HEAT A11: Updated Drug and Alcohol Treatment Types

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Introduction

The HEAT A11 target is seen as part of a ‘package’ of developments, albeit a vital part, that would enable change and delivery of the Road to Recovery and Changing Scotland’s Relationship with Alcohol: A Framework for Action.

The drugs strategy and alcohol framework are both clear that a wide range of services must be available, at the point of need, to individuals with problematic drug and alcohol use, to support their recovery. The range of services required will be significant and will need to take cognisance of the needs of dependent children and carers. For an individual drug and/or alcohol user’s complex and challenging needs to be met, a full range of high quality services must be available at the point of need.

To ensure that people with a drug and/or alcohol problem get access to the right service that meets their needs, the Scottish Waiting Times Database will record access to a range of recovery oriented interventions. This document explains the range of interventions and treatment types that will be monitored. It is important to note that interventions being monitored, and that the HEAT A11 target applies to, are tier 3 and tier 4 interventions. For further information on the 4 tier model of care, please refer to Appendix A.

This document provides guidance for data entry to the Treatment Type section of the Drug and Alcohol Waiting Times Database. Please take time to familiarise yourself with the different treatment types as it is vital we have an accurate record of both the interventions individuals are receiving and true waiting times they are facing. Current waiting times can only be reduced if there is an accurate account of the process.

This document is a result of extensive work undertaken by the Technical Support Group (TSG) that works within the framework of the HEAT A11 target. The TSG has representation from Scottish Government, Information Scotland Division (ISD), Alcohol and Drug Partnerships (ADPs), drug and alcohol service providers and Association of Alcohol & Drug Partnerships Scotland (ADPAS). The treatment type definitions have also been subject to wide consultation and engagement with stakeholders and this document has been finalised after consideration of all comments.

Notes:

1) Appendix B provides a brief definition of assessment.

2) We are not trying to provide a comprehensive list of all interventions that service users may experience – we are primarily interested in tier 3 and tier 4 interventions. There may be a variety of interventions associated with early engagement or moving service users out of treatment that are not included in the lists presented.

3) The Waiting Times Database, in itself, does not attempt to map service user journeys through treatment. Data to support service user journeys (in relation to drug misuse) is
collected in the Scottish Drug Misuse Database (SDMD), which also collects data from a wider range of services (defined as those that undertake a comprehensive assessment). Recommendations for collecting information on service user journeys for those affected by problematic alcohol use are currently being taken forward within the Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) Alcohol Essential Services Working Group.

4) We have referred to the term ‘key working’ throughout the document. We appreciate that local areas and services use differing terminology but general consensus received from stakeholders supported the use of this term. For the purpose of this document the term ‘key worker’ refers to the person who has responsibility for forming and maintaining the therapeutic relationship between worker and service user.

5) You will see within the document that we refer to a recovery support plan. We would describe a recovery support plan as : a person centred document that allows the individual to record their recovery aspirations and goals with the support that they require. The recovery support plan should include the following types of themes:
   • Social functioning
   • Finance
   • Housing
   • Physical health/mental health and wellbeing
   • Family/relationships/dependents
   • Addiction support
   • Recovery aspirations/goals

   The recovery support plan should be reviewed with the individual every 4-6 weeks with a formal review taking place every 3 months.

6) Where an individual is engaged in both problematic drug and alcohol use, the primary concern, as identified by both the service user and key worker, should be listed in the database, i.e. drugs or alcohol.

7) When completing waiting times data on the updated database you can include more than one treatment type as key workers may deliver more than one intervention throughout the duration of the agreed recovery support plan, e.g. specialist prescribing would normally be provided along with structured psychosocial intervention.

8) It is anticipated that prisons will submit to the Waiting Times Database as of 1st April 2011. Prison data will be published separately from Health Board and ADP area. It is expected treatment types (1), (2), (4), (7) and (9) will apply to recovery orientated service delivery within prisons.
PRIOR TO stage (1) Structured preparatory intervention

Individuals often come into contact with less structured support that allows them to move from a chaotic lifestyle to a less risky one. Accessing support through, for example, homelessness street teams, community and church groups, Alcohol Anonymous or Narcotics Anonymous can provide the individual access to people who are in recovery. It has been acknowledged that providing opportunities for individuals with a drug and/or alcohol problem to meet people in recovery and additional peer support can have a positive impact on the individual’s decision making process.

Peer support can help the individual identify their recovery goals and also support the following:

- Making and attending appointments
- Advocacy
- Support with relationships
- Practical advice
- General support and guidance
- Harm reduction information
- Strength based assessment

Individuals may also come into contact with other service types that are not specifically drug or alcohol focused, i.e. mental health, learning disability, criminal justice and homelessness. These services will often provide support to the individual, allowing them to address underlying issues that impact on their drug and alcohol use. All these interventions are crucial in the early recovery of individuals with drug and alcohol problems and are the bedrock of structured treatment that can follow.

For the purposes of the HEAT A11 target, services are not required to submit data on the pre-treatment stage referred to above.
(1) Structured preparatory intervention

The use of structured preparatory work provides a time limited or short term support package that allows the service user to obtain a steadier lifestyle. Practitioners will use a number of practical tools to support the service user as part of a structured recovery support plan, including:

- Drug and alcohol use diaries
- Relationship and family support
- Relapse prevention advice
- Improving self-esteem sessions

These tools will help inform the service user’s recovery support plan which will identify their recovery goals and aspirations. The use of these practical tools allows the service user to improve their mental health and wellbeing, which in turn, will support them to be ready for further, more intensive interventions in supporting their recovery from problem drug and/or alcohol use.

Treatment may also include medical assessment and interventions prior to prescribing, e.g. agreeing the levels of medication and providing in-patient support to achieve a non-chaotic lifestyle.

Both the above will require further exploration of the service user’s needs, aspirations, and treatment options which will include the initial joint planning of future care and interventions with jointly agreed goals.

Treatment must be structured and have agreed goal(s) with regular contact with a key worker as a minimum requirement. The key worker may deliver or coordinate a range of elements of care (associated with case management; monitoring progress and care planning; delivering therapeutic interventions; advocacy and practical advice).

Structured preparatory intervention is an identified intervention following assessment. While there can be therapeutic value in the process of assessment, it is clear that structured treatment can only begin after a recovery support plan has been agreed with the service user.

The treatment type start date is the first formal and time-limited appointment after a recovery support plan has been agreed with the service user.
Structured psychosocial intervention

Clearly defined, evidence-based psychosocial interventions, delivered as part of a service user’s recovery support plan, which assists the service user to make changes in their alcohol and/or drug-using behaviour. Psychosocial interventions will normally be time-limited, structured and must be delivered by competent practitioners. Competent practitioners should have relevant professional training, and regular professional supervision to ensure adherence to the treatment model and be able to demonstrate positive service user outcomes.

Structured psychosocial interventions should be identified within a recovery support plan. These interventions can be delivered in individual or group settings, and by any practitioners who have appropriate training and supervision. A number of these interventions can be developed and delivered through use of protocols to improve consistency and ease of delivery. For further information on the differentiation of counselling from other interventions please see Models of Care Update 2006 for drugs and alcohol:

Drugs:

Alcohol:

Examples of evidence-based psychosocial interventions include:

- Cognitive behaviour therapy (CBT)
- Coping and social skills training
- Social behaviour and network therapy
- Relapse prevention therapy
- Behavioural self-control training
- Motivational intervention
- Motivational enhancement therapy
- Anxiety management therapy
- Sleep hygiene programmes for sleep disturbance
- 12-step facilitation therapy
- Facilitation of entry into engagement with mutual aid groups
- Contingency management
- Community reinforcement approaches
- Some family approaches
- Cognitive-behavioural marital therapy
In this definition, psychosocial interventions are to be differentiated from a number of other interventions.

While psychosocial interventions may be delivered by a key worker this activity is not part of the key working process per se. The key worker may provide a level of ongoing face-to-face therapeutic support involving the use of some psychological techniques. If key workers do not deliver complete and consistent psychological treatment packages as part of their work with individual service users, it does not constitute a ‘structured psychosocial treatment’, e.g.

- A key worker helping a service user draw up a list of pros and cons is not delivering a full psychosocial intervention, merely using one technique commonly associated with the approach.

- Psychosocial treatment skills (e.g. particular relapse prevention techniques) may be used in face-to-face sessions (e.g. by a key worker) but this would not reach the threshold to be considered a ‘psychosocial intervention’. If such a skill were used as part of a clearly defined, consistent and evidence-based package of psychological treatment, especially when delivered by a demonstrably competent practitioner, it would then be part of a ‘structured psychosocial intervention’.

- Where key workers do deliver a planned, structured and coherent evidence-based psychosocial intervention (for which they have received training and supervision) this is likely to comprise a number of sessions and this constitutes a structured psychosocial intervention. Examples of structured psychosocial interventions could include four sessions of family therapy, or a manualised relapse prevention package.

The difference between psychosocial interventions for problem substance misuse and formal psychological therapies targeting a service user’s co-morbid mental health problems is that the latter interventions are specialist psychological treatments (such as cognitive behaviour therapy for depression or anxiety, cognitive-analytic therapy, dialectical behaviour therapy, or scheme-focused therapy for personality disorders) aimed primarily at the non-drug psychological problem. Such interventions should only be delivered by specialist practitioners such as clinical and counselling psychologists, suitably trained psychiatric staff or other specialist therapists with relevant training qualifications and supervision in the therapy model being offered. This would be delivered as part of the recovery support plan but would not constitute a ‘structured psychosocial intervention’ for problem drug or alcohol use itself.
Psychosocial interventions also differ from advice, information, simple psycho-education or other low-threshold support, which may be provided by a range of practitioners in a range of treatment settings. Some structured psychosocial interventions may be delivered as part of the process of engaging and preparing service users for change and during the ‘delivery’ phase of the service user’s treatment journey. Therefore, they may be delivered in different settings for individuals at different stages of their treatment journey.

An additional category of ‘other structured treatment’ is provided for less clearly defined counselling in the context of a structured recovery support plan.

*The treatment type start date is the first formal and time-limited appointment for psychosocial intervention.*
(3) Rehabilitation: Residential

Residential drug and alcohol rehabilitation programmes provide a range of interventions to address problematic drug or alcohol use including abstinence-oriented interventions within the context of residential accommodation.

There are a range of residential rehabilitation services, which include:

- Drug and alcohol residential rehabilitation services whose programmes suit the needs of different service users. These programmes follow a number of broad approaches including therapeutic communities, 12-step programmes and faith-based (usually Christian) programmes
- Residential treatment programmes for specific service user groups (e.g. for drug or alcohol-using pregnant women, drug or alcohol users with liver problems, drug or alcohol users with severe and enduring mental illness). Interventions may require joint initiatives between specialised drug or alcohol services (tier 3 or 4, depending on local arrangements) and other specialist inpatient units
- Some drug or alcohol-specific therapeutic communities and 12-Step programmes in prisons
- ‘Second stage’ rehabilitation in drug or alcohol-free supported accommodation where a service user often moves after completing an episode of care in a residential rehabilitation unit, and where they continue to have a recovery support plan, and receive key work and a range of drug/alcohol and non-drug/alcohol-related support
- Supported accommodation, with the rehabilitation interventions (therapeutic drug/alcohol-related and non-drug/alcohol-related interventions) provided at a different nearby site(s)

Residential rehabilitation programmes normally combine a mixture of group work, psychosocial interventions and practical and vocational activities. These components are also used in specialist residential programmes for particular service user groups (e.g. parent and child programmes).

Inpatient detoxification directly attached to residential rehabilitation programmes will fall into Treatment Modality (4) Residential detoxification/Inpatient treatment.

The treatment type start date is the date of admission to the residential establishment.
(4) Detoxification/inpatient treatment: Residential

Inpatient treatment interventions provide short episodes of hospital based (or equivalent) drug or alcohol medical treatment. This normally includes 24-hour medical cover and multidisciplinary team support for treatment such as:

- Medically supervised assessment
- Stabilisation on substitute medication
- Detoxification from illegal and substitute drugs or alcohol (or both in case of poly-dependence)
- Specialist inpatient treatment for stimulant users
- Emergency medical care for drug/alcohol users in crisis
- Comprehensive assessment of complex cases
- Recovery support planning
- Prescribing interventions for medically assisted alcohol withdrawal
- Prescribing interventions to reduce the risk of relapse
- Evidence-based psychosocial therapies and support to address alcohol misuse.

The multidisciplinary team providing inpatient treatment may include psychologists, pharmacists, occupational therapists, social workers, and other activity and support staff. Inpatient drug treatment should be provided within a recovery support plan with an identified key worker. The recovery support plan should address the service user’s hopes and aspirations, including problematic alcohol and drug use, health needs, offending behaviour and social functioning, and should be reviewed periodically.

The main settings for inpatient treatment are:

- General hospital psychiatric units (e.g. for patients with co-morbid mental illness where alcohol withdrawal is overseen by an addiction specialist
- Residential drug and alcohol crisis intervention services (in larger urban areas) emergency medical care for drug/alcohol users in crisis
- Specialist drug misuse inpatient units in hospitals
- Dedicated specialised inpatient alcohol units
- Residential rehabilitation units (as a precursor to the rehabilitation programme)
- Specialised statutory, independent or voluntary sector inpatient facilities for medically assisted alcohol withdrawal, stabilisation and assessment for complex cases
- Prisons (when people involved in problem alcohol/drug use receive specialist interventions)
Those with complex alcohol and other needs requiring inpatient interventions may require hospitalisation for their additional needs (e.g. liver problems, pregnancy) and this may be best provided for in the context of those hospital services (with specialist alcohol liaison support). Inpatient treatment provided for secondary complications arising out of the misuse of alcohol, or other needs, are not to be reported to the Waiting Times Framework.

*The treatment type date is the date of admission to the inpatient facility.*
(5) Detoxification: Community based

Community detoxification involves the provision of recovery-planned specialised drug or alcohol treatment, **to help the service user through the process of withdrawal from drugs/alcohol**. It may include the following:

- Prescribing for withdrawal from opioids with opioid or nonopioid medications such as methadone, buprenorphine or lofexidine (community detoxification)
- Prescribing for withdrawal from sedatives, such as benzodiazepines
- Prescribing for assisted withdrawal from alcohol
- Prescribing for withdrawal from stimulants

All prescribing interventions must be carried out in line with *Drug Misuse and Dependence – UK Guidelines on Clinical Management (2007)*, also known as the “clinical guidelines” or the “orange book”.

Community detoxification should be provided within a recovery-planned package of care along with ongoing professional support and input. It should be aimed at addressing the range of identified needs. The recovery support plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning, as and when appropriate.

The package of care will describe clearly how all components of the community based detoxification programme work together to help the service user achieve the goals set out in their recovery support plan.

Any detoxification programme should consider the needs for aftercare support including access to mutual aid support.

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**The treatment type start date is the date of dispensing the first dose of medication.**

**Expectation is that dispensing will take place within 24 hours of prescription being issued.**
(6) Prescribing: GP

GP prescribing is community prescribing* for drug/alcohol misuse carried out in the context of a primary care/ pharmacy setting, which normally consists of GPs and other primary care staff (depending on contractual arrangements).

GP prescribing should be provided within a recovery support plan with regular key working, and provision of appropriate psychosocial or other interventions as required. The recovery support plan should address drug and/or alcohol misuse, health needs, offending behaviour and social functioning. In some practices, the GP will assume the key worker role, but more commonly the specialist worker will take on this responsibility in collaboration with the GP.

GP prescribing services may also be supported by non-medical prescribers, such as nurses and pharmacists, as well as other staff who are competent to provide drugs interventions, such as harm reduction, interventions for blood-borne viruses and psychosocial interventions.

GP prescribing involves the provision of recovery-planned specialised drug treatment, which includes the prescribing of drugs to treat drug misuse. The range of community prescribing interventions can include the following:

- Stabilisation on substitute opioids, including dose titration
- Prescribing for a sustained period to substitute illicit drugs such as methadone and buprenorphine (maintenance prescribing)
- Prescribing for withdrawal from opioids with opioid or non-opioid medications such as buprenorphine lofexidine
- Prescribing to prevent relapse
- Stabilisation and withdrawal from sedatives, such as benzodiazepines
- Prescribing for assisted withdrawal from alcohol where appropriate
- Treatment for stimulant users, which may include symptomatic prescribing
- Non-medical prescribing (by nurses and pharmacists)

* Prescribing has been split, for convenience, into GP prescribing and Specialist prescribing. The intervention is very similar, but the setting in which it is delivered is different. Consequently, definition of this treatment type is very similar to that of treatment type (7).
GP prescribing should be guided by the Department of Health’s clinical guidelines. These cover arrangements for daily dispensing, for shared care support and for the provision of supervised consumption through community pharmacies.

*The treatment type start date is the date of dispensing the first dose of medication.*

*Expectation is that dispensing will take place within 24 hours of prescription being issued.*
(7) Prescribing: Specialist

Specialist prescribing* is prescribing for drug/alcohol misuse by a specialist service which normally consists of a multidisciplinary substance misuse team which includes specialist doctors who are usually consultant addiction psychiatrists ‘with a Certificate of Completion of Training (CCT) in psychiatry, with endorsement in substance misuse working exclusively to provide a full range of services to substance misusers’.

Specialist prescribing involves the provision of recovery-planned specialised drug treatment, which includes the prescribing of drugs to treat drug/alcohol misuse. The range of specialist prescribing interventions can include the following:

- Stabilisation on substitute opioids, including dose titration
- Prescribing for a sustained period to substitute illicit drugs such as methadone and buprenorphine (maintenance prescribing)
- Prescribing for withdrawal from opioids with opioid or non-opioid medications such as buprenorphine lofexidine
- Prescribing to prevent relapse
- Stabilisation and withdrawal from sedatives, such as benzodiazepines
- Prescribing for assisted withdrawal from alcohol where appropriate
- Treatment for stimulant users, which may include symptomatic prescribing
- Non-medical prescribing (by nurses and pharmacists)
- Specialist prescribing within prisons

* Prescribing has been split, for convenience, into GP prescribing and Specialist prescribing. The intervention is very similar, but the setting in which it is delivered is different. Consequently, definition of this modality is very similar to that of treatment type (6).

The treatment type start date is the date of dispensing the first dose of medication.

Expectation is that dispensing will take place within 24 hours of prescription being issued.
(8) Structured day programmes

Structured day programmes (SDPs), including community rehabilitation, provide a range of interventions which a service user must attend 3 to 5 days per week. Interventions tend to be either via a fixed rolling programme or an individual timetable according to service user need.

In either case, the SDP includes the development of a recovery support plan and regular key working sessions. The recovery support plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

SDPs usually offer programmes of defined activities for a fixed period of time. Service users will usually attend the programme according to specified attendance criteria, and follow a set timetable that will include group work, psychosocial interventions, educational and life skills activities.

Some service users may be attending the SDP as a follow-on or precursor to other treatment types, or may be attending as part of a criminal justice programme supervised by the probation service (e.g. Drug Treatment and Testing Order (DTTO)), or community rehabilitation.

SDPs may be attached to other drug/alcohol treatment services if they are part of a larger treatment provider. Structured day programmes are also used in prisons. In prisons, the majority of drug/alcohol treatment programmes would fall into this category.
(9) Other structured intervention

‘Other Structured Intervention’ describes a package of interventions delivered in the context of a recovery support plan with regular key working as a minimum requirement.

‘Other structured intervention’ describes structured therapeutic activity not covered under the alternative specific intervention categories set out above.

Most service users receiving ‘other structured intervention’ within recovery support plans will include a range of interventions to address their drug/alcohol misuse. These will involve interventions to address their drug/alcohol problem and support to address needs in other domains (e.g. harm reduction interventions, brief interventions and support to address other health/social needs such as housing support, child care support, job seeking etc.). The evidence base suggests that individuals can benefit from receiving treatment (i.e. individually tailored packages of care in the context of a therapeutic relationship) which does not include those treatments covered by other treatment types. This is particularly relevant for non-opiate drug misusers.

Equally, this intervention may be particularly relevant for people with alcohol problems who are receiving community-based structured, care-planned treatment in the absence of prescribing interventions or psychosocial interventions, e.g.

- Regular sessions with a key worker to address a range of social and health-related needs
- Ongoing support following alcohol withdrawal to maintain abstinence as part of the recovery support plan
- A short period of care-planned regular brief interventions to address problem alcohol use

Service users in receipt of community prescribing interventions, residential rehabilitation, inpatient treatment, structured day programmes or structured psychosocial interventions should not be additionally recorded as receiving ‘other structured treatment’. Care-planned support usually provided by the key worker is integral to all such interventions anyway.

Those receiving day care (as distinct from Structured Day Programmes) should be recorded as receiving ‘Other Structured Intervention’. Day care will have a lower requirement to attend than structured day programmes (usually 1–2 days), with a recovery support plan that specifies regular attendance at a day care resource, with regular key working. Day care is distinct from structured day programmes because it has a lower requirement to attend than structured day programmes. Some service users may have a recovery support plan that specifies regular attendance at day care with regular sessions with key work. As part of the care-planned day care they may receive a range of interventions and support including emotional and psychological support, educational and life-skills work and related activities, advice and information, harm reduction support, further assessment and subsequent referral to
alternative structured treatment. This may be particularly relevant for service users who have co-existing mental health problems.

‘Other Structured Intervention’ can describe regular sessions with a key worker, delivered in order to keep a service user engaged in the treatment system while they are waiting to start receiving another care-planned intervention (e.g. GP prescribing), if the structured interventions are outlined in an initial recovery support plan following a triage assessment.

*The treatment type start is the date of the first formal and time-limited key worked appointment.*
(10) APPENDIX A: Definitions of tiers

These definitions are from “Models of care for the treatment of adult drug users: Update 2006” by the National Treatment Agency.


Tier 1 Interventions

<table>
<thead>
<tr>
<th>Definition</th>
<th>Tier 1 interventions include provision of drug-related information and advice, screening and referral to specialised drug treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions</td>
<td>Commissioners need to ensure that a range of generic services provide, as a minimum, the following Tier 1 drug interventions:</td>
</tr>
<tr>
<td></td>
<td>• Drug treatment screening and assessment</td>
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<tr>
<td></td>
<td>• Referral to specialised drug treatment</td>
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<tr>
<td></td>
<td>• Drug advice and information</td>
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<tr>
<td></td>
<td>• Partnership or ‘shared care’ working with specialised drug treatment interventions for drug misusers within the context of their generic services. Specific drug treatment liaison schemes may need to be commissioned to fully realise partnership work.</td>
</tr>
<tr>
<td></td>
<td>Generic services should also provide their own services to drug misusers and some may be specifically designed for drug misusers (e.g. housing projects for those leaving rehabilitation). Commissioners should ensure that drug misusers are not marginalised from generic services by developing local strategic partnerships.</td>
</tr>
<tr>
<td>Settings</td>
<td>Tier 1 interventions are provided in the context of general healthcare settings (e.g. liver units, antenatal wards, Accident and Emergency and pharmacies), or social care, education or criminal justice settings (probation, courts, prison reception) where the main focus is not drug treatment.</td>
</tr>
</tbody>
</table>

Tier 2 Interventions

<table>
<thead>
<tr>
<th>Definition</th>
<th>Tier 2 interventions include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.</th>
</tr>
</thead>
</table>
| Interventions | Tier 2 interventions that should be commissioned in each local area include:  
• Triage assessment and referral for structured drug treatment  
• Drug intervention which attracts and motivates drug misusers into local treatment systems, including engagement with priority groups, such as pregnant women, offenders and stimulant users  
• Interventions to reduce harm and risk due to BBVs and other infections for active drug users, including dedicated needle exchanges and the support and co-ordination of pharmacy-based needle exchanges  
• Interventions to minimise the risk of overdose and diversion of prescribed drugs  
• Brief psychosocial interventions for drug and alcohol misuse (including for stimulants and cannabis problems if it does not require structured treatment)  
• Brief interventions for specific target groups including high-risk and other priority groups  
• Drug-related support for clients seeking abstinence  
• Drug-related aftercare support for those who have left care-planned structured treatment  
• Liaison and support for generic providers of Tier 1 interventions  
• Outreach services to engage clients into treatment and re-engage people who have dropped out of treatment  
• A range of the above interventions for drug-misusing offenders |
| Settings | Tier 2 interventions may be delivered separately from Tier 3 but will often also be delivered in the same setting and by the same staff as Tier 3 interventions. Other typical settings to increase access are through outreach (general detached or street work, peripatetic work in generic services or domiciliary (home visits) and in primary care settings.  
Pharmacy settings are important due to their unique role in pharmacy based needle exchange schemes and their role in supervised consumption of prescribed drugs.  
Criminal justice settings – including initial contact and assessment by CJIT workers in police custody suites, magistrates courts and crown courts – working closely with probation as well as CARATs and prison healthcare provision within the prison estate.  
Drug treatment interventions for offenders may be delivered in the community by CJIT workers in the prison by CARATs and some drug treatment programmes. |

Tier 3 Interventions

<table>
<thead>
<tr>
<th>Definition</th>
<th>Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison.</th>
</tr>
</thead>
</table>
| Interventions | Tier 3 interventions that should be commissioned in each local area include:  
- Comprehensive drug misuse assessment  
- Care planning, co-ordination and review for all in structured treatment, often with regular keyworking sessions as standard practice  
- Community care assessment and case management for drug misusers  
- Harm reduction activities as integral to care-planned treatment  
- A range of prescribing interventions, in the context of a package of care and in line with Drug Misuse and Dependence–Guidelines on Clinical Management, known as ‘the Clinical Guidelines’. This will be updated alongside the relevant forthcoming National Institute for Clinical Excellence (NICE) guidelines and technology appraisals, and in line with other evidence-based clinical standards with specific interventions, including prescribing for stabilisation and oral opioid maintenance prescribing; community-based detoxification; injectable maintenance prescribing, and a range of prescribing interventions to prevent relapse and ameliorate drug and alcohol-related conditions  
- A range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviour  
- Structured day programme and care-planned day care (e.g. interventions targeting specific groups)  
- Liaison services for acute medical and psychiatric health services (e.g. pregnancy, mental health and hepatitis services)  
- Liaison services for social care services (e.g. child protection and community care teams, housing, homelessness)  
- A range of the above interventions for drug-misusing offenders |
| Settings | Tier 3 interventions are normally delivered in specialised drug treatment services with their own premises in the community or hospital sites. Other delivery may be by outreach (peripatetic work in generic services or other agencies or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions.  
Some of the Tier 3 work based in primary care settings (shared care schemes and GP-led prescribing services), as well as pharmacies, but drug specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care.  
Drug treatment interventions for offenders may be delivered in prison settings by CARATs and some drug treatment programmes  
Community criminal justice programmes, such as DRRs, are delivered in contracted community drug treatment services (statutory or voluntary) or in-house by probation staff on probation premises. |

### Tier 4 Interventions

<table>
<thead>
<tr>
<th>Definition</th>
<th>Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare.</th>
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</table>
| Interventions | Tier 4 interventions that should be commissioned to meet local area needs include:  
- Inpatient specialist drug and alcohol assessment, stabilisation, and detoxification/assisted withdrawal services  
- A range of drug and alcohol residential rehabilitation units to suit the needs of different service users  
- A range of drug halfway houses or supportive accommodation for drug misusers  
- Residential drug and alcohol crisis intervention units (in larger urban areas)  
- Inpatient detoxification/assisted withdrawal provision, directly attached to residential rehabilitation units for suitable individuals  
- Provision for special groups for which a need is identified (e.g. for drug-using pregnant women, drug users with liver problems, drug users with severe and enduring mental illness). These interventions may require joint initiatives between specialised drug services and other specialist inpatient units.  
- A range of the above interventions for drug-misusing offenders. |
| Settings | Ideal settings to provide inpatient drug detoxification and stabilisation are specialised dedicated inpatient or residential substance misuse units or wards. Inpatient provision in the context of general psychiatric wards may only be suitable for some patients with co-morbid severe and enduring mental illness, but many such patients will benefit from a dedicated addiction specialist inpatient unit.  
Those with complex drug and other needs requiring inpatient interventions may require hospitalisation for their other needs – for example pregnancy, liver problems and HIV-related problems – and this may be best provided for in the context of those hospital services (with specialised liaison support).  
Continuity of care is essential for preserving gains achieved in residential treatments. Therefore, there is a compelling argument for providing, for suitable patients, inpatient detoxification beds attached to residential rehabilitation units (provided there are adequate medical supports). Other patients need inpatient detoxification first in an addiction specialist inpatient unit (e.g. because of severity and complexity), but this still requires significant strengthening of the links with residential rehabilitation provision, to ensure the seamless transition of clients between the two.  
Service users requiring residential rehabilitation or halfway houses may wish to be located away from their area of residence and drug misusing networks. Within prisons, specialist detoxification units, therapeutic communities (drug specific) and some (residential) 12-Step programmes are Tier 4 interventions. |
(11) APPENDIX B: A note on assessment

The following definitions from the Models of Care Update 2006 for drugs and alcohol may help to clarify where assessment ends (for the purposes of recording information in the Scottish Waiting Times Framework). When we talk about assessment in this context, we are describing ‘Comprehensive Assessment’, as defined below: assessment that leads to the development of a recovery support plan. We recognize that such an assessment does in itself have therapeutic value, however, it will not constitute in itself, a tier 3 or 4 intervention. Consequently, the treatment type start date will be the first date after a recovery support plan is established – this may be partway through a comprehensive assessment.

Models of Care – Drugs – 2006


Models of Care – Alcohol – 2006


Substance misuse assessment is a process to establish the nature and extent of drug and alcohol misuse, what level of need an individual may have and what interventions are required. Assessment varies in its depth and level of detail, depending on the purpose and anticipated outcome of the assessment process. Models of Care 2006 identified 3 levels of assessment: screening, triage and comprehensive assessment, and provides a detailed description of each level of assessment.

Screening assessment

Screening assessment is a brief process that aims to establish if an individual has a drug/alcohol problem, related or coexistent problems and whether there is any immediate risk for the service user. The assessment should identify those who require referral to drug/alcohol treatment services and the urgency of the referral. Screening assessment may include an element of brief opportunistic intervention aimed at engaging or preparing the service user for treatment. Screening assessment is likely to be carried out in generic settings.
**Triage assessment**

Triage assessment usually takes place when an individual with problem drug/alcohol use first contacts specialist drug/alcohol treatment services. The aim of triage assessment is to determine the seriousness and urgency of the individual’s problem(s) and the most appropriate type of treatment for them. It involves a fuller assessment of the individual’s drug/alcohol problem(s) than is conducted at screening; assessment of a service user’s motivation to engage in treatment; current risk factors; and the urgency of need to access treatment. As a result of a triage assessment, a service user might be offered services within the assessing agency or onward referral to another service. A further outcome of triage assessment is that, where appropriate, work is undertaken to further engage and prepare the service user for treatment.

Following triage-level assessment, it may be good practice to produce an initial recovery support plan for service users. For service users taken onto Criminal Justice intervention services this may be essential, but it may also be useful in other treatment services, particularly for service users who are identified as at high risk, who have complex drug/alcohol-related problems or are likely to be hard to engage.

Within prisons, initial recovery support plans may be appropriate for prisoners in the very early days of custody, or those who are due to be released shortly after the triage is undertaken.

The initial recovery support plan is to facilitate a focus on a service user’s engagement in the treatment system; to ensure their immediate needs are met; to build a therapeutic alliance; and to ensure appropriate support if they are waiting to undergo comprehensive assessment. Not all service users will be required to undergo a comprehensive assessment, and some may remain on their initial recovery support plan and be reviewed until they are discharged from treatment.

**Strength-based Assessment**

Strength-based assessment is defined as the measurement of those emotional and behavioural skills, competencies and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one’s ability to deal with adversity and stress; and promote one’s personal, social and academic development.

Strength based assessments allow the service user and worker to begin the development of a therapeutic and trusting relationship. A strength-based assessment will encourage the service user to identify their individual strengths and how they will support their recovery journey. The information gained from the assessment will form the service user’s recovery plan and overall individual service design.
Comprehensive assessment

Comprehensive assessment is targeted at drug/alcohol misusers with more complex needs and those who will require structured drug/alcohol treatment interventions. The assessment aims to determine the exact nature of the service user’s drug/alcohol problems, and coexisting problems in the other domains of health (mental and physical), social functioning and offending. A full risk assessment should also be conducted. Comprehensive assessment may be conducted by more than one member of a multidisciplinary team, because different competences may be necessary to assess different areas of service user need (e.g. a doctor needs to assess service users for prescribing interventions involving controlled drugs – a supplementary prescriber may also be involved or a psychologist may need to carry out psychometric assessment).

Comprehensive assessment can be seen as an ongoing process rather than a single event. Comprehensive assessment will be carried out when a service user may:

- Require structured and/or intensive intervention
- Have significant psychiatric and/or physical co-morbidity
- Have significant level of risk of harm to self or others
- Be in contact with multiple service providers
- Have a history of disengagement from drug treatment services
- Be pregnant or have children ‘at risk’.

Comprehensive assessment provides information that will contribute to the development of a recovery support plan for a service user.