve the identification of the risks and needs in a child's life as part of a wider assessment of the child's development. In particular, any action to support a child should be co-ordinated through a single Child's Plan. Both the family and the services involved should be clear about the purpose of the Plan and what is expected of each family member and service to achieve recovery.

The new updated **Getting Our Priorities Right (GOPR) guidance**¹² (2013) reflects and is framed in the context of the national GIRFEC approach and the recovery agenda. The guidance sets out a framework for information sharing between services. Issues to be considered include consent, confidentiality, 'need-to-know' basis, relevance of information to be shared, proportionality in the amount of information shared, method by which it will be securely shared, and a record must be kept of what, when, who with, how and the purpose of any information shared.

The guidance states that when working with parents with problematic alcohol and/or drug use, services should always consider the possible impacts on any dependent children, be alert to their needs and welfare and respond in a coordinated way with other services to any emerging problems.

GOPR includes 'Practice Points for Adult Services' in their role in the support and protection of children. Services with individual roles and responsibilities included in the GOPR guidance document include health, education, social work (children and families; criminal justice and adult support); alcohol and drug services; third sector; advocacy and welfare support services; housing, police and Children's Reporters.

A national data system is in development by NHS Information Services Division on behalf of the Scottish Government, the **Drug and Alcohol Information System (DAISy)**, to gather a range of outcomes-related data throughout the recovery journey of people accessing specialist drug and alcohol treatment services across Scotland.

¹¹ See Scottish Government website: www.scotland.gov.uk/Publications/2008/05/22161610/0

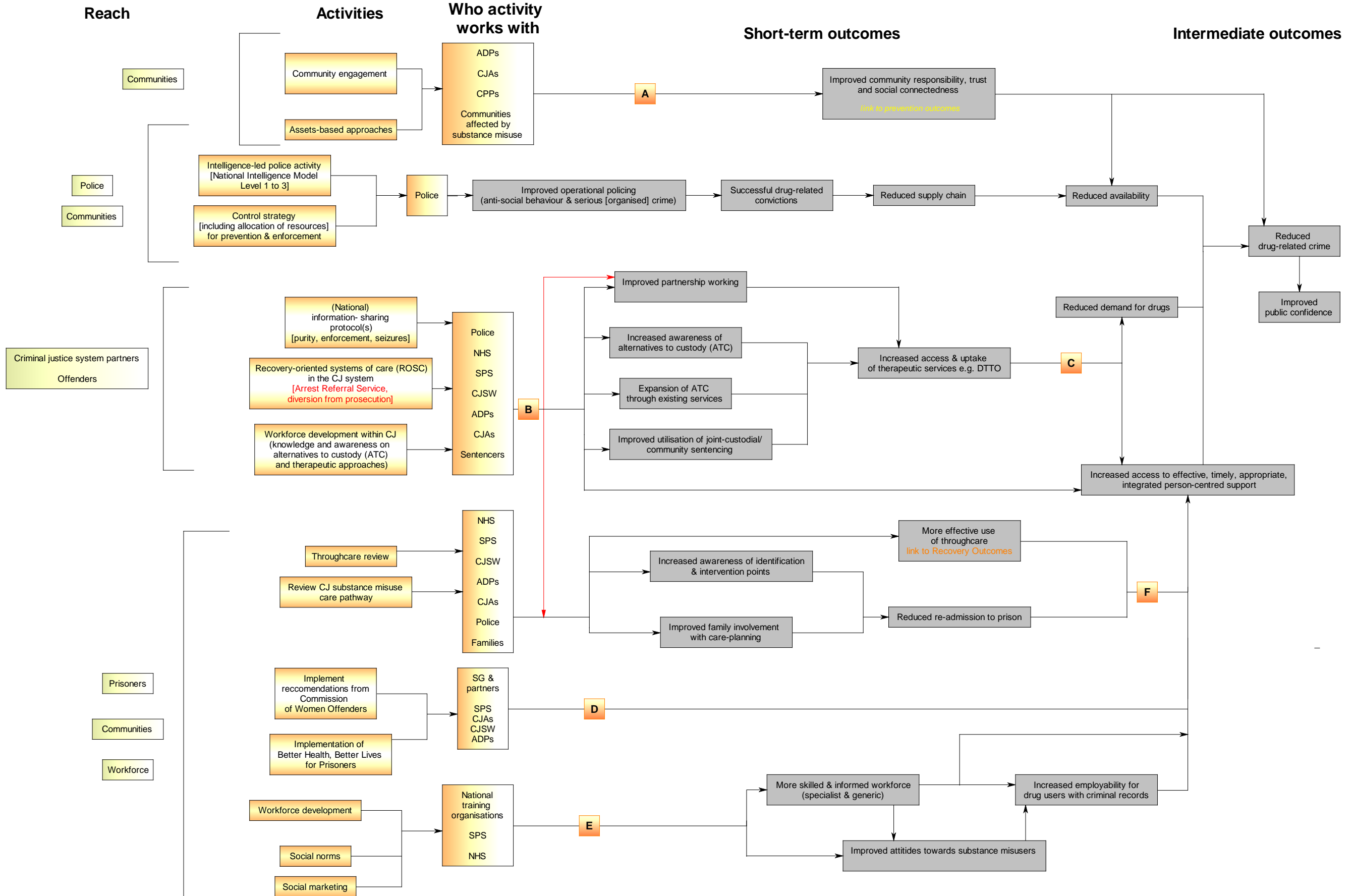
¹² See Scottish Government website: www.scotland.gov.uk/Publications/2013/04/2305

The Children and Young People's Act (2014) makes provision about the rights of children and young people; to make provision about investigations by the Commissioner for Children and Young People in Scotland; to make provision for and about the provision of services and support for or in relation to children and young people; to make provision for an adoption register; to make provision about children's hearings, detention in secure accommodation and consultation on certain proposals in relation to schools; and for connected purposes.
www.legislation.gov.uk/asp/2014/8/introduction/enacted

Summary: There is highly processed evidence for the use of screening and assessment tools to improve appropriate referrals among vulnerable children and families. Review-level evidence, attachment theory and effective interventions further demonstrate the importance of early identification and support for parents and children at risk. Policy and practice guidelines support and protect information sharing protocols for a coordinated response.

Problem Drug Use Outcomes Framework MODEL 4: Enforcement

Please note: red coloured arrows only indicate where lines cross



Logic Model 4: Enforcement

Introduction

This section should be read in conjunction with the 'Enforcement' nested logic model developed for the *Outcomes Framework for Problem Drug Use*. The outcomes framework comprises three other nested logic models (for prevention, recovery and families) brought together by an overarching strategic outcomes logic model. The outcomes were defined by stakeholders in line with national development needs and the Scottish Drugs Strategy (*The Road to Recovery*). The primary focus of this document is to set out the public health recovery-based approach related to demand reduction, recognising persistent offending behaviours of individuals as a direct result of their dependent drug use.

This rationale document summarises the available evidence to support the desired outcomes described in the model. The relevant links in the chains have been lettered (A to F) and reflected in the model for ease of reference. Where available, evidence has been drawn from key sources: National Institute for Health and Care Excellence (NICE) public health guidance (and relevant NHS Health Scotland Commentaries/ Scottish Perspectives); NICE and Health Development Agency (HDA) public health briefings; Scottish Intercollegiate Guidelines Network (SIGN) clinical guidelines; the Cochrane Collaboration and the University of York Centre for Reviews and Dissemination. We have called this information 'highly processed evidence'.

Additional sources of evidence and theory have been drawn from relevant key systematic reviews and literature reviews and reports commissioned by the Scottish Government, the UK Government and national organisations and collaborators. Further papers were identified in conjunction with lead stakeholders and topic experts. Scottish policy and practice notes from national strategies and guidance documents are also cited. References are provided for further information.

Health inequalities impact assessment: health inequalities are systematic differences in health between different groups within a society, which are potentially avoidable and deemed unacceptable. All public sector and many private sector agencies have a contribution to make to reducing health inequalities. A health inequalities impact assessment (HIIA) is a tool which offers an integrated approach to impact assessment encompassing legally protected characteristics, human rights, wider population groups and social determinants of health. The main aim of an HIIA is to strengthen the contribution of policies and plans to reducing health inequalities by improving equity of access, ensuring non-discriminatory practice and acting on the social determinants of health.

All new public sector policies and programmes must be impact-assessed to meet the requirements of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.¹ As a planning tool, this outcomes framework is intended to guide the development of local and national interventions. Accordingly, for the purposes of the framework, the rationale and validation process of the links in the nested logic models has, where possible, given due consideration to the HIIA. A summary 'HIIA note' highlights where identified protected characteristics or vulnerable groups were featured in the evidence.

Further information is available in the introductory narrative of this outcomes framework and NHS Health Scotland full impact assessment guidance materials are available online: www.healthscotland.com/equalities/hiaa/index.aspx

National policy driver – *The Road to Recovery* (2008)

The Scottish Government national drugs strategy, *The Road to Recovery: a new approach to tackling Scotland's drugs problem* (2008), states that it is essential to recognise the impact of action that a wide range of policies will have in tackling the factors associated with problem drug use. The policy clearly states the association between socio-economic disadvantage, deprivation and health inequalities and progression to problem drug use.

Based on Sally Macintyre's framework (2007)² of guiding principles for effective policies and interventions to address health inequalities for the 2008 Ministerial Task Force, interventions for problem drug users are assessed as most likely to have some impact on health inequalities, as they target a disadvantaged group and provide intensive support.

The national drugs strategy *The Road to Recovery* represents a shift in emphasis from merely a punitive approach to drug law enforcement activities towards treatment, rehabilitation and recovery.

The Scottish Government believes in continued steps to reduce the harms and protect communities through law enforcement given the illegal nature of drug possession (including reduction and disruption of supply targeting drug dealers) through a coordinated global response. For people who use drugs, services located in the criminal justice system seek to connect and support individuals into treatment services in the community and assist individuals in their road to recovery from dependent drug use.

¹ Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012:
www.legislation.gov.uk/sdsi/2012/9780111016718/contents

² Macintyre S. *Inequalities in health in Scotland: what are they and what can we do about them?* Glasgow: MRC Social and Public Health Sciences Unit; 2007.

On enforcement and availability the policy states:

‘We want to get to a position where targeted enforcement activity means reducing supply for a sustained period, long enough to let other agencies involved in drug use intervene to promote treatment services, education and ultimately achieving demand reduction.’

(Scottish Government 2008:35).

The policy outlines a therapeutic approach for criminal justice services to enable access to treatment and recovery services, including arrest referral service; drug courts; DTTO, with improved information sharing protocols for integrated service provision and partnership working (notably post-release). The policy recognises the challenge of engaging those on short sentences and supports consideration of the replacement of short sentences with community disposals.

Key enforcement-related outcomes defined in the strategy at the time of publication:

- Stronger and safer communities to live, work and invest.
- To see more people recover from problem drug use and reduce drug-related crime and drug-related deaths.
- Improved continuity of care on admission during a sentence and on release into the community.
- To address health inequalities.

Additional policy contexts include:

- *The Sexual Health and Blood Borne Virus Framework 2011–15*
- *The Mental Health Strategy*
- *Better Health, Better Lives for Prisoners: A framework for improving the health of Scotland’s prisoners*
- *Reducing Reoffending: National Strategy for the Management of Offenders*

Evidence and supporting rationale for enforcement outcomes

A Evidence for community engagement and assets-based approaches

In a health improvement briefing by NHS Health Scotland assets-based approaches are defined as ‘mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits’. Thus empowering and enabling individuals and communities to gain more control over their lives and circumstances.

The mobilisation of assets to promote health and wellbeing is described as follows:

‘Under the umbrella of community development, community engagement and community planning, a range of methods have been developed which aim to identify and mobilise the assets of communities and individuals. Asset mapping – identifying and recording the strengths and contributions of the people and other resources available to a community – is often considered the key first step to enable individuals and communities to recognise what resources may be available to them. How these assets or resources can be used may then contribute to a plan aimed at addressing the problems they have identified. Other specific techniques include co-production, appreciative inquiry, time banking and social prescribing.’

The briefing cites the evidence review by NICE for Public Health Guidance on community engagement to improve health. Recommended actions include the prerequisites, infrastructure, approaches and evaluation of community engagement, while highlighting barriers to engagement and gaps in economic evidence. NHS Health Scotland’s briefing (2011) is clear that emerging evidence on assets-based approaches and improvements in health is currently only from case studies and published evidence on the impact of these approaches on health remains very limited.

The briefing cites The Commission on the Future of Public Services (2011), the Review of Equally Well (2010) and the Chief Medical Officer as supporting and advocating the principles of asset-based approaches. Tools, techniques and resources are also included.

Sigerson D, Gruer L. *Asset-based approaches to health improvement*.
Edinburgh: NHS Health Scotland; 2011.
www.healthscotland.com/documents/5535.aspx

As part of the Mental Health Outcomes Framework (NHS Health Scotland, 2012) limited highly processed evidence was identified from NICE public health guidance to suggest direct and indirect community engagement activities may impact on social capital. A chain of change ‘Increasing social connectedness, relationships and trust in families and communities’ is outlined in [logic model 3](#) of the Mental Health Outcomes Framework. The evidence summary below supports the rationale for community engagement activities in the following logic model link:

Community engagement activities, individual and community-based arts programmes and social prescribing will contribute to individuals and communities having increased knowledge and awareness of services and promote motivation and access to services and programmes for all. This, in turn, will increase attendance, participation and engagement therefore contributing to increased trust in the community, increased social support and social networks.

Evidence summary on community engagement

- There is limited highly processed evidence in the mental health sector about effective interventions to promote community engagement and participation, build social capital and increase trust. There is some review-level evidence that direct and indirect community engagement activities may impact on social capital.³
- Informed by reviews of effectiveness evidence, NICE public health guidance 09 *Community engagement to improve health* made 12 action recommendations which together are intended to present 'the ideal scenario for effective community engagement.' These include prerequisites for community engagement, infrastructure, approaches and evaluation of community engagement programmes. The NHS Health Scotland commentary on this guidance supported these action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.⁴
- Evaluations of other community-based projects such as Communities that Care (CtC) suggest that they can result in improvements in family and community relations as well as other behavioural impacts⁵. Long-term evaluations in the UK have not been undertaken to date.

A further chain of change in the Mental Health Outcomes Framework 'Increasing social inclusion and decreasing inequality and discrimination' is outlined in logic model 4. The evidence summary below supports the rationale for social exclusion activities in the following logic model link:

Having access to education, culture, leisure and the arts as well as basic needs will increase social inclusion.

Evidence summary on social exclusion

- There is no highly processed evidence in the health sector about which are the most effective strategies for increasing access to education, culture, leisure and the arts and how this might impact on mental health outcomes. Drawing on a review of literature and research as well as consultations and field studies, *Mental Health and Social Exclusion: A report by the Social Exclusion Unit* identifies a number of actions to address social exclusion including actions relating to supporting families and community participation

³ NHS Health Scotland. *Commentary on NICE Public Health Guidance: Community engagement to improve health*. Edinburgh: NHS Health Scotland; 2008.

⁴ NHS Health Scotland. *Commentary on NICE Public Health Guidance: Community engagement to improve health*. Edinburgh: NHS Health Scotland; 2008.

⁵ Hosman C and Jané-Llopis E. The Evidence of Effective Interventions for Mental Health Promotion. In Herman H, Saxena S, Moodie R (Eds). *Promoting mental health: Concepts, emerging evidence and practice*. Geneva: World Health Organization; 2005.
www.who.int/mental_health/evidence/en/promoting_mhh.pdf

(enabling people to lead fulfilling lives the way they chose) and getting the basics right (access to decent housing, financial advice and transport).⁶

- Models of learning indicate, for example, that engagement in learning results in wider benefits to health and wellbeing through the development of skills and competencies (e.g. cognitive skills, technical/vocational skills, resilience, beliefs about self and social and communication skills), social networks and qualification.⁷
- Rowling and Taylor (2005) argue that community-based arts programmes can contribute to community health through collaborative and inclusive processes, social cohesion and a sense of belonging.⁸

Logic Model 3 of the Mental Health Outcomes Framework is available here: www.healthscotland.com/OFHI/MentalHealth/logicmodels/MH_LM3.html

Logic Model 4 of the Mental Health Outcomes Framework is available here: www.healthscotland.com/OFHI/MentalHealth/logicmodels/MH_LM4.html

The full Mental Health Outcomes Framework, including evidence, tools and resources, is available here: www.healthscotland.com/OFHI/MentalHealth/content/MHtools.html

In a Scottish Government Justice Analytical Services evidence review on reducing crime encouraging communities to exercise informal guardianship of their own public spaces was identified as a potential strategy for deterring crime. Generating 'collective efficacy' or 'community cohesion' to reduce rates of crime within neighbourhoods is based on the link concluded from seminal research conducted in the United States by Sampson and Raudenbush (1999). The theory is that communities with high collective efficacy are more effective in exercising control or guardianship on their public spaces and deter potential offenders through an increased risk of detection. The review cites Sampson & Raudenbush's (1999) definition of collective efficacy as 'linkages of cohesion and mutual trust with shared expectations for intervening in support of neighbourhood social control'. This empirical study concluded that collective efficacy is promoted by housing stability and undermined by concentrated disadvantage.

Scottish Government. *What Works to Reduce Crime? A Summary of the Evidence*. Edinburgh: Justice Analytical Services, Scottish Government; 2014.

⁶ Social Inclusion Report. Mental Health and Social Exclusion: Social Exclusion Unit Report. London: HMSO; 2004.

⁷ Foresight Mental Capital and Wellbeing Project. Final Report. London: The Government Office for Science; 2008.

⁸ Rowling L, Taylor A (2005). Intersectoral approaches to promoting mental health. In H Herman, S Saxena and R Moodie (Eds). *Promoting mental health: Concepts, emerging evidence and practice*. Geneva: World Health Organization; 2005.
www.who.int/mental_health/evidence/en/promoting_mhh.pdf

Scottish policy and practice note:

The ***Report of the Ministerial Task Force on Health Inequalities*** (2013) second review of Equally Well looked at how communities are being engaged in the decisions that affect them and also the importance that 'place' has on health inequalities. Two of the priority areas identified in the review were:

- Development of social capital
- Support for the implementation of a Place Standard

In support of the creation of health the report includes the following definition of social capital: 'Social capital describes the pattern of networks among people and the shared values which arise from those networks. Greater interaction between people generates a greater sense of community spirit.'

The definition used by the Office for National Statistics, taken from the Office for Economic Co-operation and Development (OECD), is 'networks with shared norms, values and understandings that facilitate cooperation within or among groups'.

The report states higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes, and lower crime rates. There are a number of different aspects to social capital:

- levels of trust (for example, whether individuals trust their neighbours)
- membership (for example, to how many clubs, societies or social groups individuals belong)
- networks and social contacts (for example, how often individuals see family and friends)

Shared norms, values and understandings relate to shared attitudes towards behaviour that are accepted by most individuals and groups as a 'good thing'.

The Task Force report highlights the growing recognition of a need to shape places which are nurturing of positive health, wellbeing and resilience. The report cites the Single Outcome Agreement (SOA)⁹ guidance published in 2012 that highlighted the importance of tackling place as a key determinant of health, followed by the recent policy statement *Creating Places*¹⁰ that recognised that the quality of the built environment affects everyone, and that it is the purpose of architecture and urban design not only to meet our practical needs but also to improve the quality of life for the people of Scotland. To that end, the Scottish Government has committed to developing a Place Standard. See: www.scotland.gov.uk/Publications/2014/03/2561

⁹ *Single Outcome Agreements: Guidance to Community Planning Partnerships*. Edinburgh: Scottish Government and COSLA; 2012. www.scotland.gov.uk/Topics/Government/local-government/CP/SOA2012/SOA2012

¹⁰ *Creating Places – A policy statement on architecture and place for Scotland*. Edinburgh: Scottish Government; 2013. www.scotland.gov.uk/Publications/2013/06/9811/downloads#res-1

The Place Standard will be a resource that will be used to assess the quality of places, both existing places and new developments. It will consider a range of key themes that can impact on the health and quality of life of the people who live in a place.

Summary: Limited highly processed, review level evidence and plausible theory support the link between enhancing individual and community strengths to foster resilience of residents and develop community responsibility and connectedness, and deter crime.

B Evidence for integrated recovery-oriented services

Scottish policy and practice note:

Recovery from drug addiction and dependence is acknowledged to be a highly individual and rarely linear process. In the Scottish Government national drugs strategy, ***The Road to Recovery: a new approach to tackling Scotland's drugs problem (2008)*** recovery is defined as 'a process through which an individual is enabled to move from their problem drug use, towards a drug-free lifestyle as an active and contributing member of society' and states that 'recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment... an aspirational and person-centred process'.

Redesigning the community justice system in Scotland

The changes follow a 2012 consultation on options to make improvements to the way services for offenders are planned, managed and delivered. Key changes include:

- transferring responsibility for the planning and delivery of community justice services from Scotland's eight Community Justice Authorities to the 32 Community Planning Partnerships (CPPs). This will ensure criminal justice social workers maintain their links with colleagues in local authorities, while developing stronger links with partners in areas like health, housing and welfare to improve how they work together to tackle re-offending
- a national strategy for community justice and reducing reoffending. This will set the national strategic direction for CPPs to plan and deliver services as well as providing the framework against which progress can be assessed and improvement driven. A new national body will be created to provide independent assurance to Ministers on the successes of community justice partners in tackling re-offending. This will give community justice the leadership it needs to continue the progress towards tackling crime and making communities safer.

www.scotland.gov.uk/Topics/Justice/policies/reducing-reoffending/community-justice (April 2014)

Criminal Justice and Licensing (Scotland) Act 2010 made a number of changes to how our justice system operates including: Make sentences served in the community more robust, immediate and visible through the creation of the Community Payback Order (CPOs), and introduce a presumption against short prison sentences of three months or less. These were introduced in February 2011. The community sentencing provided by CPOs is crucial for making realistic alternatives to custody available and for supporting rehabilitation. See: www.scotland.gov.uk/Topics/archive/law-order/criminal-justice-bill

Reducing Reoffending: National Strategy for the Management of Offenders (2006)

This strategy outlines a common set of objectives to give a shared focus to all those working with offenders in any capacity.

Outcomes for communities: Scotland is a safe place to live. But too many communities and individuals suffer the effects of crime. Communities need to feel safer as well as be safer. So we want to see:

- Increased community safety and public protection through a consistent approach to managing offenders on community and custodial sentences.
- Increased public confidence in the effectiveness of work with offenders.
- Improved understanding of community disposals.
- Improved understanding of the role of prisons.
- Improved satisfaction for victims, sentencers and beneficiaries of work by offenders.
- Appropriate care of victims, including appropriate and timely information.
- Timely information and, where appropriate, involvement for the families of offenders.

Outcomes for offenders: We know that certain factors will reduce the chance of an individual reoffending. We will expect agencies to work together to enhance services for offenders to achieve the following outcomes:

- Sustained or improved physical and mental wellbeing.
- The ability to access and sustain suitable accommodation.
- Reduced or stabilised substance misuse.
- Improved literacy skills.
- Employability prospects increased.
- Maintained or improved relationships with families, peers and community.
- The ability to access and sustain community support, including financial advice and education.
- The ability to live independently if they choose.
- Improvements in the attitudes or behaviour which lead to offending and greater acceptance of responsibility in managing their own behaviour and understanding of the impact of their offending on victims and on their own families.

The **Commission on Women Offenders** stated that convictions for frequent low-level offences, often a result of significant underlying issues, such as drug and alcohol addiction and mental health problems, could be better addressed in the community.

The Commission concluded that services and programmes need to be tailored to the multiple and complex needs of women offenders to achieve reductions in reoffending and better outcomes for local communities.

The final report made recommendations which offer practical proposal to reduce reoffending among women. See:

www.scotland.gov.uk/About/Review/commissiononwomenoffenders

Summary: Scottish policy directives support all organisations with a contribution to make to managing offenders to work together in a coordinated way to deliver enhanced outcomes for individuals and communities.

C

Evidence for therapeutic services and diversion from prosecution

NICE Clinical Guideline 51 general considerations on drug misuse psychosocial interventions include:

- In order to reduce loss of contact when people who misuse drugs transfer between services, staff should ensure that there are clear and agreed plans to facilitate effective transfer.
- Routine screening for recent drug use should be offered in mental health and criminal justice settings.
- For people in prison who have drug misuse problems, access to and choice of treatment should not depend on whether the person is participating in treatment voluntarily or is legally required to do so. And treatment options should be comparable to those available in the community, with additional consideration specific to the prison setting. For example for those who choose to remain abstinent after release from prison, residential treatment should be considered as part of an overall care plan (given known high risk of overdose post-release).

NICE. Clinical Guidance 51: Drugs Misuse: Psychosocial Interventions. London: NICE; 2011.

HIIA note: This guideline covers psychosocial interventions for adults and young people who misuse opioids, cannabis or stimulants (for example, cocaine or amphetamine). It does not specifically cover people with dual diagnosis; people who misuse alcohol, prescription drugs or solvents; diagnosis or primary prevention; people younger than 16 years.

The Advisory Council on Misuse of Drugs' overview of the evidence on recovery from drug and alcohol dependence cites UK research evidence (Skodbo et al 2007) that coercion can be an effective way of getting people into treatment.

Advisory Council on Misuse of Drugs. *Recovery from drug and alcohol dependence: an overview of the evidence*. London: ACDM; 2012.

A Scottish review of criminal justice interventions for drug users also concludes that equitable outcomes are achieved for those who access treatment through the criminal justice system as those who access it voluntarily. (Also citing previous work by Hough (1996) which concluded legally coerced treatment was no less effective than treatment entered into voluntarily and evidenced over time by McSweeney et al. (2006).)

Malloch M. *Interventions for Drug Users in the Criminal Justice System: Scottish Review*. Glasgow: The Scottish Centre for Crime and Justice Research; 2011

In their review of the evidence for supply control, Strang et al. (2012) surmise that although contested the evidence of effectiveness of sanctions such as wide-scale arrests and imprisonment as a deterrent of drug use and related criminal offending is at best weak. However, increasing evidence is cited from criminal justice programmes suggesting 'specific, brief and immediate sentences (e.g. overnight)' for individuals who fail drug tests in their supervision orders can produce considerable reduction in drug use and offending. The authors note this evidence comes from mandated abstinence programmes for drug and drink-driving offenders on community release, and programmes for addicted physicians and pilots.

There is review-level evidence that drug courts, as an intervention to support offenders into treatment, are more effective at retaining drug users than other diversion programmes, although the scale-up of such interventions is noted to have been challenging.

Strang J, Babor T, Caulkins J, Fischer D, Humphreys K. Drug policy and the public good: evidence for effective interventions. *Addiction 2 Series. The Lancet*. 2012;379.

Drug courts

Evidence indicates that drug courts are effective in reducing recidivism; the strength of the evidence varies by drug court type with effects smaller in juvenile drug courts. And programmes with eligibility for non-violent offenders only had larger reductions in general recidivism.

Evidence of adult drug courts suggests that participants have reduced recidivism during and after drug court treatment, with effects lasting at least three years. Effectiveness is largely robust to programme variations. However, evidence supporting the importance

of leverage and intensity (dismissing charges and more frequent status hearings) were significant in relation to specifically reducing drug-related recidivism.

Mitchell O, Wilson DB, Eggers A, MacKenzie DL. Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice*. 2012;40:60–71.

HIIA note: The review aimed to identify studies that explicitly considered the circumstances of children, young people or families exposed to parental substance misuse.

There is limited evidence from US-based models of family treatment drug courts that these can be effective in supporting parents to enter treatment, stay in longer and complete treatment. Some aspects were less conclusive, such as child welfare results. The basic model includes regular, frequent court hearings, intensive judicial monitoring, timely substance abuse treatment and other needed services, frequent drug testing, and rewards and sanctions linked to parental compliance with their service plan with the primary motivation for parents involved in FTDCs is the goal of being reunited with their children. Findings from a large-scale prospective study (Worcel et al., 2008) indicate that FTDCs did not decrease children's stays in out of home placement, but they did increase the likelihood of the family being reunited. Clarity is needed as to whether this positive outcome is a result of the model's influence on treatment or whether the model uniquely contributes to family reunification.

Mitchell F, Burgess C. *Working with families affected by parental substance misuse: a research review*. Edinburgh: Scottish Child Care and Protection Network, Scottish Government; 2009.

Drug treatment

The Best et al. (2010) Scottish-Government-commissioned review cites evidence from a meta-analysis of drug treatment studies (Prendergast et al., 2002) that concludes drug abuse treatment is effective in reducing both drug use and offending. This review suggested that the younger the age of treatment participants the better predictor of reductions in crime.

Best et al. *Research for Recovery: A Review of the Drugs Evidence Base*. Edinburgh: Scottish Government; 2010.

There is evidence of effectiveness from multiple seminal large-scale longitudinal treatment outcome studies that treatment for drug dependence works to reduce drug use, improve mental and physical health, and reduce levels of crime [for a summary of findings see Best et al. (2010)]. Findings from these multiple 'what works in practice' studies at two to five years follow-up suggest a minimum three months treatment duration is critical to contributing to successful outcomes.

- The UK National Treatment Outcome Research Study (NTORS – prospective study from 1995). Economic analysis at two years follow-up suggests the majority

of calculated economic benefits associated with treatment are accounted for by reductions in criminal behaviour from reduced heroin use.

Godfrey C, Stewart D, Gossop M. *Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study*. NTORS; 2004.

- Analysis of criminal activity at five years follow-up suggests crime reductions statistically significant and represent substantial changes in behaviour and have considerable personal, social and clinical importance.

Gossop M, Trakada K, Stewart D, Witton J. Reductions in criminal convictions after addiction Tx: 5-year follow up. *Drug and Alcohol Dependence*. 2005;79. HIIA note: The client sample from which the above evidence is derived, i.e. the target group for the intervention, was deemed to be similar to the demographic and drug-using profiles of the overall voluntary treatment seeking population in England and Wales at time of study (DoH 1999). The mean age of follow-up sample 29.6 years; approximately three quarters were male, 91% identified as white/UK, clients had long-term heroin dependence [mean duration of heroin use at treatment intake was nine years]. Clients reported polydrug use, including many clients presenting with alcohol problems in addition to their drug-use problem. 90% had received addiction treatment during previous two years and 21% reported receiving psychiatric treatment.

The Drug Treatment Outcomes Research Study (DTORS) is a major national longitudinal evaluation of drug treatment in England. Participants were recruited from treatment facilities between February 2006 and March 2007. Findings suggest evidence of treatment effectiveness with significant and substantial reduction in drug use and offending, with the criminal justice system (CJS) an equally valid route into drug treatment, with few differences in outcomes compared to non-CJS referrals. In addition, when the net gains in health from drug treatment and the savings in crime-related costs as a result of reduced offending were calculated, treatment was cost-effective and cost-beneficial.

Donmall M, Jones A, Davies L, Barnard M. *Summary of Key Findings from the Drug Treatment Outcomes Research Study (DTORS)*. London: Home Office Research Report 23; 2009.

HIIA note: The sample of adults were broadly representative of the treatment seeking population in England. Research participants were predominantly male (73%) and White (89%) [compared to 4% who were of mixed ethnicity; 3% Black; 3% Asian, and 2% who were designated as an 'other' ethnic group]. The age group was typical of a drug treatment group with 20% aged from 16 to 24; 45% aged from 25 to 34, 27% from 35 to 44, and 7% aged 45 and over. 35% of treatment seekers were referred to treatment through the criminal justice system.

Summary: There is highly processed and review-level evidence of the effectiveness of therapeutic services within criminal justice settings in reducing drug use and drug-related crime. As defined in the introduction to this document, Scottish policy directives are also supportive of this approach.

D**Evidence for a holistic, whole-systems approach for person-centred care and management of offenders**

In the literature and policy review conducted for the Better Health, Better Lives for Prisoners framework the authors cite the WHO (2007) definition of health promoting prison that includes a holistic approach:

‘The phrase health promoting prison is used to cover the prisons in which: the risks to health are reduced to a minimum; essential prison duties such as the maintenance of security are undertaken in a caring atmosphere that recognises the inherent dignity of every prisoner and their human rights; health services are provided to the level and in a professional manner equivalent to what is provided in the country as a whole; and a whole-prison approach to promoting health and welfare is the norm.’

The authors also cite a narrative review by De Viggiani (2006) that sees the whole-prison approach as a public health prevention model that could benefit society by tackling exclusion and inequality, as determinants of health and acknowledged precursors to criminal behaviour. In this vein, a whole-prison approach is described as necessary for prisons to meet standards of safety, purposeful activity, effective resettlement and respect [HM Inspectorate of Prisons for England, Wales and Northern Ireland tests for a healthy prison].

Brutus L, Mackie P, Millard A, Fraser A, Conacher A, Hardie S, McDowall L, Meechan H. *Better Health, Better Lives for Prisoners: A framework for improving the health of Scotland’s prisoners. Volume 2: Supporting material for the framework.* 2012.

Scottish policy and practice note:

In November 2011, responsibility for prison healthcare was transferred to the NHS. The three quality ambitions of **NHSScotland Quality Strategy** (2010) are:

Safe: There will be no avoidable injury or harm to people from healthcare, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all time.

Person-centred: Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making.

Effective: The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

See: www.scotland.gov.uk/Topics/Health/Policy/Quality-Strategy
www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf

Better Health, Better Lives for Prisoners: A framework for improving the health of Scotland's prisoners (2012) supports a new partnership between the Scottish prisons and NHS Scotland. It sets out priorities for health improvement, advocates for a whole-prison approach and recognises that the inter-related risk-factors are best tackled through comprehensive, integrated programmes.

[www.scotphn.net/pdf/2012_06_08_Health_improvement_for_prisoners_vol_1_Final_\(Web_version\)1.pdf](http://www.scotphn.net/pdf/2012_06_08_Health_improvement_for_prisoners_vol_1_Final_(Web_version)1.pdf)

In 2013, the ***Healthier People, Safer Communities*** report was published with recommendations to the Offender Health Collaborative (OHC)¹¹ to assist in the development of a strategic response to improving offender health and wellbeing. As part of the personalisation agenda, a medium-term recommendation was to 'consider how a universal model for an offender personal wellbeing plan can be promoted, integrated into current and future case management procedures and support the concept of one offender/one plan incorporating the elements of prison in-reach and relationship building with a key worker'.

Recommendations for a broader framework adapted for offenders are also developed. A second phase is proposed: Improving the Health of Offenders in the Community, with opportunities for implementation through community planning processes and the drive to improve community re-integration. A wider public-health approach to reducing re-offending is identified within the context of strengths-based and asset-based approaches, with guidance on personal planning for health and wellbeing. The report states:

'Offending is a determinant of health, however, poor health and the many inter-related social and economic problems experienced by communities in Scotland are also known determinants of offending. Greater collaboration between health and criminal justice through a public health-based approach could allow for more joined-up working with support and interventions targeted and delivered throughout the life course, addressing broad determinants and risk factors and enabling those in contact with the criminal justice system to get the personalised support they require. It could facilitate greater crossover at an operational and strategic level between health and criminal justice to deliver on shared outcomes around alcohol, illegal drugs, mental health, blood-borne viruses, smoking, engagement with primary care, learning disabilities, parenting and family support, education skills and employability, desistance and workforce development.'

Available online: www.scotphn.net/pdf/Offender_Health_Report_2013.pdf

¹¹ The OHC currently has membership from SPS, NHS Health Scotland, Scottish Public Health Network (ScotPHN), Scottish Health Promotion Managers Group (SHPMG), local NHS Health Promotion Services and the Community Justice Authorities (CJAs).

The Commission on Women Offenders was established by the Scottish Government in June 2011 to look at ways to improve outcomes for women in the criminal justice system. The Scottish Government published its response accepting 33 of the 37 recommendations and set out plans for taking these forward in the short and long term, while considering the remaining four in more detail. See:

www.scotland.gov.uk/About/Review/commissiononwomenoffenders

In its final report, the Commission acknowledged that many women in the criminal justice system are frequent reoffenders with complex needs that relate to their social circumstances, previous histories of abuse and mental health and addiction problems. Recommendations encompass service redesign, alternatives to prosecution, alternatives to remand, sentencing, prisons, community reintegration and leadership, structures and delivery.

Service redesign recommendations include the development of a multidisciplinary approach with a named key worker for women at risk of reoffending or of custody as a single point of contact as they move through the criminal justice system, including any periods in custody, to coordinate the planning and delivery of interventions. In addition to support compliance with court orders, intensive mentoring for practical support on a wide range of issues related to offending behaviour should be available to women.

Summary: International and UK evidence-informed policy directives support the link for a person-centred holistic approach to improve outcomes for offenders.

E Evidence for staff training and development

NICE Clinical Guideline 51 general considerations on drug misuse psychosocial interventions include the following:

- All interventions for people who misuse drugs should be delivered by staff who are competent in delivering the intervention and who receive appropriate supervision.
- People who misuse drugs should be given the same care, respect and privacy as any other person.

NICE. Clinical Guidance 51: *Drugs Misuse: Psychosocial Interventions*. London: NICE; 2011.

In the literature and policy review conducted for the Better Health, Better Lives for Prisoners framework the authors conclude in their evidence summary of literature to reduce harmful use of illicit drugs in prison that prison residential officer addictions education would help positive engagement with prisoners about reducing their drug

use. A holistic throughcare approach is also identified, to involve families (where helpful), addictions, mental health, housing, education and employment services to break the cycle of drug use, mental health problems, worklessness, homelessness and imprisonment.

Brutus L, Mackie P, Millard A, Fraser A, Conacher A, Hardie S, McDowall L, Meechan H. *Better Health, Better Lives for Prisoners: A framework for improving the health of Scotland's prisoners. Volume 2: Supporting material for the framework.* 2012.

Available US-based evidence suggests that offering treatment to female drug-using offenders is effective in reducing drug use and reducing re-incarceration (but not rearrest). The review authors highlight conclusions from a specially adapted therapeutic community study on the importance of providing gender-specific sensitive and comprehensive approaches within the criminal justice system (Sacks 2008). In addition the recognition of trauma in gender responsive treatment (GRT) was an important aspect of recovery that needs to be addressed due to its impact on a range of other outcomes, also perhaps enhancing treatment satisfaction consequently encouraging retention and recovery (Messina 2010).

Perry AE, Neilson M, Martin-St James M, Glanville JM, McCool R, Duffy S, Godfrey C, Hewitt C. Interventions for female drug-using offenders. *Cochrane Database of Systematic Reviews.* 2014.

There is some evidence that communicating positive stories of people with substance use disorders reduced stigmatising attitudes among the general public towards heroin and alcohol dependence. However, information factsheets did not achieve meaningful change in stigmatising attitudes among the general public.

In relation to professional groups, the available evidence suggests educational interventions targeting medical students achieve enhanced results when contact-based approaches facilitating interaction with people with substance misuse problems are included in training and curricular. There was evidence of improving attitudes and comfort levels towards working with this population, notably significant increases in comfort were found from specialist prenatal clinic placements working with pregnant women with substance use disorders. Finally, skills-training working with police officers and interventions targeting substance use counsellors have also demonstrated positive effects on stigma-related outcomes.

Livingston JD, Milne T, Fang ML, Amari E. The Effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction.* 2011;107:39–50.

HIIA note: The evidence identified pregnant women who use substances as one of the target groups.

Scottish policy and practice note:

The Commission on Women Offenders was established by the Scottish Government in June 2011 to look at ways to improve outcomes for women in the criminal justice system. Recommendations encompass service redesign, alternatives to prosecution, alternatives to remand, sentencing, prisons, community reintegration and leadership, structures and delivery.

Recommendation 30: Gender-specific training for all professionals working with women prisoners. After accepting this recommendation, the Scottish Government second annual update on progress (October 2013) stated an SPS induction package for new staff in being revised following an operational pilot, and a comprehensive training plan for existing staff is being developed for roll out to staff Summer 2014. The training includes the SPS's guidance on managing women offenders; training on mental health, trauma, mentalisation and borderline personality disorders and training on services and reintegration for women offenders.

Summary: There is highly processed and review-level evidence to support specific training for criminal justice staff in addiction, trauma and gender-specific needs of women and offenders to enable effective engagement and care planning for recovery. There is evidence from one systematic review that a range of interventions may influence positive outcomes in reducing social and structural stigma associated with substance misuse.

F Evidence for throughcare and community reintegration

NICE Clinical Guideline 51 on drug misuse psychosocial interventions' general considerations state:

- For people in prison who have drug misuse problems, access to and choice of treatment should not depend on whether the person is participating in treatment voluntarily or is legally required to do so. And treatment options should be comparable to those available in the community, with additional consideration specific to the prison setting. For example, for those who choose to remain abstinent after release from prison, residential treatment should be considered as part of an overall care plan (given known high risk of overdose post-release).
- Best practice for the treatment and care of people who misuse drugs should have the opportunity to make informed decisions about their care and treatment, in partnership with healthcare professionals. Good communication between staff and service users is essential. Treatment and care, and the information service users are given about it, should be culturally appropriate. It should also be accessible to

people with additional needs, such as physical, sensory or learning disabilities, and to people who do not speak or read English.

- Assessment should have a holistic approach to care planning with the service user with consideration given to specific needs, history of drug use and previous experience of treatment, goals and preferences
- Staff should support service users in fulfilling their care plan with a supportive relationship, developing coping strategies, access to wider range of services and maintaining engagement as well as ensuring successful collaboration with other care providers.

NICE. *Clinical Guidance 51: Drugs Misuse: Psychosocial Interventions*. London: NICE; 2011.

In the literature and policy review conducted for the *Better Health, Better Lives for Prisoners* framework the authors cite evidence that prisoners who are able to keep meaningful contact with their families are less likely to reoffend due to improved resettlement on release. Evidence of the protective quality of 'social bonds', including where an offender values and is valued as, being part of a family unit, is also cited from literature on desistance from reoffending.

Brutus L, Mackie P, Millard A, Fraser A, Conacher A, Hardie S, McDowall L, Meechan H. *Better Health, Better Lives for Prisoners: A framework for improving the health of Scotland's prisoners. Volume 2: Supporting material for the framework*. 2012.

A Cochrane systematic review identified limited evidence of unclear quality from US-based studies that therapeutic communities with aftercare for drug-using offenders with co-occurring mental illness reduces criminal activity and re-incarceration (but not rearrest or self-reported drug use) following treatment. However, the review authors highlight the paucity of evidence and the variability in the study measurement process for the desired outcomes.

There is little information from current evidence as to how to address the complex issues of individuals with mental illness and co-occurring substance abuse, and it is not known how treatment facilitates the specific rehabilitation needs of offenders with drug use and mental health problems. From the limited studies the review authors discuss several successful treatment elements reported throughout the five US-based trials:

- i. treatment engagement, with informal support from family and friends encouraging
- ii. specifically adapted programmes to needs of mental health clients
- iii. (longer) retention improved outcomes.

Perry AE, Neilson M, Martin-St James M, Glanville JM, McCool R, Duffy S, Godfrey C, Hewitt C. Interventions for drug-using offenders with co-occurring mental illness. *Cochrane Database of Systematic Reviews*. 2014.

HIIA note: Participants in included studies were drug-using offenders with co-occurring mental illness regardless of gender, age or ethnicity. Drug misuse

was classified as occasional, dependent or abusive use of drugs. Offenders were defined as individuals involved in the criminal justice system. Offenders were judged to have co-occurring mental illness where this was explicitly stated in the paper – a combination of standard diagnostic tests, nature of the intervention (e.g. mental health court) and demographic participant details (e.g. describing a history of psychiatric illness or serious mental disorder with co-occurring substance misuse) were used to identify study samples with mental health problems.

In a Cochrane systematic review, limited US-based evidence suggests that offering treatment to female drug-using offenders is effective in reducing drug use and reducing re-incarceration (but not rearrest). There is insufficient evidence to determine if treatment type and setting affect outcomes. [Although three case management and cognitive skills-based intervention studies did significantly reduce re-incarceration.] However, the review authors highlight the paucity of evidence available.

One study (Johnson 2011) did show a reduction in monthly primary drug use. The review authors note that this is consistent with other studies that indicate a gender effect in prison substance misuse treatment outcomes, with women having lower drug use rates than men in the months after release from prison when they have engaged in a treatment programme during their sentence. A gender-specific pathway for community reintegration has been suggested by researchers based on this gender effect also observed in relation to aftercare treatment completion and re-offending behaviour.

Perry AE, Neilson M, Martin-St James M, Glanville JM, McCool R, Duffy S, Godfrey C, Hewitt C. Interventions for female drug-using offenders. *Cochrane Database of Systematic Reviews*. 2014.

HIIA note: Participants in included studies were all female drug-using offenders regardless of age or ethnicity. Drug misuse was classified as occasional, dependent or abuse of drugs. Offenders were defined as individuals subject to the criminal justice system.

In their Scottish-Government-commissioned evidence review, Best et al (2010) cite recovery research focusing on relapse (Litt and Mallon 2003) and recidivism (Lemieux 2002) demonstrating the role of sober/support or social networks incorporated into the treatment and aftercare of offenders in maintaining positive outcomes.

Best D, Rome A, Hanning KA, White W, Gossop M, Taylor A, Perkins A. *Research for Recovery: A Review of the Drugs Evidence Base*. Edinburgh: Scottish Government; 2010.

Case management

Cochrane review-level evidence suggests case management is effective as a strategy for linking community and treatment services for persons with substance-use disorders in need of a variety of support. However, effects differ depending on availability, access and model of case management (with the most promising effect found for strengths-

based approaches and the use of a manual to guide and standardise delivery). Findings related to drug-use outcomes varied but overall did not provide convincing support that case management is effective to reduce illicit drug use, although a small effect was found when compared with other specific treatment such as motivational interviewing or drug counselling. A small number of studies found evidence of a moderate significant effect for improvements in housing and small (yet non-significant) but consistent effect on legal outcomes (e.g. number of days incarcerated, charges for drug-related offences). This evidence is drawn from studies that concerned patients who were out of treatment when assigned to case management or control.

Hesse M, Vanderplasschen W, Rapp R, Broekaert E, Fridell M. Case Management for persons with substance use disorders. *Cochrane Database of Systematic Reviews*. 2007.

HIIA note: Interventions targeted substance misusers [including alcohol, opiate dependent and cocaine], in treatment and non-responders; homeless; veterans; (ex-) offenders; dual diagnosis patients; all but one of the studies reported male participants with age range 29 to 45 years.

Scottish policy and practice note:

The Road to Recovery (2008) Scotland's drug strategy states a need to ensure continuity of care on admission, on transfer to other prisons during a sentence and on release into the community. Information-sharing will underpin this between prisons and community service providers.

All prisoners with addiction difficulties have their needs assessed and appropriate treatment arranged through the Scottish Prison Service's Integrated Case Management (ICM) process, with those subject to statutory supervision on release linked to community-based services as part of their multi-agency ICM case conference risk management plan to ensure necessary supports are in place post-release. The policy states: 'Assisting prisoners with their drug problems helps prevent further reoffending on release and promotes integration.'

The Commission on Women Offenders was established by the Scottish Government in June 2011 to look at ways to improve outcomes for women in the criminal justice system. Recommendations encompass service redesign, alternatives to prosecution, alternatives to remand, sentencing, prisons, community reintegration and leadership, structures and delivery.

Community reintegration recommendations include introduction of inter-agency protocols on prison discharge and homelessness, arrangements for access to benefit entitlement immediately upon release from prison and community

reintegration support for all women offenders during and after their custodial sentence.

In accepting these recommendations, the Scottish Government recognise the vital role of housing in the sequence of interventions to help a women desist from crime and will therefore work with local authorities to achieve a consistent approach across Scotland. The Scottish Government has developed a pilot scheme in HMP Cornton Vale in collaboration with the UK Department for Work and Pensions to enable pre-release applications for relevant benefit entitlements for prompt access on release.

Reintegration and throughcare support will be part of the establishment of Community Justice Centres recommended by the Commission and a key aim of the group on services and through-care as part of Phase 2 of the Reducing Reoffending Programme.

See: www.scotland.gov.uk/About/Review/commissiononwomenoffenders

Summary: There is highly processed and review-level evidence for throughcare planning on release from prison. With the role of family and housing highlighted as critical elements of aftercare support requirements to foster reintegration into the community. The limited evidence of effectiveness regarding case management suggests it may support facilitation of these ends.

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Appendix A: Core Outcomes for Alcohol and Drug Partnerships

1 Health

People are healthier and experience fewer risks as a result of alcohol and drug use: a range of improvements to physical and mental health, as well wider well-being, should be experienced by individuals and communities where harmful drug and alcohol use is being reduced, including fewer acute and long-term risks to physical and mental health, and a reduced risk of drug or alcohol-related mortality.

2 Prevalence

Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others: a reduction in the prevalence of harmful levels of drug and alcohol use as a result of prevention, changing social attitudes, and recovery is a vital intermediate outcome in delivering improved long-term health, social and economic outcomes. Reducing the number of young people misusing alcohol and drugs will also reduce health risks, improve life-chances and may reduce the likelihood of individuals developing problematic use in the future.

3 Recovery

Individuals are improving their health, well-being and life-chances by recovering from problematic drug and alcohol use: a range of health, psychological, social and economic improvements in wellbeing should be experienced by individuals who are recovering from problematic drug and alcohol use, including reduced consumption, fewer co-occurring health issues, improved family relationships and parenting skills, stable housing; participation in education and employment, and involvement in social and community activities.

4 Families

Children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances: this will include reducing the risks and impact of drug and alcohol misuse on users' children and other family members; supporting the social, educational and economic potential of children and other family members; and helping family members support the recovery of their parents, children and significant others.

5 Community safety

Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour: reducing alcohol and drug-related offending, re-offending and anti-social behaviour, including violence, acquisitive crime, drug-

dealing and driving while intoxicated, will make a positive contribution in ensuring safer, stronger, happier and more resilient communities.

6 Local environment

People live in positive, health-promoting local environments where alcohol and drugs are less readily available: alcohol and drug misuse is less likely to develop and recovery from problematic use is more likely to be successful in strong, resilient communities where healthy lifestyles and wider wellbeing are promoted, where there are opportunities to participate in meaningful activities, and where alcohol and drugs are less readily available. Recovery will not be stigmatised, but supported and championed in the community.

7 Services

Alcohol and drugs prevention, treatment and support services are high quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery: services should offer timely, sensitive and appropriate support, which meets the needs of different local groups (including those with particular needs according to their age, gender, disability, health, race, ethnicity and sexual orientation) and facilitates their recovery. Services should use local data and evidence to make decisions about service improvement and re-design.



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