Assessing the availability of and need for specialist alcohol treatment services in Scotland

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Glossary

Access
The number of individuals who attend a specialist alcohol treatment service for assessment and potentially for treatment.

Alcohol and Drug Partnership (ADP)
Thirty ADPs were established in 2009 to coordinate approaches to alcohol and drug issues across Scotland. ADPs are responsible for developing local strategies to deliver improved core and local outcomes on the basis of local need, and for making investment decisions to achieve these (Scottish Government1).

Alcohol Brief Intervention (ABI)
A short, evidence-based, structured conversation about alcohol consumption with an individual that seeks in a non-confrontational way to motivate and support them to think about and or plan a change in their drinking behaviour in order to reduce their consumption and or their risk of harm (Scottish Government2).

Alcohol Dependence
A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations (National Institute for Clinical Excellence3).

Alcohol Related Brain Damage (ARBD)
An umbrella term that accommodates the various psychoneurolgical/cognitive conditions that are associated with long-term alcohol misuse and related vitamin deficiencies (Royal College of Psychiatrists4).

Alcohol Use Disorders (AUD)
Alcohol-use disorders cover a wide range of mental health problems as recognised within the international disease classification systems. These include hazardous and harmful drinking and alcohol dependence (National Institute for Clinical Excellence3).

Alcohol Use Disorders Identification Test (AUDIT)
The AUDIT was developed by the World Health Organization (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment. It can help identify excessive drinking as the cause of the presenting illness. It provides a framework for intervention to help risky drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking. The AUDIT also helps to identify alcohol dependence and some specific consequences of harmful drinking (Babor et al5).

Assessment
An appointment offered to an individual with an alcohol problem to identify their needs and aspirations with a view to establishing a clear statement of the type and level of treatment, care and support (NHS National Services Scotland6).
Availability
The provision of services that offer specialist alcohol treatment interventions for people with alcohol dependence.

CAGE
CAGE is a short questionnaire used to screen for excessive drinking. CAGE is an acronym of the original four item questionnaire which posed questions about Cutting down drinking, being Annoyed by criticism of their drinking, feelings of Guilt about drinking, and an ‘Eye opener’ or drinking first thing in the morning (Ewing7).

Capacity
The total resource available to deliver specialist alcohol treatment interventions, including staff and equipment.

Demand
The total number of individuals in the general population with alcohol dependence referred, including self-referred, to a specialist alcohol treatment service over a given period of time.

Discharged
An individual is discharged from a service when their treatment ends. A planned discharge occurs with the agreement of the individual and the service, normally when the individual’s needs have been met. An unplanned discharge occurs when the individual disengages from the service without prior agreement (NHS National Services Scotland6).

Harmful drinking
A pattern of alcohol consumption that is causing mental or physical damage (National Institute for Clinical Excellence3). In units of alcohol, harmful drinking is categorised in health guidelines as consumption for men of more than 50 units per week and for women more than 35 units per week.

Hazardous drinking
A pattern of alcohol consumption that increases an individual’s risk of harm. Some would limit this definition to the physical or mental health consequences, as in harmful use. Others would include the social consequences. The term is currently used by WHO to describe this pattern of alcohol consumption (National Institute for Clinical Excellence3). In units of alcohol, hazardous drinking is categorised in health guidelines as consumption for men of more than 21 units up to 50 units per week, and for women of more than 14 units up to 35 units per week.

In treatment
An individual is in treatment when they attend a service to receive the care and support stated in their recovery plan or agreed with the individual (NHS National Services Scotland6).

Need
The number of individuals in the general population with alcohol dependence who could benefit from a specialist alcohol treatment intervention.
Prevalence-Service Utilisation Ratio (PSUR)
A numeric estimate of the gap between the need for, and uptake of, treatment.

Referral
Written, face-to-face or telephone contact with an alcohol treatment service regarding an individual’s alcohol problem. The contact can emanate from various sources including the individual (self-referral), other alcohol treatment services, GPs, and hospitals (NHS National Services Scotland\(^6\)).

Tier 1 interventions in alcohol treatment services
Tier 1 interventions include: identification of hazardous, harmful and dependent drinkers; provision of information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions (National Treatment Agency for Substance Misuse\(^8\)).

Tier 2 interventions in alcohol treatment services
Tier 2 interventions include provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment (Ibid.).

Tier 3 interventions in alcohol treatment services
Tier 3 interventions include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care coordinated and care-planned (Ibid.).

Tier 4 interventions in alcohol treatment services
Tier 4 interventions include provision of residential, specialised alcohol treatments which are care-planned and coordinated to ensure continuity of care and aftercare (Ibid.).

Utilisation
The number of individuals with alcohol dependence referred who successfully access and uptake specialist alcohol treatment. In other words, the number of individuals in treatment at a given time.
Executive Summary

This research assessed the availability, demand and utilisation of specialist alcohol treatment services in Scotland following publication of Changing Scotland’s Relationship with Alcohol: A Framework for Action (Scottish Government). The study assessed the impact of additional resources that accompanied the Framework which set out a range of proposals to tackle alcohol misuse in Scotland by reducing alcohol consumption, supporting families and communities, promoting positive attitudes and choice, and improving treatment and support. The research also examined the feasibility of assessing the capacity of specialist alcohol treatment services within a small number of case study areas. The study was part of an extensive ongoing programme of work Monitoring and Evaluating Scotland’s Alcohol Strategy (MESAS) led by NHS Health Scotland.

A comprehensive mixed methods approach was adopted to meet the study objectives. A survey of specialist alcohol treatment services delivering tier 3 and 4 interventions, which achieved a response rate of 87.2%, gathered information on service availability and individual service users, including information on demand in the form of individuals in treatment. Need was established from the 2012 Scottish Health Survey (SHeS) using a score of 16 or more on the Alcohol Use Disorders Identification Test (AUDIT) questionnaire as an indicator of possible alcohol dependence. The Prevalence-Service Utilisation Ratio (PSUR) was calculated using data on demand and need with sensitivity analysis undertaken to address concerns regarding the possible underestimation of alcohol consumption within survey data. A series of individual and group interviews were undertaken with service commissioners, providers and users in three case study Alcohol and Drug Partnership (ADP) areas to examine barriers and facilitators to developing specialist alcohol service availability, including capacity; 62 individuals were involved in this process. In addition, the feasibility of assessing service capacity was examined in the case study areas and subsequently a capacity assessment exercise was piloted and undertaken in two areas.

The study found that 149 specialist alcohol treatment services delivered tier 3 and 4 interventions to almost 32,000 individuals across Scotland during 2012. More than 8 out of 10 specialist alcohol treatment services also delivered drug treatment services; half of the services delivered only tier 3 interventions while 43% delivered both tier 3 and tier 4 interventions. SHeS data showed that 3.1% of adults aged 16+ in Scotland were possibly alcohol dependent which equated to an almost 138,000 individuals. The PSUR was estimated to be 1:4.3, in other words approximately 1 in 4 alcohol dependent adults accessed specialist alcohol treatment in 2012. Sensitivity analysis, to address underestimation associated with survey based measures of alcohol consumption, resulted in a range of PSUR figures up to 1:8.3 if alcohol dependence was 6% of the adult population i.e. approximately double the prevalence rate reported in SHeS.

It was not possible to compare the 2012 PSUR figure to a previous estimate in Scotland reported in the Scottish Alcohol Needs Assessment (Drummond et al) because of methodological differences between the two studies. However, this research has established a baseline PSUR from which future change can be measured. Comparison with historic data from England, subject to data caveats,
suggests that it is plausible to assume that a greater proportion of alcohol dependent adults in Scotland were accessing treatment in 2012. The Scottish figure also compares favourably with international standards where an access ratio of 1 in 5 would be regarded as high.

Interviews and focus groups with service commissioners, providers and users in the three case study ADP areas described the positive impact of the additional funding and resources that accompanied the Framework for Action. The most direct impact was evident in additional staff with some services reporting that this provided extra capacity which contributed to a reduction in caseloads, facilitated support to greater numbers of service users and increased frequency of contact with those in treatment. Service commissioners and staff also reported a more holistic assessment of support needs and more effective treatment with an increased understanding of the importance of recovery and preventative work and the Framework for Action was identified as a key driver of this change. HEAT target A11 was also identified as a factor although some staff were critical of the work involved in collating information on the target and reporting it for the Drug and Alcohol Treatment Waiting Times database. Staff identified a range of referral routes including GPs, hospital-based Alcohol Liaison Nurses, partner agencies and self-referrals, which may partly reflect the implementation of Alcohol Brief Interventions in priority health settings and the accompanying HEAT target H4; some service users described poor experiences of signposting from NHS services including GPs and A&E. A wide range of other developments were reported during the case study interviews and focus groups including convergence with drug treatment services, mergers and co-location, growth of the third sector which links with the Scottish Government’s policy to encourage the sector’s delivery of public services, positive relationships among service commissioners and providers, increasing service user involvement in the design of services, and the increasing role of peer-led recovery services.

The interviews also identified barriers and facilitators to the future development of specialist alcohol treatment service availability, a number of which reflected the recommendations contained in the Quality Alcohol Treatment and Support report (Scottish Government11). One of the main issues related to gaps in service reach including individuals who either do not recognise their need for treatment or are reluctant to access support, as well as gaps in treatment availability such as for those affected by Alcohol Related Brain Damage. Other issues included historic weaknesses in needs assessment processes, staffing such as skills development and the impact of vacant posts, demand such as the increasing complexity of cases, and the impact of missed appointments on services including on capacity.

Following discussions with service commissioners and providers, the study established that a capacity assessment exercise was feasible in two ADP areas. Subsequently, staff in four services in these areas took part in a capacity assessment exercise which established that direct service user contact accounted for approximately a third of the time staff spent on alcohol-related activities; slightly more time was spent on service user related activities not involving direct contact with the service user. The annual capacity of the services was estimated at 225 individuals per year in area 1 and 249 individuals per year in area 2. The capacity assessment exercise was intended as a means of assessing the feasibility of the
exercise. The lessons learnt were therefore as important as the results and lessons emerged on non-participation and application of the methods.

The development of the national Drug and Alcohol Information System (DAISy) led by NHS ISD should address many of the data weaknesses encountered during this research including limited information on individuals broken down by the protected characteristics and information regarding the outcomes achieved by individuals. Improved data gathering on specialist alcohol treatment services would benefit future alcohol needs assessments.

Overall the research has shown that 149 specialist alcohol treatment services delivered tier 3 and 4 interventions across Scotland during 2012. The additional resources that accompanied the Framework for Action enabled these services to support almost 32,000 individuals which was approximately a quarter of those in need. The study has established a methodology which will enable utilisation of services by those in need to be updated in the future. Engagement of a greater proportion of alcohol dependent adults will be informed by learning from the barriers and facilitators identified in this report. The findings of this research will be of interest to the Scottish Government, the wider NHS in Scotland, as well as the 30 ADPs and 149 specialist alcohol treatment services delivering tier 3 and 4 interventions across Scotland. It is also hoped that the findings are of benefit to individuals who use specialist alcohol treatment services.
1. Introduction

1.1 Background

The Scottish Government’s strategic approach to tackling alcohol misuse was set out in Changing Scotland’s Relationship with Alcohol: A Framework for Action (Scottish Government) published in 2009. The Framework built on existing approaches and also set out a range of new proposals to tackle alcohol misuse in Scotland by reducing alcohol consumption, supporting families and communities, promoting positive attitudes and choice, and improving treatment and support. It has been implemented alongside changes to the alcohol licensing process introduced in the Licensing (Scotland) Act 2005 which came into force in 2009, and new legislation set out in the Alcohol etc (Scotland) Act (2010) and the Alcohol Minimum Pricing (Scotland) Act 2012. The term ‘alcohol strategy’ refers to the range of initiatives outlined in the Framework and the complementary legislation (NHS Health Scotland). The alcohol strategy is based upon a whole population approach that aims to reduce consumption of alcohol and so reduce alcohol-related harm and improve the health and well-being of the Scottish population.

NHS Health Scotland leads the Monitoring and Evaluating Scotland’s Alcohol Strategy (MESAS) programme on behalf of the Scottish Government. The overarching aim of the MESAS programme is to assess how, and to what extent, the package of measures contained in the Scottish alcohol strategy (taken together and or individually) has contributed to reducing alcohol-related harms. A Theory of Change approach has been adopted which assumes that alcohol-related harms will reduce if population alcohol consumption decreases. The MESAS programme comprises a portfolio of seven individual studies and ongoing monitoring of key indicators. Annual Reports (NHS Health Scotland) have been published since 2011 highlighting progress with the programme. This study, to assess the availability of, and need for, specialist alcohol treatment, was one strand of the MESAS programme.

Accompanying the Framework, record investment to tackle alcohol misuse was announced in the 2008/09 budget totalling £120 million over three years – an increase of over £85 million on previous funding. The primary aim of this additional funding was to improve the identification, support and treatment of people misusing alcohol as well as develop the alcohol treatment workforce. The increased investment reflected the Framework’s focus on preventative work, including the delivery of alcohol screening and brief interventions. It was also intended to support the development and building of capacity in specialist alcohol treatment services. Investment was channelled through Health Boards to facilitate resource allocation that met local need. At the time Alcohol and Drug Action Teams (ADATs) were responsible for coordinating local delivery on behalf of Health Boards. Following a stocktake (Scottish Government) ADATs were replaced by Alcohol and Drug Partnerships (ADPs) in 2009 to deliver a consistent approach that linked with the community planning process across Scotland. There are 30 ADPs which are mainly coterminous with local authority and Community Planning Partnership boundaries;

membership of the ADPs includes representatives of local authorities, Health Boards, the third sector, and Police Scotland. The Scottish Government, NHS Scotland and the Convention of Scottish Local Authorities (CoSLA) agreed a framework for ADPs in 2009 which set out partners’ responsibilities and focused activity on shared outcomes (Scottish Government16).

The Scottish Government produced guidance to support the delivery of effective alcohol treatment services delivering tier 3 and 4 interventions. The Quality Alcohol Treatment and Support (QATS) report contained a number of recommendations to assist ADPs with the commissioning and delivery of person-centred, recovery-orientated, outcome-focused local services (Scottish Government11). It also recommended that ADPs and local services should have a robust needs assessment and equality impact assessments to ensure the needs of all groups within local communities are identified and met. Other key recommendations focused on service user involvement, outcome monitoring, staff development, and links with mutual aid organisations.

To drive improvements in the effectiveness of service provision the Scottish Government set HEAT (Health improvement, Efficiency, Access, Treatment) targets. Target A11 specified that, by March 2013, 90% of people needing help with an alcohol problem would wait no longer than three weeks from referral received to appropriate treatment that supports their recovery. In addition, target H4 specified that 75% of those identified as requiring an alcohol brief intervention (ABI) should receive one by 2010/11, which equated to a target of 149,449 ABIs cumulatively over the period 2008/09 to 2010/11.

A key element of the alcohol strategy has been embedding ABIs within health and other services in Scotland. Implementation of ABIs was prioritised in three health settings - primary care, Accident and Emergency, and antenatal services. An evaluation, conducted as part of the MESAS programme, found that ABIs had generally been embedded in NHS settings (Parkes et al17). HEAT target H4 was met in March 2011 and subsequently replaced by a HEAT standard aimed at maintaining and embedding performance and delivery achieved through the original target. One of the aims of the implementation of ABIs was to identify individuals with alcohol dependence and where appropriate signpost or refer them to specialist alcohol treatment services. The ABI evaluation noted that referrals had not increased substantially across all NHS Boards at that time. However, it highlighted views expressed by some Health Board leads that there had been an increase in the ‘right people’ being seen in specialist alcohol services as those being referred appeared to be more motivated to seek help.

1.2 Alcohol consumption and harms

The 2013 MESAS Report (NHS Health Scotland14) outlines the extent of alcohol consumption and alcohol-related harms in Scotland. Overall the evidence demonstrates that alcohol consumption and alcohol-related harms have declined in recent years, however both consumption and harms remain high in comparison to historic levels.
The report includes analysis of alcohol retail sales data, widely considered to be the most robust means for monitoring population levels of alcohol consumption. Analysis of alcohol retail sales data shows sales of 10.9 litres of pure alcohol per adult in 2012. This represents a 3% fall from the previous year when per adult sales were 11.3 litres. This continues a recent downward trend in retail sales since 2009, although over the longer term retail sales were higher in 2012 than they were in 1994, the earliest year for which data is available. Per adult sales in 2012 were 19% higher in Scotland than in England and Wales, continuing a trend evident since 1994.

Self-reported weekly alcohol consumption in Scotland has declined from 14.1 units in 2003 to 11.3 units in 2012; consumption among men in 2012 was 15.2 units and 7.6 units for women (Scottish Government18). The proportion of adults who reported exceeding the recommended weekly and or daily drinking guidelines decreased from 47% in 2003 to 41% in 2012 (Ibid.). While self-reported alcohol consumption was higher among men than women, the gender gap had narrowed as the reducing levels of alcohol consumption were more pronounced among men. The MESA report notes that declining alcohol consumption has been most prominent since 2008 in two groups: young adults aged 16 to 24 years, and those characterised as drinking at 'harmful' levels i.e. men consuming more than 50 units per week or women consuming more than 35 units per week. The mean weekly alcohol consumption of harmful drinkers was found to be substantially higher among those living in the most deprived areas in Scotland.

The Alcohol Use Disorders Identification Test (AUDIT) questionnaire was included in the SHes for the first time in 2012 and it showed that 19% of adults displayed signs of an alcohol use disorder, 25% of men and 13% of women (Ibid.). The overall figure is made up of hazardous drinkers with an AUDIT score of 8 to 15 (16%), harmful drinkers with an AUDIT score of 16 to 19 (2%) and possible alcohol dependent drinkers with AUDIT score of 20+ (1%). Prior to 2012, SHeS used the CAGE questionnaire which showed that problem drinking among men had increased slightly from 12% in 1998 to 13% in 2011 while the rate for women had increased more markedly from 5% to 10% over the same period.

Alcohol misuse has been linked to a range of health-related harms including high blood pressure, heart disease, stroke, liver disease, some cancers, and depression. The MESA report shows that the alcohol-related acute hospital discharge rate in Scotland in 2011/12 was 691 per 100,000 population. Although this figure represents a decline of 14% since 2007/08, the rate in 2010/11 was around four times higher than it was in the 1980s. Data for 2012/13 shows that the recent decline continued with a year-on-year fall of 7.5% in the alcohol-related acute hospital discharge rate compared to 2011/12 (NHS National Services Scotland19). The MESA report also highlights that the alcohol-related acute hospital discharge rate for men (989 per 100,000) was more than double that for women (393 per 100,000) in Scotland in 2011/12.

In terms of alcohol-related deaths, the MESA report highlights that mortality rates in Scotland in 2012 were 18 per 100,000 population, 25 per 100,000 for men and 11 per 100,000 for women. Scotland’s alcohol-related mortality rates had declined by 36% from a peak in 2003 however the rate was substantially higher in 2012 than in
the 1980s. Alcohol-related deaths rates in Scotland were approximately 1.8 times higher for men and for women than in England and Wales; further, while Scotland’s rates have been declining in recent years, in England and Wales they have remained relatively stable. Within Scotland, over a ten year period the relative gap in alcohol-related mortality rates between the most and least deprived communities had narrowed although the rate in the most deprived decile (as measured by the Scottish Index of Multiple Deprivation) was 7.7 times greater than in the least deprived decile.

The overall societal cost of alcohol misuse in Scotland was estimated at £3.6 billion in 2007 (Scottish Government20). The total consisted of estimates of £1.5 billion in wider social costs, £870m in lost productive capacity, £730m from the cost of crime, £270m in health costs, and £230 in social care costs.

1.3 Research aims and objectives

The overall aim of this study was to assess the impact of additional resources on the availability, demand and utilisation of specialist alcohol treatment services and to examine the feasibility of assessing the capacity of specialist alcohol treatment services within a small number of case study areas.

The study had the following key objectives:
1. To assess the availability of specialist alcohol treatment services (tiers 3 and 4).
2. To assess the current service need (i.e. prevalence of alcohol dependence) and demand (i.e. referrals/waiting times) for specialist alcohol treatment services.
3. To provide a service utilisation ratio for specialist alcohol treatment services.
4. To explore, in a small number of case study areas, the feasibility of assessing service capacity within specialist alcohol treatment services.
5. Where feasible, to assess the ratio of service capacity to the estimated demand for specialist alcohol treatment services within the case study areas.
6. To explore, within the case study areas, barriers and facilitators to developing specialist alcohol treatment service availability, including capacity.
2. Research methods

2.1 Overview of methods

A mixed methods approach was adopted in this study to address the study objectives:

- A national survey of specialist alcohol treatment providers across Scotland to establish the availability of treatment services (objective 1).
- Analysis of the survey of providers to assess demand and utilisation of specialist alcohol treatment services and examine the characteristics of individual service users (objective 2).
- Analysis of SHeS data to assess prevalence of alcohol dependence and the need for specialist alcohol treatment (objective 2).
- Analysis of need and demand data to estimate a Prevalence-Service Utilisation Ratio (objective 3).

In addition to the quantitative analyses, case studies were undertaken in three ADP areas. The case studies comprised:

- An initial review of the feasibility of assessing service capacity (objective 4) and the subsequent application of capacity assessment research tools (objective 5).
- Interviews with service commissioners, providers and users to examine the barriers and facilitators to developing specialist alcohol service availability, including capacity (objective 6).

The study was overseen by a Research Advisory Group comprising representatives from NHS Health Scotland, NHS National Services Scotland Information Service Division (ISD) and the Scottish Government Health Analytical Services Division (see Appendix 1). Members of the Group provided constructive input throughout the study, including detailed feedback on the development of key research tools and advice and guidance in response to emerging issues.

The research brief highlighted that demand, utilisation and capacity analyses should consider differences by the protected characteristics defined by the 2010 Equality Act, subject to data availability. The Act made it illegal to discriminate against a person on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion and belief, sex, or sexual orientation which are collectively known as protected characteristics. The research brief acknowledged that data may be restricted to gender, age and ethnicity due to the limited availability of data on the other protected characteristics. In addition, analysis was to consider variations across Scotland subject to data availability.

Relevant services were defined as specialist alcohol treatment providers in Scotland delivering tier 3 and 4 interventions to adults aged 16 or over. The timeframe for assessment of availability, demand, utilisation and capacity was defined as the 12-month period January to December 2012.

2.2 Availability of specialist alcohol treatment services across Scotland

The ISD Drug and Alcohol Treatment Waiting Times (DATWT) database was initially examined as a potential source of quantitative information on services and individual
service users. A review of the database and discussions with the team at NHS ISD responsible for its upkeep identified that the data required for this study could not be generated from the DATWT database. The main issue with the DATWT data was the recording of treatment episodes rather than individuals in treatment. The possibility of extracting data on individual service users was explored with ISD using individual identifiers such as name, postcode, Community Health Index number and demographic information. Although such information is recorded by services at the start of each case, service users can choose not to share the information outside the service and ISD data showed that a quarter of records held on the database for 2012 had been entered anonymously i.e. with no individual identifiers; it was not possible therefore to extract robust data on individuals. The level of anonymous cases also limited the availability of information on service users’ protected characteristics. A survey of alcohol treatment providers was therefore required to meet the research objectives.

A questionnaire to gather information on services and individual service users was developed in collaboration with the Research Advisory Group. This was piloted by nine services from seven ADP areas and feedback from this exercise informed the final draft which was used in the study. The final questionnaire contained 17 questions collecting information on the service, delivery area, and individual service users, as well as views on future challenges and opportunities. To assist completion, question-by-question guidance was included in the final questionnaire. The survey was available both electronically (via the web) and in hard copy for services with limited internet access, those experiencing problems completing the online version and those that preferred such means.

Relevant services to be surveyed were those providing treatment for individuals with alcohol dependence including services providing treatment for individuals with co-occurring alcohol dependence and problem drug use. The survey included the instruction that information was only required on alcohol dependent individuals. Services were identified by a two stage process. Firstly, a list was generated from the DATWT database containing 420 service entries. The list included multiple entries for some services made up of component parts with the separate entries relating to different locations or types of treatment. The pilot demonstrated that the list also contained services delivering: tier 2 interventions only; drug only treatment providers; and or services for those aged under 16 years, all of which were beyond the scope of the research. Therefore, ADP coordinators provided the local knowledge to exclude services from this list which were outside the study scope and identify single services listed separately. In total, ADP coordinators identified 170 services and a key contact such as the manager or team leader where known; missing contacts were sourced by the researchers. All services were emailed a link to the survey. Twenty one services responded stating that the survey was not relevant to them as they were: drug only services; providers of tier 1 or 2 interventions; focused exclusively on young people (under 16s); or new services that were not operating in 2012. The total sample size was therefore reduced to 149 specialist alcohol treatment services.

In total 130 of the 149 services responded to the survey, a response rate of 87.2%. 117 services provided information on individuals in treatment - a key element of the survey required to estimate the PSUR - representing 78.5% of all 149
services. More than half of the services responding to the survey (n=65) provided information for the calendar year 2012 while 50 services provided information for the period April 2012 to March 2013 and two services provided partial information covering six or nine month periods which was extrapolated to a full 12 months; information on all services was included in the analysis. The data was reviewed to identify gaps and possible inaccuracies, and where necessary referred back to the service for checking; where relevant additional information was provided by services.

Absolute figures contained in this report on services and individuals supported by them relate to all 149 alcohol treatment providers delivering tier 3 and 4 interventions in Scotland. Data are based on the survey responses extrapolated to the 149 services; the number of survey responses is noted where appropriate.

As stated above 117 services provided the number of individuals in treatment during 2012. Estimates for the 32 services that did not provide the data were based on the midpoint between local and national averages of individuals in treatment per service. The midpoint was used as estimates using solely local or national averages were tested but discounted as some unrealistic results were produced.

Data on individuals in treatment also took account of referral between services which would lead to double counting by applying the inter-agency referral figure of 8.2% used in a previous study – the Scottish Alcohol Needs Assessment (SANA) (Drummond et al). The SANA study involved services delivering tier 2 to 4 interventions and it is possible that the inter-agency referral rate for services delivering tier 3 and 4 interventions would be different. However, in the absence of a reliable figure for services delivering tier 3 and 4 interventions the inter-agency referral rate of 8.2% has been used in this study.

As well as individuals in treatment, the survey also gathered data on individuals at other stages of the treatment process in 2012 and information was provided by 96 services on the number of individuals referred, 88 services on the number of individuals assessed and 86 services on the number of individuals discharged. Extrapolation of this data was initially undertaken to estimate missing data and provide a national figure for all 149 services. However further exploration of the data identified a number of caveats and the Research Advisory Group concluded that it was insufficiently robust to be included in this report.

Services identified the ADP areas where they delivered services and ADP information on service availability was analysed. The majority of ADPs were served by fewer than five services which limited the relevance of information such as tiers, type of services, and history by ADP area. The ADP-level results contained in this report therefore focus on information on individuals in treatment. Analysis of information on individuals for some ADPs has been grouped where services in an area cover more than one ADP and it was not possible to identify information for separate ADPs. Therefore data on individuals was analysed for Ayrshire made up of East, North and South Ayrshire ADPs, Tayside made up of Angus, Dundee and Perth and Kinross ADPs, and Forth Valley made up of Clackmannanshire, Falkirk and Stirling ADPs.
2.3 Quantitative assessment of need and demand

SHeS 2012 was the source of data on the prevalence of alcohol dependence (Scottish Government\(^{18}\)). AUDIT was introduced as part of the SHeS methodology in 2012 replacing the six-item version of the CAGE questionnaire from which estimates of problem drinking were previously calculated. AUDIT is a 10-item questionnaire covering alcohol consumption, alcohol dependence and alcohol-related problems as a means of identifying potential levels of alcohol use disorders. World Health Organization Guidelines state that AUDIT scores of 8 to 15 should be interpreted as an indicator of medium level alcohol problems and scores of 16 or more as an indicator of high levels of alcohol problems (Babor et al\(^{5}\)). The third MESAS Report (NHS Health Scotland\(^{14}\)) included the following key to interpreting AUDIT scores:

- 0 to 7: low-risk drinking behaviour, or abstinence
- 8 or above: indicator of an alcohol use disorder
- scores of 8 to 15: hazardous drinking behaviour
- scores of 16 to 19: harmful drinking behaviour
- 20 or above: warrants further investigation for possible alcohol dependence.

SHeS 2012 was published in September 2013 and contains AUDIT data at a national level. Percentages for the different levels of AUDIT score were broken down by gender and age; using National Records Scotland Mid-2012 Population Estimates the percentages were converted to population estimates in this study.

This study used an AUDIT score of 16+ as an indicator of alcohol dependence as this was the level used in SANA and a similar study in England where an AUDIT score of 16+ was referred to as an indicator of ‘moderately and severely dependent drinkers’ (Drummond et al., 921\(^{21}\)). Care should be taken when comparing alcohol dependence from different reports as the terminology can vary between publications. Both the SANA research and the English alcohol needs study referred to an AUDIT score of 16+ as an indicator of alcohol dependence. The MESAS Annual Reports use the phrase possible alcohol dependence for AUDIT scores of 20+ and SHeS presents data for scores of 16 to 19 as harmful and 20+ as possible dependence.

Sensitivity analysis was undertaken on the alcohol dependence figure sourced from SHeS due to the fact that self-reported surveys are known to underestimate alcohol consumption. The SHeS 2012 Report notes that ‘surveys often obtain lower consumption estimates than those implied by alcohol sales data. The disjuncture can largely be explained by participants’ underreporting of consumption, but there is also some evidence that survey non-responders are more likely than responders to engage in risky health behaviours, including hazardous alcohol use’ (Scottish Government, 55\(^{18}\)). The SHeS sample is drawn from household populations and therefore excludes disadvantaged groups such as homeless individuals and prisoners who are likely to exhibit high levels of alcohol dependence; for example, 41.3% of prisoners who completed the AUDIT questionnaire as part of the 2013 Scottish Prisoner Survey had an AUDIT score of 16 or more (McCoard et al\(^{22}\)). The under-reporting of alcohol consumption is also affected by ‘poor recall, social desirability…and inaccuracy of assumed standard drink strengths and sizes’ (NHS Health Scotland, 38\(^{12}\)). Research has also been conducted on the representativeness of SHeS and underestimation of health issues such as alcohol dependence; the research examined alcohol-related and all-cause mortality rates
among SHeS respondents compared with the general population and found that SHeS respondents reported lower alcohol consumption levels than would be expected if the survey sample had been truly representative (Gray et al.\textsuperscript{23}). Analysis has shown that the SHeS derived self-reported consumption figure in 2012 accounted for 54% of the retail sales in Scotland during the year (NHS Health Scotland\textsuperscript{14}). Despite these limitations, survey data is widely used as it provides information on alcohol consumption patterns and how these vary across different population subgroups.

The research brief requested analysis on the availability of services by Health Boards if practicable. The Research Advisory Group revised this to ADP level analysis to reflect the strategic role that ADPs have in developing and commissioning alcohol treatment services. AUDIT data were not available at ADP level from the SHeS 2012 because the survey’s sampling framework was not designed to produce single year ADP-level data or the grouping of ADPs which had been suggested as an alternative. At Health Board level, only NHS Greater Glasgow & Clyde had a large enough sample (n>500) to allow analysis of 2012 AUDIT data; NHS Fife and NHS Lothian had samples above 500. However, when responses without AUDIT data are removed the sample drops below this level making the data unreliable.

The research brief included an overarching requirement that quantitative analysis addressed the protected characteristics. However, AUDIT 2012 equalities data is limited to age and gender breakdown at the Scotland level. No data are available for the other protected characteristics.

2.4 Prevalence-Service Utilisation Ratio

Estimating the Prevalence-Service Utilisation Ratio (PSUR) was a key element of this study. Put simply, the PSUR is the ratio of the need compared to use. More specifically it is the number of individuals with alcohol dependence – estimated from SHeS 2012 data – compared to the number of individuals in specialist alcohol treatment – estimated from the survey of treatment providers. The absence of SHeS data at ADP level limited the PSUR analysis to a ratio for Scotland as a whole.

2.5 Qualitative analysis of barriers and facilitators to developing specialist alcohol service availability, including capacity

The case study work addressed two elements of the research methodology: an exercise to explore the feasibility of assessing service capacity within specialist alcohol services, and qualitative analysis of barriers and facilitators to developing specialist alcohol service availability, including capacity.

Given the anticipated time commitment required for participation in case studies from ADP staff and specialist alcohol services it was felt that the most effective way to identify case study areas was to invite ADP coordinators to nominate their area and if necessary select the sample from within this pool. Six ADPs expressed initial interest in taking part and all were included in the case study research. The ADP coordinators were important facilitators throughout the case study process as they played a key role in achieving buy-in from local services.
Three of the six ADP areas withdrew entirely from the case study work due to local factors that affected their ability to participate. One of the three ADP areas that agreed to participate in the case studies committed solely to the qualitative research. The initial intention had been for the case study research to take place across all areas over the same two-week period. However, initial discussions with the ADP coordinators and service managers identified this was not achievable due to local factors on the most opportune time to conduct the research.

Interviews were conducted with different stakeholder groups in each ADP case study area, including: representatives and commissioning staff from the ADP; managers of the specialist treatment services delivering tier 3 and 4 interventions; a selection of staff at various levels within each specialist service; and a sample of individuals who had received support from specialist services within the area.

Specific semi-structured interview schedules were developed for use with each group, addressing themes relevant to the particular cohort, using language and tone appropriate to the target audience. The research tools were developed with input and final approval from the Research Advisory Group. A pilot conducted in one ADP area demonstrated that the tools and methodology were broadly fit for purpose with some minor revisions. The schedules covered the following themes:

- Local models of service provision.
- Partnership working between complementary services and referral agencies.
- Views on treatment availability, need and demand.
- Changes to services since 2008.
- Factors influencing capacity.
- Future issues that might affect the capacity and delivery of services.

An information sheet and consent form was also developed for dissemination to all potential interviewees well in advance of their interview and all participants were given time at the start of the interview to reread the document and ask questions.

Fieldwork arrangements were progressed with managers from each service. Interviews were arranged according to the preferences and availability of those willing to take part in the research. In the majority of cases, commissioning staff and service managers were interviewed individually with staff members interviewed separately. Some of the staff interviews were conducted using a group discussion format. This was done where managers felt that group discussions, instead of individual interviews, were all that could be reasonably asked of their service; others were able to accommodate the release of staff for individual interviews on a rotating basis. In some cases, staff from delivery services were concerned about participation in the research and sought reassurances around confidentiality, for example, several asked about the data gathering, sharing and storage methods and sought reassurances about access to interview recordings. One interview was not recorded at the request of the participant.

In order to secure participation from services a flexible approach was adopted that fitted around practitioners’ availability and preferences. Time pressures in some services meant they were only able to accommodate group discussions rather than individual interviews. This may have limited the extent to which practitioners felt
willing to share their personal views; although in every group discussion the dynamic between staff appeared to be relaxed and open, the researchers did not identify reluctance to speak or a sense the staff felt required to defer to their colleagues’ views although some were more talkative than others. There was also a potential risk of service manager influence given their key role in the process of selecting interviewees. To combat this, the researchers highlighted the desire to secure participation from a range of staff at various levels within a service and emphasised a preference to conduct interviews on an individual basis, wherever possible.

A mixture of group discussions and individual interviews were carried out with service users recruited by service managers and or those resourcing peer group activities. At each group discussion participants were offered the opportunity to speak to the researcher outside the group setting if required, although none did. As is the case in all research with individuals who have been supported by a service there is a risk of possible bias in feedback from service users who may seek to use the interview as an opportunity to express their gratitude for support received. The researchers took care to reassure participants about the purpose of the study while going through the information and consent sheets with all participants. It was emphasised that the research was part of a national study, not a service evaluation, and that results would be reported in terms of themes from interviews – not attributed to individual services or reported back to staff.

All interviews were conducted at the preferred location of the interview participant. The interviews with commissioning staff typically took an hour to an hour and a half, those with managers and service staff lasted 40 minutes to an hour (in most cases the full hour). Individual discussions with service users typically lasted 30 minutes, group discussions lasted 45 minutes in one area and an hour and a half in the other.

A conversation café between staff and service users in one case study area was also observed; the event was part of the ADP’s service redesign process. In another area, useful information about tier 3 and 4 interventions was gleaned through interviews with a local referral partner delivering tier 2 interventions. This outside perspective proved useful in terms of discussing barriers and facilitators to engagement with services. They also facilitated input from former service users who had previously accessed tier 3 or 4 support and these individuals were more reflective on their overall experience of recovery than those still receiving tier 3 and 4 interventions.

A summary of the qualitative research methods used in the three case studies and the number of participants is provided in Table 1.
### Table 1: Case study research

<table>
<thead>
<tr>
<th>Area</th>
<th>Profile</th>
<th>Staff involved in the design and delivery of services</th>
<th>Service users</th>
<th>Total</th>
</tr>
</thead>
</table>
| **Area 1 (pilot)** Qualitative research and capacity assessment | Local population of less than 100,000  
Area with a significantly higher than average number of people affected by alcohol misuse  
An ageing population and steadily decreasing shift in population numbers | 1 x commissioning staff  
3 x service managers  
6 x service staff (five individual interviews, one joint interview with two staff members) | 2 x individual interviews  
Focus group with 7 participants | 10 x staff  
9 x service users  
Total: 19 |
| **Area 2** Qualitative research and capacity assessment | Local population of 100,000–150,000  
Area with significantly higher than average number of people who are considered income deprived  
Approximately 25% of the population live in rural areas | 1 x commissioning staff  
3 x service managers  
13 x service staff (two individual staff interviews, and three joint discussions with two, three and eight staff members) | 3 x individual interviews  
Observation of a conversation café with approximately 30 service users and staff members – (service user consultation forum) | 17 x staff  
3 x service users (direct interview)  
Total: 20 |
| **Area 3** Qualitative research only | Local population of 150,000–200,000  
A steady growth in population numbers  
Approximately 80% of the population live in urban areas | 2 x commissioning staff  
3 x service managers  
12 x service staff (two individual interviews and two joint discussions with five staff each) | Focus group with 6 participants | 17 x staff  
6 x service users  
Total: 23 |

Analysis of the qualitative information began with an initial review of the entirety of notes, recordings and interview transcripts. Following this, thematic analysis of content was undertaken to map content against its contribution towards addressing the key study objectives (identification of facilitators and barriers), and grouped under prominent areas of interest. Qualitative findings were also considered in light of their relation to the data gathered through the survey and capacity assessment exercise.

Analysis identified repetition in response/theme across and within ADP areas highlighting frequently raised points of views, comments that reinforced or linked to key themes, and any statements at odds with other views expressed across the range of individuals who participated in the research. For example, while in many cases issues raised by service providers aligned with the comments made by service users, service managers’ views sometimes differed from those of their staff or focused on other aspects of the topic discussed. Stakeholders’ roles within the
process of service delivery and design influenced the nature of their contribution – some spoke from a strategic perspective whereas others focused on operational matters and direct experiences.

2.6 Feasibility of assessing service capacity within specialist alcohol services

The research brief highlighted the methods outlined in *An Introductory Guide for Clinicians and Service Managers: Capacity for Psychological Therapies Services* (Scottish Government\(^2\)) as the basis for potential capacity assessment in the case study areas. The approach essentially involves staff at relevant services keeping timesheets for a two-week period to establish the percentage of time spent on various tasks. This information can then be used alongside staff numbers (including vacant posts) to estimate the overall capacity of services, and from that the capacity within the case study area overall.

The time capture tool used in the above study was more complex than necessary for this research. A simpler timesheet was adapted to improve potential take-up by services, with time broken down against the following four tasks:

- Direct contact with service users such as assessment, case review with service users present, and the delivery of support, activities or treatment.
- Other related activities not involving direct contact with the service user, including associated administration such as case notes, meetings with referral agencies, supervision, case review without service user present, and supporting ‘significant others’.
- Supporting activities including general administration such as timesheets, travel, staff meetings, and training/CPD.
- Other tasks which were to be specified by staff.

The timesheet, guidance and approach were piloted with staff in one service in Area 1 and after minor revisions to wording were used in the other services in the two case study areas. The timesheet is shown in Appendix 2.

The amount of time staff spent in direct contact with service users is used to calculate capacity. The Guide (Ibid.) established that Whole Time Equivalent (WTE) staff work an average of 42 weeks out of 52 taking account of holidays and sick leave. This is used to calculate the monthly amount of time available for direct contact with service users. The average number of appointments per case and the average time per appointment is used to calculate the average monthly demand per case. Dividing the monthly amount of time available for direct contact with service users by the average monthly demand per case provides a capacity figure which is the number of cases a service can see per month.
3. Quantitative results

3.1 Alcohol treatment services in Scotland

3.1.1 Overview

Based on information provided by ADP coordinators there were 149 specialist alcohol treatment services delivering tier 3 and 4 interventions in Scotland in 2012.

Absolute numbers contained in this report are estimates for the 149 services based on survey responses extrapolated to provide data for Scotland as a whole or ADPs, applying the methods described in chapter 2. Any deviations from the survey baseline of 130 services are highlighted where appropriate.

3.1.2 Distribution and remit

The distribution of the 149 services across Scotland ranged from single services in East Renfrewshire and Orkney ADPs to 40 services in Glasgow City ADP – see Appendix 3 (Table 8). Some rural areas had relatively large numbers of services reflecting a dispersed delivery model in settings such as Highland (13 services), Aberdeenshire (10 services) and Outer Hebrides (7 services). In approximately half of the ADPs there were five or fewer services.

The majority of services (95.4%) had a local remit supporting individuals within the ADP area or a small number of neighbouring ADPs. Relatively few services specified that they supported individuals from across Scotland (4.6%) – these services were all residential rehabilitation providers.

3.1.3 Sectors

The statutory sector – local authorities and NHS – was the main provider of alcohol treatment services across Scotland accounting for just over half of all services (Figure 1). Third sector provision was also significant accounting for approximately 45% of alcohol treatment services. One service was described as a partnership between statutory and third sector providers. The private sector consisted of two residential rehabilitation centres.

Figure 1: Specialist alcohol treatment services in Scotland by sector, 2012 (%)
3.1.4 Substance misuse

The majority of alcohol treatment services providing specialist tier 3 and 4 interventions also delivered drug treatment services (86.0% of 129 services responding to the survey question). Approximately one in seven services focused exclusively on alcohol treatment (14.0%). In absolute terms, there were an estimated 128 services providing alcohol and drug treatment and 21 providing alcohol only treatment.

3.1.5 Tiers

Figure 2 shows that half of the specialist alcohol treatment services in Scotland delivered only tier 3 interventions (50.4% of 129 services responding to the survey question). A sizeable proportion (42.6%) delivered both tier 3 and tier 4 interventions and approximately 1 in 14 services delivered only tier 4 interventions. In absolute terms, there were an estimated 75 services delivering tier 3 interventions, 64 delivering tier 3 and 4 interventions, and 10 delivering only tier 4 interventions.

Figure 2: Specialist alcohol treatment services in Scotland by tier, 2012 (%)

3.1.6 History of service development

Scotland’s specialist alcohol treatment providers have operated in their current form over varying timescales as shown below in Figure 3 which is based on 128 services that provided this information. The peak in 2003 was mainly the result of the establishment of Glasgow Addiction Services (GAS) and the 14 services it delivers in that year; GAS was formed from pre-existing services including Glasgow City Council Drug Project, Glasgow Drug Service and Alcohol Problem Service.

A number of services existed prior to 1990 demonstrating the long-standing nature of specialist alcohol treatment provision in Scotland. Overall the figure shows that there has been considerable change since 2000 with the years 2002, 2006, 2007, 2010 and 2011 witnessing the establishment of a number of specialist alcohol treatment services in their current form.
Figure 3: Current specialist alcohol treatment services in Scotland by year the service took its current form (n)

Approximately half of services were reconfigured having previously existed in a different form (53.1%). Figure 4 below shows the year services took on their current form separating the reconfigured services from the entirely new services. The graph shows that a number of new services were created in the early and mid 2000s. For the reconfigured services, as well as the GAS influenced peak in 2003, the years 2010 and 2011 were also prominent.

Figure 4: New and reconfigured specialist alcohol treatment services in Scotland by year (n)

Some of the reconfigured services provided further information on the nature of the changes with the most frequent responses summarised below:
- Significant changes to the services provided such as adding treatment services to existing education and prevention services, working with people with Alcohol Related Brain Damage, or offering group programmes as well as individual counselling.
- Integration of NHS and local authority services.
• Expansion of existing drug services to include alcohol treatment.
• Expansion of existing alcohol services to include drug treatment.
• Amalgamation of separate alcohol and drug services.
• Change in service provider following tendering or review.

3.1.7 Individuals in treatment

An estimated 32,000 individuals were in treatment with specialist alcohol services in Scotland in 2012. The total is based on the actual number of individuals in treatment provided by 117 (78.5%) services via the survey and estimates for the remaining services using the methods described in chapter 2. ADP-level estimates are shown in Table 9 in Appendix 3.

The majority of individuals in treatment were in services delivering only tier 3 interventions (62.8%). A further 35.7% were in services delivering both tier 3 and 4 interventions, with 1.7% in services delivering only tier 4 interventions. This pattern varies from the distribution of services by tier of intervention shown in figure 2.

Two thirds of individuals in treatment were male (66.3%) and one third were female (33.7%). Applied to the total number of service users, there were an estimated 21,075 males and 10,725 females in specialist alcohol treatments services in Scotland in 2012. However, only 58 (38.9%) of the 149 services provided information on service users by gender and these figures should be interpreted with caution.

Less than a quarter of services (36 of the 149) provided information on service users by age, ethnicity (35), offenders (18), homeless (17), people with disabilities (10), asylum seekers (9), refugees (9), and Gypsy/Travellers (9). The data was therefore deemed to be unrepresentative and is not analysed further in this report.

3.1.8 Future challenges and opportunities

The providers’ survey included an open-ended question gathering services’ views on future challenges and opportunities that might impact on their ability to meet the needs of individuals. Services identified a range of issues which have been grouped into broad categories.

Funding was identified as the main challenge. Providers expressed concern about perceived future budget cuts and the impact this would have on the delivery of services. These concerns related both to core services and services which had been established with time-limited funding commitments. Funding concerns related to all sectors, although they were most prominent in the third sector as demonstrated by the following comment:

‘The economic climate and the squeeze on funding is a huge anxiety for our organisation and the effect that it could have on the service to vulnerable individuals’ (third sector provider).

Additional comments related to specific funding issues, for example:
'The biggest challenge ahead is in the way national resources are currently invested in the ‘front end’ of treatment services. NHS staff are skilled and expert in this stage of care and I believe that training and selection of nurses and other staff from the statutory organisations who have a recovery focus should be funded. More investment in shifting some of the staff resources towards the exit end of treatment services would go a long way in truly establishing a recovery-orientated service’ (third sector provider).

‘Funding for rehab placements and move on accommodation are an issue for us as a homeless team – projects have not been re-funded that were vitally important to our staff and clients alike’ (statutory sector provider).

Services also highlighted service redesign as an important issue. It was identified as both a challenge in terms of potential tendering and possible loss of services, and an opportunity in terms of new or expanded services.

Other challenges and opportunities included: increasing demand, recruitment and retention, Welfare Reform, the increasing complexity of client needs, re-tendering and commissioning, meeting targets, the implementation of Self Directed Support, health and social care integration, and Alcohol Related Brain Damage.

3.2 Need: Alcohol dependency in Scotland

3.2.1 Overview

AUDIT data from SHeS 2012 demonstrates that approximately one fifth of adults in Scotland reported drinking behaviour consistent with an Alcohol Use Disorder. The majority of these adults were estimated to be hazardous drinkers with an AUDIT score between 8 and 15. SHeS data should be interpreted subject to the potential data limitations discussed in chapter 2.

Using an AUDIT score of 16 or more as an indicator of alcohol dependence, the same score used in the SANA and a similar study in England (Drummond et al.), 3.1% (95% CI, 2.3%–3.9%) of the adult population aged 16+ displayed signs of moderate or severe alcohol dependence; this equates to almost 138,000 individuals. The 3.1% figure consists of 1.9% of the adult population with harmful drinking indicated by an AUDIT score of 16 to 19 and 1.2% of the adult population with possible alcohol dependence indicated by an AUDIT score of 20+.

<table>
<thead>
<tr>
<th>Alcohol Use Disorder</th>
<th>Percentage</th>
<th>Estimated number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk drinking/abstinence (0–7)</td>
<td>81.3%</td>
<td>3,577,382</td>
</tr>
<tr>
<td>Hazardous drinking (8–15)</td>
<td>15.5%</td>
<td>683,760</td>
</tr>
<tr>
<td>Harmful drinking (16–19)</td>
<td>1.9%</td>
<td>85,006</td>
</tr>
<tr>
<td>Possible alcohol dependence (20+)</td>
<td>1.2%</td>
<td>52,780</td>
</tr>
<tr>
<td>All</td>
<td>100.0%</td>
<td>4,398,929</td>
</tr>
</tbody>
</table>

Source: Scottish Health Survey 2012
3.2.2 Gender and age

Possible alcohol dependence indicated by an AUDIT score of 16+ varied by gender and age. Among Scottish males, an estimated 4.2% (95% CI, 2.9%–5.6%) showed signs of alcohol dependence – twice the rate for females (2.1%; 95% CI, 1.4%–2.9%). Numerically such rates equate to 88,925 males and 49,125 females (gender figures do not sum to total due to rounding).

Signs of possible alcohol dependence were highest among young adults and generally decrease with age as shown in figure 7. Possible alcohol dependence by age varies among males and females, with males aged 25–34 and 45–64 displaying higher levels than females of the same age.

Figure 7: Individuals with possible moderate and severe alcohol dependence (AUDIT score of 16+) by gender and age, 2012 (%)

Source: Scottish Health Survey 2012

3.2.3 Sensitivity analysis of alcohol dependence

As highlighted in chapter 2, the Research Advisory Group requested sensitivity analysis was undertaken as part of this study to reflect the limitations of using self-report surveys to estimate levels of alcohol consumption. SHesS reported that 3.1% of the adult population aged 16+ displayed possible alcohol dependence indicated by an AUDIT score of 16+. The sensitivity analysis that follows includes possible alcohol dependence between 4% and 6% of the adult population aged 16+ (see Table 3).

The scenarios include a figure of 5% of adults with possible alcohol dependence similar to the 4.9% of adults aged 16 to 74 in Scotland who displayed signs of alcohol dependence indicated by an AUDIT score of 16+ reported in the Psychiatric Morbidity Survey in 2000 (Singleton et al.25), the only other occasion to date when the AUDIT questionnaire was used in a Scotland-wide survey and also the figure used in the SANA study. At 5% an estimated 219,950 adults in Scotland would be possibly alcohol dependent. Table 3 also includes a scenario of 6% of adults with possible alcohol dependence which takes into account the evidence that self-reported alcohol consumption is approximately half of the level of retail sales (NHS Health...
Scotland\(^\text{14}\). At 6% an estimated 263,925 adults in Scotland would be possibly alcohol dependent.

**Table 3:** Scenarios of estimated possible alcohol dependence (AUDIT score 16+) (n and %)

<table>
<thead>
<tr>
<th>Possible alcohol dependence</th>
<th>SHeS, 2012</th>
<th>SHeS, 2012 (95% CI)</th>
<th>Other scenarios of alcohol dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>3.1%</td>
<td>2.3%</td>
<td>5%</td>
</tr>
<tr>
<td>Estimated number of individuals</td>
<td>137,787</td>
<td>101,175</td>
<td>171,558</td>
</tr>
</tbody>
</table>

### 3.3 Prevalence-Service Utilisation Ratio

#### 3.3.1 Overview

With almost 32,000 individuals in treatment and 138,000 individuals with possible alcohol dependence, the PSUR in Scotland in 2012 was estimated to be 1 to 4.3 (Table 4). In other words, approximately one in four adults with alcohol dependence accessed treatment in 2012. Another way of expressing this is that 23.1% of alcohol dependent individuals in Scotland in 2012 accessed specialist alcohol treatment.

#### 3.3.2 Sensitivity analysis

The sensitivity analyses of alcohol dependence shown in Tables 4 and 5 were produced to inform this PSUR analysis. Assuming the SHeS estimate of 3.1% for the level of moderate or severe alcohol dependence is an underestimate, the PSUR would overstate the proportion of individuals with alcohol dependence who accessed treatment. PSURs for other scenarios of alcohol dependence range from 1 to 5.5 if alcohol dependence was 4% to 1 to 8.3 if alcohol dependence was 6%.

**Table 4:** PSURs based on SHeS (n and %)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>SHeS 2012</th>
<th>Sensitivity analyses reflecting degree of uncertainty around the SHeS estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol dependence (%)</td>
<td>3.1%</td>
<td>2.3% 3.9%</td>
</tr>
<tr>
<td>Alcohol dependence (n)</td>
<td>137,787</td>
<td>101,175 171,558</td>
</tr>
<tr>
<td>Individuals in alcohol treatment</td>
<td>31,796</td>
<td>31,796 31,796</td>
</tr>
<tr>
<td>Individuals in need accessing treatment</td>
<td>23.1%</td>
<td>31.4% 18.5%</td>
</tr>
<tr>
<td>Ratio</td>
<td>4.3</td>
<td>3.2 5.4</td>
</tr>
</tbody>
</table>

**Table 5:** PSURs sensitivity analysis (n and %)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>SHeS 2012</th>
<th>Sensitivity analyses for higher alcohol dependence percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol dependence (%)</td>
<td>3.1%</td>
<td>4% 5% 6%</td>
</tr>
<tr>
<td>Alcohol dependence (n)</td>
<td>137,787</td>
<td>175,957 219,946 263,936</td>
</tr>
<tr>
<td>Individuals in alcohol treatment</td>
<td>31,796</td>
<td>31,796 31,796 31,796</td>
</tr>
<tr>
<td>Individuals in need accessing treatment</td>
<td>23.1%</td>
<td>18.1% 14.5% 12.1%</td>
</tr>
<tr>
<td>Ratio</td>
<td>4.3</td>
<td>5.5 6.9 8.3</td>
</tr>
</tbody>
</table>
3.3.3 Gender

The PSURs for males and females in Scotland in 2012 were broadly similar at 1 to 4.2 and 1 to 4.6 respectively although care should be taken interpreting these figures due to the limited provision of data on individuals in treatment by gender. Expressed as the percentage of alcohol dependent individuals who accessed specialist alcohol treatment, the figures were 23.7% for males and 21.9% for females.
4. Case Studies

This chapter presents the findings of the qualitative research with alcohol treatment service commissioners, providers and users across three case study areas. The main focus of the interviews was on developments since 2008 following the investment that accompanied Changing Scotland's Relationship With Alcohol: A Framework for Action. Key themes included additional resources, a focus on recovery and preventative work, additional reporting requirements, changing referral routes and service pathways, convergence with drug treatment services, growth of the third sector, positive relationships between stakeholders, increasing service user involvement, and peer-led recovery services. As well as changes since 2008 the interviews also identified a number of ongoing issues which are also summarised in this chapter including service gaps, service planning, staffing, demand and missed appointments. The findings of the capacity assessment exercise are also presented and capacity issues raised during the interviews are referenced throughout.

4.1 Developments since 2008

4.1.1 Additional resources

Across interviews ADP staff, service managers and staff identified a range of ways in which the additional resource had been put to use. For example staff in one service in Area 3 reported that additional resources had paid for staff posts, providing extra capacity which contributed to a reduction in caseloads (from 70 service users per member of qualified staff to 30, over a five year period), facilitating support to greater numbers of service users and increased frequency of contact with those in treatment. Staff from a service in Area 3 explained they had increased capacity by using space provided by partner agencies such as rooms in GP surgeries, which aided their delivery in rural areas. ADP staff in Area 2 explained the funding had been used to create entirely new strands of work, an alcohol relapse prevention service, support for people leaving criminal justice services where alcohol had contributed to their offence, and an intervention and support service for children and young people using alcohol. One service manager commented:

‘Certainly the extra money has helped us to deliver alcohol services and secure posts that we didn’t have before. It has made a difference and helped us build the partnership; you can see it working its best at times like these when we are short of staff’ (service manager, Area 3).

Some staff members felt that the additional resource had brought a renewed focus on alcohol services, for example one staff member in Area 1 described a welcome ‘shift in balance’, explaining a perception that there had been more of a focus on drug services at a local and national level in the years preceding the Framework for Action.

4.1.2 Recovery and preventative focus

Service commissioners and staff reported a shift within specialist alcohol treatment provision since 2008, with an increased understanding of the importance of recovery. In general, staff comments across Areas 1, 2 and 3 reflected an opinion that
changes had led to a more holistic assessment of support needs and more effective
treatment. Commissioning staff, service managers and staff frequently mentioned
the Framework for Action as a key driver of change in terms of a renewed focus on
recovery and prevention.

In Area 2 commissioning staff highlighted local investment in preventative work such
as maintaining alcohol awareness days within the local authority and appointing a
schools’ worker to engage young people on the subject of alcohol misuse. There
was a view that such activity, if effective, could lead to reduced need for alcohol
treatment services in future. Commissioning staff and one service manager within
this area also highlighted their work to pilot the use of Self Directed Support (SDS)*
funds with service users; they plan to extend this activity if evaluation proves its
effectiveness.

Staff and service managers expressed a view that the additional resources had
focused on recovery-orientated activity often provided by third sector partners.
However, examples of a variety of posts and services within statutory services were
also identified, for example an Alcohol Related Fall service delivered by occupational
therapists in Area 2. There was a concern however that in some cases new services
had recently been scaled back or ended due to funding issues and similar concerns
were raised in the survey as reported in chapter 3.

4.1.3 Additional reporting requirements

Service managers and staff frequently expressed the view that there had been an
increase in reporting requirements linked to A11:HEAT target and the consensus
was that this impinged on the contact time with service users. While staff consistently
referred to the HEAT target as having had a positive impact in terms of speed of
access to treatment, several were critical of the volume of paperwork involved in
reporting. Similarly there were negative views on the paperwork associated with
aspects of case management and ad hoc requests for additional evidence and
information. For example one staff member said:

‘every time something is added to an assessment, you’re maybe told at the
time “it’s only one question” but if you’ve got ten wee bits added over the last
six months then …another thirty minutes…is added on’ (staff member, Area
2).

In Areas 2 and 3 staff mentioned that the requirement to share information with
partners across various tracking systems necessitated significant data entry
duplication, which affected service user contact time.

A service manager in Area 3 noted that they were recently involved in an initiative
which identified that nurses spent half or less than half of their time in face-to-face
contact with patients.

* SDS is a Scottish Government initiative which allows an individual to choose the support they
receive to meet their health and social care needs; www.selfdirectedsupportscotland.org.uk/
Typically staff in all three areas described capacity in relation to their ability to meet waiting time targets within existing resources. While staff alluded to busy workloads they felt able to meet targets although many made comments such as ‘we could always do with more staff’. In Area 1 there had been a pilot to assess service users within two weeks instead of three; the assessment time was eventually pushed back to three weeks as managers struggled to meet this target.

One staff member in Area 3 reflected that while the introduction of the A11:HEAT target had been very positive, the faster process meant that in some cases service users did not have time to psychologically prepare to address their drinking behaviour, which rendered treatment less effective, in their opinion. In Area 1 a practitioner suggested that targets limited the ability to use discretion with regard to appropriate use of interventions, explaining that a small minority of individuals seek detox in order to facilitate further drinking, behaviour the staff member said that service users describe as going in the ‘spin dryer’. This staff member said that providing detox to people in this state made them feel they were becoming complicit in harmful drinking activity.

Across case study areas staff described different formats for recording assessment, referral and case management processes, using a mixture of electronic and paper-based tools. Managers outlined challenges in migrating entirely to electronic systems, for example staff from a service in Area 3, who work in rural areas, frequently resort to paper diaries and case notes due to a lack of access to laptops. This creates duplication of reporting activity (copying paper notes on to computer systems). Staff from a service in Area 2 described travelling long distances from remote rural areas so that they could return to their base and input the initial assessment within the required time (six hours) and one said ‘everyone seems so driven by…statistics…and sometimes I think there is an ignorance towards the locality of these people [service users] and the travel and other factors that are involved in seeing them’. One manager in Area 2 had recently implemented a pilot project, providing mobile devices that could be used offline and would easily upload data once staff members returned to their base.

A service manager in Area 2 noted that they did not feel national reporting frameworks fit with person-centred approaches given that they focus on treatments delivered by services, as opposed to outcomes for individuals. In this area commissioning staff use a range of outcome measurement tools, asking services to report to their Community Planning Partnership (CPP) on outcomes for individuals in addition to providing statistics for the DATWT dataset, however outcome information is not part of the national reporting framework as yet.

Staff highlighted a recent change in terms of reporting requirements related to Job Centre Plus, for example staff in Areas 2 and 3 described a small number of instances where they had been asked to provide evidence of service user attendance at alcohol treatment services. They were not able to provide this due to client confidentiality but feared not doing so might have negative financial consequences for the person they were supporting. Others described self-referrals that they felt were motivated by clients wishing to provide evidence to Job Centre Plus staff to support a benefit claim; however none of the service users who participated in interviews mentioned welfare issues as a factor leading to their
engagement with treatment. On this theme service users described support from their treatment staff to engage with agencies such as Job Centre Plus, for example:

‘I hadn’t signed on the brew [Job Centre Plus] for about ten years and they wanted to see me and the lassie in here [treatment staff] went to the brew with me. It saved me having to put up with all their nonsense, spinning me dinghies, because when someone comes in with a bit of authority they [Job Centre staff] couldn’t be nicer to you. It helped a hell of a lot and they ended up apologising to me’ (service user, Area 2).

4.1.4 Changing referral routes and service pathways

Across the three case study areas staff described a combination of referral routes with direct referrals from GPs, hospital-based Alcohol Liaison Nurses, partner agencies and self-referrals from service users. For example ‘most of the referrals come from GPs through a system called SCI – it’s an electronic thing that referrals go through. Admin check that every day just after lunch and we also accept self-referrals and basically referrals from just about any source’ (service manager, Area 1).

It was noted that referral processes had changed in recent years, with a shift from direct referrals into specific services, to processes that facilitated joint assessment followed by allocation to the most appropriate local service. These changes were designed to ensure that service users received support from the most appropriate agency.

Various service pathways were identified although all began with an assessment of client needs followed by the development and implementation of an individual care plan. Commissioning staff in Area 2 described changes to the model of treatment, shifting from a linear pathway whereby clients progressed through a series of steps, requiring those who disengaged to return to the start of the process and repeat it – to a more flexible, person-centred approach. In this model clients were more involved in the planning of their support, a greater range of support including mental health treatment was covered by their care plan, and individuals could re-engage at any point of their treatment if they chose to. Other changes had also been put in place to offer holistic support. For example, where required, staff from the community mental health team attended assessment meetings to inform decisions on the most appropriate primary care provider. Weekend services were also established in response to service users’ requests for support outside working hours.

Commissioning staff, service managers and staff across the case study areas expressed views that suggested the move towards a more holistic approach to treatment and support would lead to a greater number of service users sustaining their recovery and fewer relapses. This has the potential to release capacity in services by reducing the demand in support from repeat users. In turn, smaller caseloads will provide additional capacity for the delivery of more intense and effective work with those presenting to services for the first time.

Commissioning staff and service managers in Area 3 worked together to develop an entirely new operational model as part of this process, establishing several drop-in
services at key locations across the local authority, staffed on a rota basis by all specialist alcohol treatment providers. In addition to making services more accessible to potential service users and thereby encouraging self-referrals, particularly among women, there was activity to raise awareness of the drop-in among potential referral partners particularly GPs. Staff in Area 3 suggested that public awareness of support had increased in line with campaigns that highlighted the need to address harmful drinking behaviour. The consensus across interviews with staff in this area was that the move to a locality model would increase capacity over time as it allowed more effective working relationships with partner agencies to develop, supported teams coming together to share good practice and provided a route for staff to offer greater continuity of support to service users.

Many service users described missed opportunities for referral to treatment, typically relating these to the attitudes of medical staff. Staff in Area 2 and service users across Areas 1, 2 and 3 described instances of poor treatment at A&E, linking this to negative judgements and attitudes of doctors and nurses towards people attending because of alcohol misuse. For example, a service manager said:

‘you tend to find that because they [service users] are chronic and almost have a revolving door admission they are not well liked by medical and nursing staff’ (service manager, Area 3).

One service user recounted attending A&E on an almost weekly basis over the space of a year without anybody suggesting that alcohol treatment was available; it was only when this person was made homeless and received support from a third sector agency that they became aware of alcohol recovery services. Conversely, a service manager in another area suggested that alcohol related presentations at A&E were a key point at which alcohol misuse was identified, with support provided in hospital by the Alcohol Liaison Nurse who would refer potential service users on to treatment providers.

Staff and service users expressed mixed views on referrals from GPs. Many staff described very close working with GPs, effective referral practices and ongoing dialogue as part of case management. These staff said improved partnership working with GPs had contributed to higher numbers of referrals. However, some service users across Areas 1 and 2 were critical of their experiences, describing frustrating and contradictory practice. For example, one service user in Area 2 had stayed sober for the morning to ask their GP for a referral to alcohol support however their doctor said that if it was possible for them to abstain from alcohol for a GP appointment they did not require treatment. Another individual in Area 2 attended their GP under the influence of a limited amount of alcohol to ask for help, saying they would not have been able to make the journey without a drink, however their GP had refused to see them, telling them to come back when sober. In Area 1 a service user said their friend’s GP had ‘given up’ and refused further referrals for treatment after frequent relapses. They said this individual had been so desperate for a referral that they committed an offence – swearing at a police officer – in order to be arrested and access medical support through an alternative route.

There was a suggestion from staff in Area 1 that substantial caseloads sometimes impacted on their ability to coordinate interventions, for example it might not be
possible to align activities, requiring separate visits for detox appointments and complementary tasks such as motivational work.

Staff in the three areas suggested that the shift to comprehensive treatment and recovery was sometimes surprising to service users – and in some cases, off-putting – because it required active engagement and long-term commitment to recovery on their part. For example, one staff member in Area 2 recounted a service user saying ‘you expect me to do what?!’ when they outlined the range of support that could be put in place. Others suggested that some of the clients who used services over long periods of time had a ‘mind-set’ which needed to be challenged as they were mainly interested in detox. Across interviews comments by staff and service users demonstrated that service users’ engagement with alcohol treatment varied in terms of time, intensity, support and setting.

Development and refinement in assessment criteria was also mentioned across interviews with service managers and staff. The shift to comprehensive treatment and recovery required increased awareness of local partners’ services and more sophisticated assessment processes. For example staff in Area 2 said that in addition to child protection they now considered other factors such as gender-based violence, and adult support and protection.

4.1.5 Convergence with drug treatment

In many cases specialist drug and alcohol treatment services had merged and or co-located since 2008/09, with only a handful of staff interviewed holding a role relating solely to alcohol support. There had been significant work involved in the merger process to standardise referral, assessment, and case management approaches.

Views on the impact of these changes varied – some staff welcomed the development, suggesting that the shift towards addressing addictions, irrespective of the substance used, had led to more effective support and had helped to break down barriers between alcohol and drug services. Others were more critical – highlighting, for example, different behaviours across alcohol and drug users that merited separate treatments. Several staff noted that supporting drug users was more time intensive and required different skills. There was also a view that drug treatments represent a disproportionate share of resources compared to the absolute numbers of alcohol and drug users supported by their service. A negative view about the merger of alcohol and drug treatments was expressed by some staff who felt the change in their role could affect staff retention in the longer term.

Commissioning staff, managers and service staff also discussed the effect of the merger of alcohol and drug treatment services on service users. One service manager believed there had been no obvious change from the service users’ perspective. However, staff in an Area 2 service suggested that some individuals requiring alcohol support were ‘put off’ engaging with services due to the presence of drug users in the waiting room area and stigma of accessing services that cater for drug users. A range of views were expressed by those accessing treatment, for example one said:
‘I think it’s better that drug and alcohol users are separate’ (service user, Area 1).

Whereas another said:

‘I’ve never seen it as a problem; an addiction is an addiction’ (service user, Area 2).

4.1.6 Growth of the third sector

Commissioning staff, service managers and some service staff commented on the growth in third sector provision since 2008, suggesting that it created greater choice and facilitated tailored pathways for service users. A staff member in Area 3 felt that third sector provision led to more capacity in their (NHS) service as the option for throughput meant they no longer had to ‘hold’ clients that required some level of ongoing support. This was reflected in comments by those accessing support, for example:

‘years ago there were only three addiction workers for the whole area – now there are all these voluntary agencies topping things up. I dealt with…service and they basically gave me a detox and sent me a letter and told me I was cured. I was shocked and there was nothing in place to help me after. But now there’s a lot more recovery support’ (service user, Area 1).

In Area 3 some staff reported that service users expressed a preference for third sector providers compared to statutory agencies and staff said they were aware of this, linking it to the users’ experience and finances (the third sector agencies had funding to provide social activities, refreshments and reimbursements for service users’ travel expenses). This perception was echoed in discussions with service users in that area who cited factors such as the additional benefits (refreshments and reimbursements) as indicators that the third sector provider ‘cared more’. However service users in Area 2 suggested this could lead to distorted motivations for engagement:

‘two years ago folk were coming here when they were giving out free bus passes and…as soon as they got it, you never saw them again, until their pass ran out…here for anything you can get for nothing’ (service user, Area 2).

Service users across the case study areas said they valued support from third sector staff with personal experience of alcohol recovery (either their own or that of a close relation) although in these discussions they frequently emphasised that the sharing of such information between staff and users was discreet.

It was highlighted by staff and service managers from both public and third sector services that third sector providers are able to extend the capacity of their service by support from volunteers – often former service users who have had a sustained period of recovery.
4.1.7 Positive relationships between stakeholders

The majority of staff described stakeholder relationships between the ADP, treatment providers and partner agencies in positive terms. Often this was linked to good relationships with the individuals holding senior posts, most of whom have worked in the area for a long time.

Comments on relationships between treatment providers were particularly positive and staff frequently highlighted that new joint assessment practices had resulted in closer working, creating better knowledge and understanding between staff in treatment services. For example, staff in Area 3 highlighted that the drop-in service helped to foster close working relationships between treatment providers.

In Areas 1 and 3 there had been significant change in ADP structures and processes in recent years, typically involving efforts to streamline activity and hold fewer staff meetings. Views on the effects of these changes differed. In Area 1 staff said there was less contact with the ADP, suggesting they were less connected and had limited scope to influence activity as a result. However, in Area 3 staff and managers described changes within ADP structures in positive terms and highlighted more effective working and an increased sense of partnership. Managers and staff in Area 2 were also positive about the partnership arrangements in place, for example:

‘I think there are good links between partners; we have a weekly meeting which all services attend – that’s there to ensure that referrals are shared between services or discussed between services, and I think there is plenty of communication that goes on between the staff and services; I’m unaware of anyone feeling uncomfortable, for example to pick up the phone with another service, whether it be with a referral, a concern, a question or a request for input’ (service staff, Area 2).

Relationships within the wider local context were also discussed. For example a manager in Area 3 suggested that their ADP was not sufficiently ‘meshed’ within civic structures and raised this as a potential threat, putting the partnership at risk of change that it was not able to influence. In Area 2 commissioning staff and service managers felt the ADP’s profile within the CPP was a particular strength, with mention of the benefits from aligned CPP and ADP agendas.

Additional influences were also mentioned when staff described the impact of policy developments within their ADP area. For example Area 2’s strategy linked closely to that of the CPP, with staff suggesting that the CPP’s focus on person-centred approaches and investment in harm prevention had informed the ADP’s planning and decisions around use of resource. Commissioning staff in Area 3 highlighted that the ADP had been one of the first to adopt outcome measurements. While this was described as a positive process and a key driver for improvements to services, staff suggested that their understanding of outcomes had since progressed and that the early work required revisiting. Similarly, commissioning staff in Area 1 highlighted that there had been closer alignment between the ADP and the Local Authority strategy resulting in a greater focus on outcomes within their ADP strategy.
4.1.8 Increasing service user involvement

The extent of user engagement in service planning varied across case study areas although in every area, processes to involve service users in the design of services had recently been established. Both staff and service users described this in positive terms feeling that there would be more activity of this nature in future and that it would lead to improvements in the reach and effectiveness of services. Some of the service users described participation in service design as an important part of their recovery.

Managers and staff described a shift in terms of increasing service user involvement in the development of treatment and recovery plans, for example:

‘sometimes they [the plans] look very simple, but that’s deliberate – it’s the service users’ plan rather than what we think’ (service manager, Area 3).

4.1.9 Peer-led recovery

Another change mentioned by commissioning staff, managers, staff and service users across case study areas is the increased provision of resources to develop peer-led recovery networks. Resources have been used for various activities such as Self Management Addiction Recovery Training (SMART) in Areas 2 and 3, providing venues for service-user led meetings, suggesting activities for those in recovery to take part in such as hill walking, and raising awareness of funding available to cover costs such as transport. Staff and managers across all three areas suggested that peer-led recovery networks provide an additional local resource that could increase capacity to deliver ongoing recovery support. Service users also mentioned the effectiveness of such activity:

‘there are about fifteen or sixteen of us at the [weekend] meetings, and they cannae say it's not productive – one member of staff dealing with fifteen or sixteen people who are getting benefit out of coming to those meetings’ (service user, Area 2).

Staff in Area 3 also expressed a view that peer-led recovery has the potential to reduce the number of relapses, thereby freeing up time to support other individuals.

4.2 Ongoing issues – barriers and facilitators

As well as gathering views on the key developments since 2008 reported above, interviews in the three case studies identified a number of ongoing issues, some common to every area. These are summarised below.

4.2.1 Service gaps

Staff identified the following gaps in service reach and treatment availability:

- shortage of access to prescribing GPs causing delays in detox treatments
- limited access to psychiatrists
• problem drinkers within the local population who do not recognise they need support or wish to engage in treatment services
• high disengagement rates where service users do not complete their treatment or sustain recovery
• limited support for those service users engaged in harmful drinking who only wish to reduce the amount they drink, not stop entirely
• a gap in treatment, pathways and support for those affected by Alcohol Related Brain Damage (ARBD)
• (in Areas 1 and 3) lengthy waiting times for residential detox services, during which staff struggle to keep service users motivated
• lack of interventions designed specifically for binge drinkers
• scope to work more closely with families; both to support those affected by alcohol misuse and engage in preventative work to change drinking cultures
• gaps in follow-up support to assist service users to sustain recovery
• (Area 1) difficulties in accessing community mental health services for alcohol users because the local mental health team will not engage with individuals being supported for substance misuse.
• (Area 1) a change in that those admitted for rehabilitation services are required to be illicit substance free which limits the use of this service by those with more complex needs.

Service users also mentioned gaps in support. Some described difficulties in getting a referral for alcohol treatment from medical staff and several suggested that service opening times should be extended over weekend periods, with comments such as ‘there’s an acknowledgement that the weekends are very long for people in recovery’. Many suggested they had friends who required treatment but were not ready to engage in services for example:

‘I know drinkers who could do with support but they are not too sure about what it [support] involves and are too embarrassed to get help’ (service user, Area 1).

4.2.2 Service planning

Across the three case study areas, commissioning staff and some service managers alluded to historic weaknesses in needs assessment processes. A manager in Area 1 questioned whether a needs assessment had ever taken place, feeling that local services had simply adapted to meet the number of referrals without any sense of strategy or understanding of overall levels of need. Another service staff member in this area gave an example of funding from a partner agency being withdrawn on the basis that there was limited take-up of the service – however, they suggested that issues lay with the referral process, not the level of demand. Across all areas commissioning staff and managers frequently mentioned that efforts were underway to improve the evidence base and identify gaps in services.

4.2.3 Staffing

The interviews with commissioning staff, managers and staff identified the following key staff functions:
• comprehensive assessment, often performed in partnership with other agencies
• key worker taking lead responsibility for the support of individuals on their caseload
• drug prescribing, coordination of medication and monitoring symptoms of physical withdrawal
• supporting service users to address factors that have contributed to their addiction, for example through counselling
• delivering complementary therapies and activities to support recovery and sustained change
• providing specialist support, for example, Occupational Therapists and Psychiatrists.

In the majority of cases staff turnover was low among ADPs and treatment providers, although some service managers described periods of reduced team capacity, due to staff illness or maternity leave. Typically commissioning staff and managers had worked locally – either within the same ADP or a neighbouring area – for a long period. Within Area 3 it took a number of months for a vacant ADP coordinator position to be filled and their replacement required time to become familiar with the local operating context and establish effective working relationships. Unfilled staff vacancies directly limit capacity and this was evident in one of the services in case study area 1.

Staff in Area 3 suggested that the limited availability of prescribing staff had led to increased waiting times and a ‘rush’ to deliver support once prescriptions became available. One service manager said that ongoing issues with the recruitment and retention of prescribing medical staff had led to caseloads reaching five hundred, and described innovative methods of securing access to prescriptions. These included the appointment of a non-medical staff member who is qualified to prescribe methadone, thereby releasing other prescribers’ time for alcohol detox patients; and the piloting of a GP enhanced service to secure input from local doctors with an interest in the field of alcohol recovery.

Across interviews service managers described lengthy waits to fill vacant posts due to NHS requirements to evidence an inability to meet workloads within existing resources, followed by a review to identify whether or not posts could be filled by a redeployed staff member. Once these avenues are exhausted approval is given for advertisement, which means that overall the recruitment process can take between three and six months. In a linked discussion, staff in Area 3 also described periods of scarcity in supply of key medication such as Disulfiram and one instance where the entire local supply ran out, causing relapse, distress to service users and a significant increase in the demand for support from treatment services.

It was highlighted by managers across each area that the complex nature of alcohol treatment work and the assessment skills required – being able to ask the right questions, in an appropriate manner, at the right time – often necessitated a period of support and training for new staff, impeding services’ ability to operate at full capacity. Although this was mainly a historic issue for treatment providers who have already undergone merger or co-location processes, it is highlighted as a factor with the potential to affect the capacity of services that undergo such activity in future. This is particularly relevant given the ongoing process of health and social care services integration. Linked to the issue of health and social care integration,
commissioning staff, managers and staff across case study areas highlighted uncertainty as well as new ideas as to what would happen during this process, for example comments included ‘social work might merge into alcohol services’ and ‘the ADP function could be delivered by public health’.

Service managers described drawing on a wider range of staff and skills in recent years, for example to provide holistic support to clients, offer greater choice (complementary therapies as well as pharmacological interventions) or with increasing use of occupational therapists, counsellors and psychologists. In addition managers and staff frequently reflected that paperwork and planning are particularly important, for example:

‘I think diary and time management are absolute core skills for ourselves’
(staff member, Area 2).

A service manager in Area 3 also suggested that embedding a process to review and reflect on practice would lead to continuous improvements in service delivery. Service users also recounted instances of insensitivity from staff members that could also be addressed, potentially, by further training. For example one service user described their initial assessment interview as ‘traumatic’ explaining that:

‘over an hour they asked me everything, very personal, difficult questions including what had happened to me as a child’ (service user, Area 1).

Across all case study areas managers and staff mentioned that NHS colleagues’ enthusiasm for alcohol recovery work varied. While recognising that a culture shift had taken place it was suggested that staff ‘still had some way to go’ with the perception that they were more interested in delivering detox treatment than other aspects of recovery such as addressing the causes of addiction. A staff member in Area 1 felt there was the potential for service users to receive different support, depending on who was managing their case; some staff might focus on detox, whereas other would take a more holistic approach.

Commissioning staff, managers and staff across case study areas expressed a view that harnessing administrative resource to greater effect could improve capacity. For example a manager in Area 3 suggested that that administrative staff could take on more of a role in communicating with service users to cut down on time wasted as a result of missed appointments; staff in another service in Area 3 mentioned that identifying clinical space for work in community settings is time consuming as another task that could be taken on by administrators.

4.2.4 Demand

Increasingly complex caseloads were reported by staff and managers, which they felt took up more time and affected their capacity. Indeed, many of the service users who participated in interviews had additional health issues that necessitated care from a range of health partners, including alcohol-related injuries (such as burns) and long-term conditions.
Several other themes emerged from staff interviews, concerning the demand for specialist alcohol treatment services. While staff emphasised their views were based on observations, not data, increases in demand within the following groups were noted:

- a change in the socio-economic profile of service users with a small increase in referrals of professionals – ‘white collar workers’ – some of whom were close to a crisis point, but still in employment
- greater numbers of recently retired people whose drinking habits had significantly increased once employment ended
- an increase in young people with physical impairments caused by the significant levels of alcohol they have consumed
- a shift in the male to female profile of service users with increases in the number of females
- relapses linked to crises such as service users’ welfare payments being withdrawn as a result of a new assessment process.

There were mixed views from staff as to whether or not the changes described above result from new drinking behaviours, or reflect improved referral processes and enhanced service accessibility. In terms of behaviour, many staff suggested changes to social drinking patterns – for example binge drinking – were linked to culture as well as the availability and price of alcohol. Service users did not talk about trends in drinking or make links to alcohol availability; their comments focused on their own behaviour and typically described drinking as a response to feelings, a crisis, traumatic events or difficult periods of their life.

Staff and service users frequently raised the issue of readiness for support. A theme in these discussions was the challenge of balancing treatment accessibility while recognising that recovery requires commitment on the part of the service user. Several service users described ongoing contact with treatment providers for years before developing a sustained commitment to recovery. Themes in these conversations included being told that ‘one more drink’ would kill them or a ‘light bulb moment’, after years of recovery and relapse, where they realised that they had ‘had enough’. The issue of readiness and motivation can affect services’ capacity. Across case study areas staff and service users expressed views that individuals who are not ‘ready’ absorb resources that might be better invested in those fully committed to treatment and more likely to sustain recovery.

Service users in Area 2 highlighted an increase in the number of individuals referred for alcohol support by criminal justice agencies, for example through a Drug Treatment and Testing Order:

‘there seem to be some people here who have been sent by court...you pick it up in discussions in meetings. Then they disappear after a while’ (service user, Area 2).

They suggested this was detrimental, feeling that people referred through this route were not motivated to stop drinking or interested in accessing support and exhibited behaviour that could be dismissive and disruptive:

‘they don’t want to be here’ (service user, Area 2).
These service users also mentioned that the presence of individuals who were still actively drinking (i.e. smelled of alcohol) made it difficult for others who were committed to recovery.

Future pharmacological developments in alcohol treatment and recovery, including drugs that help people to control their drinking, were also mentioned in interviews with staff. One staff member in Area 2 and a service manager in Area 3 suggested that new drugs have the potential to attract a wider cohort of service users and thereby increase demand for support (the Area 2 staff member gave the example of professionals who wish to manage, as opposed to stop, their drinking habit).

4.2.5 Missed appointments

Missed appointments affect staff capacity and represent a challenge in terms of effective use of staff resources; during interviews service managers and staff commented on aspects of service delivery that they felt contributed to non-attendance. One service manager in Area 1 highlighted that a new safety policy prevented initial assessment at service users’ homes unless there were grounds for exception. They felt that requiring individuals to attend their first appointment in a clinical setting was a barrier to engagement and resulted in wasted time due to a high number of non-attended appointments. This person also suggested that the initial home visit was important in terms of establishing a relationship with the service user. In Area 3, a service manager highlighted that a year ago staff were told a policy about service user contact via text message was in development, and until it was published there was to be no contact through this medium. The manager was critical of this decision, suggesting that text messages are an important tool with regard to engagement and also play a key role in encouraging and reminding service users about appointments, thereby reducing non-attendance rates.

It was highlighted by an Area 3 service manager that steps could be taken to reduce missed appointments, with interpersonal skills and motivational interviewing training of key importance.

4.3 Service Capacity

Services in two of the case studies took part in a capacity assessment exercise. Staff in these services completed timesheets recording how their time on alcohol-related activities was allocated. As highlighted in chapter 2 the exercise was intended as a means of assessing the feasibility of a capacity exercise to identify the lessons learnt from the methods as well as examining service capacity in the participating areas. The results of this capacity assessment process are presented below and the lessons are discussed in chapter 5. The findings for each service and each area should be considered in isolation and not compared between services or areas as the services vary and operate under different circumstances. The percentages presented are the time allocated to the tasks shown as a proportion of the total hours allocated to alcohol-related activities.
4.3.1 Case study area 1

In case study area 1, all relevant staff from the area’s two specialist alcohol treatment services took part in the exercise. Nine staff took part in total, two from service A and seven from service B.

Staff spent the most time on service-related activities not involving direct contact with clients (38.2%) with direct contact time with service users accounting for 31.5%. Supporting activities accounted for approximately a quarter of staff time (27.7%). The actual time spent on direct client contact over the fortnight of the exercise was 128.5 hours – this equates to 449.8 hours per month and 5,397 hours per year.

Service A was relatively small operating with only two members of staff with a third post unfilled at the time of the capacity assessment exercise. Service A was also a specialist alcohol treatment service whereas service B was an alcohol and drug treatment service where the capacity assessment exercise showed that approximately 59% of staff time was spent on alcohol-related work.

Table 6: Case study area 1 staff time allocation (%)

<table>
<thead>
<tr>
<th>Time</th>
<th>Service A</th>
<th>Service B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct contact with service users</td>
<td>14.0%</td>
<td>41.8%</td>
<td>31.5%</td>
</tr>
<tr>
<td>Other service user related activities</td>
<td>46.0%</td>
<td>33.7%</td>
<td>38.2%</td>
</tr>
<tr>
<td>(not involving direct contact with the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>service user)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting activities</td>
<td>38.0%</td>
<td>21.6%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Other</td>
<td>2.0%</td>
<td>2.9%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Total alcohol-related activities</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Applying the methodology contained in the capacity assessment guide (Scottish Government25) the annual capacity of the services in case study area 1 is 225 individuals per year; this is based on an annual demand per individual of 26 hours and it takes into account the unfilled staff post in service A. Information from the survey of providers found that these services had 329 individuals in treatment during 2012 (demand). Therefore, a ratio of service capacity to the estimated demand for specialist alcohol services is 1 to 1.5 (225 to 329) – in other words for every individual the service has the capacity to treat they actually supported 1.5 individuals in 2012. These figures are discussed in chapter 5.

4.3.2 Case study area 2

In total seven staff from the two specialist alcohol treatment services in case study area 2 took part in the capacity exercise, three from service C and four from service D. Three members of staff did not submit timesheets, two from service C and one from service D.

Staff spent the most time on service related activities not involving direct contact with clients (39.0%) with direct contact time with service users accounting for a third of their time. Supporting activities accounted for a quarter of staff time. The actual time spent on direct client contact over the fortnight of the exercise was 106.3 hours – this equates to 371.9 hours per month and 4,462.5 hours per year. Both service C and D
were alcohol and drug treatment providers. The above figures will be an underestimate as three members of staff did not submit timesheets.

**Table 7: Case study area 2 staff time allocation (%)**

<table>
<thead>
<tr>
<th>Time</th>
<th>Service C</th>
<th>Service D</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct contact with service users</td>
<td>43.3%</td>
<td>27.5%</td>
<td>33.4%</td>
</tr>
<tr>
<td>Other service user related activities</td>
<td>30.4%</td>
<td>44.0%</td>
<td>39.0%</td>
</tr>
<tr>
<td>(not involving direct contact with the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>service user)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting activities</td>
<td>22.8%</td>
<td>26.5%</td>
<td>25.1%</td>
</tr>
<tr>
<td>Other</td>
<td>3.4%</td>
<td>2.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total alcohol-related activities</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The annual capacity of the services in case study area 2 is 249 individuals per year; this is based on annual demand per individual of 26 hours and it takes into account staff delivering services who did not submit timesheets during the exercise. It has not been possible to calculate a ratio of service capacity to the estimated demand in case study area 2 as the services in the ADP also deliver services in neighbouring ADPs and a figure for individuals in treatment in the ADP area during 2012 was not available from the survey of providers.
5. Discussion

This chapter interprets the quantitative findings described in chapter 3 and the case study findings described in chapter 4. The discussion focuses on the research objectives and how each has been addressed; the findings are compared to previous research where relevant and shortcomings are also identified. In addition, the key issues identified in the findings chapters are explored in more detail and policy implications are highlighted where relevant.

5.1 Need, demand and utilisation

Chapter 3 addressed a number of the study’s research objectives finding that almost 32,000 individuals accessed specialist alcohol treatment services, and almost 138,000 individuals were possibly alcohol dependent (as indicated by an AUDIT score of 16+); the PSUR was therefore estimated to be 1 to 4.3. Chapter 3 also presented scenarios for higher rates of potential alcohol dependence than that found by the SHeS (3.1%) and under these scenarios the PSUR ranged from 1 to 5.5 if possible alcohol dependence was 4%, to 1 to 8.3 if possible alcohol dependence was 6%. The figures were produced to address the potential limitations of SHeS data highlighted in chapter 2 which related to sampling, recall, and measurement bias. The absence of SHeS data on alcohol dependence at the ADP level meant that it was not possible to estimate PSUR figures for Scotland’s 30 ADPs; further research is planned as part of the MESAS programme to address this gap.

The SANA study included an estimated PSUR of 1 to 12.1 in 2006/07. However, the figure is not directly comparable to the 2012 data due to methodological differences between the two studies. SANA included alcohol treatment services in Scotland providing tier 2 to 4 interventions whereas this study focused solely on specialist services providing tier 3 and 4 interventions. In addition, the SANA study used the total number of alcohol patients offered interventions whereas this study used the actual number of individuals in treatment. Although it is not possible to analyse change in the PSUR over time in Scotland, having now established a figure for 2012 a baseline has been created from which future change can be measured if the methods are replicated. Doing so will allow trends in the use of specialist alcohol treatment services by those in need to be monitored over time.

For the first time AUDIT data was available from the SHeS in 2012 and future data from the survey will track trends in the prevalence of alcohol dependence in Scotland. The alcohol dependence figures used in the SANA study, sourced from the Psychiatric Morbidity Survey (PMS) in 2000, was 4.9%. However, the survey sampling frameworks differed with the 2000 sampling adults aged 16 to 74 whereas the 2012 survey sampled adults aged 16+. Future comparisons from 2012 will use the same methods and will therefore be comparable, although still subject to caveats about the limitations of SHeS data.

The 2007 PMS in England found that 3.8% of adults aged 16+ (5.8% of men, 1.9% of women) had an AUDIT score of 16 or more (McManus et al26) which equates to approximately 1,526,000 adults. Using this data and an estimate of 109,675 people receiving alcohol treatment in 2012/13 (Public Health England27) a PSUR of 1:13.9 (7.2%) can be calculated for England; a similar figure has been published (NICE28).
The English in treatment figure was gathered from information recorded on the National Drug Treatment Monitoring System which records individuals accessing tier 3 and 4 interventions – a comparable indicator to the one used in this research. These PSURs suggest that a greater proportion of alcohol dependent adults in Scotland (23.1%) were accessing treatment than in England (7.2%), and this remains the case with the PSURs generated from the sensitivity analysis undertaken as part of this study, even under more conservative assumptions regarding prevalence. It is therefore plausible to assume that a greater proportion of alcohol dependent adults in Scotland were accessing treatment in 2012.

The Scottish Government has not set a target for the proportion of alcohol dependent individuals accessing treatment. The UK Department of Health previously identified a target of 15% which was informed by work in North America (Rush29). There, a model was developed in the 1990s with the authors regarding access of 1 in 10 (10%) as low, 1 in 7.5 (15%) as medium and 1 in 5 (20%) as high (Department of Health30). Using the SHeS estimates of alcohol dependence, the access level in Scotland in 2012 (1 in 4.3) would be regarded as high on this model or medium (1 in 8.3) under more conservative assumptions regarding prevalence.

Analysis of need and demand by protected characteristics and ADPs was restricted by data availability and this is discussed in more detail below. The limited analysis by protected characteristics that was possible enabled PSURs to be estimated of 1 to 4.2 for males and 1 to 4.6 for females although these figures are based on a response rate of 38.9% and should therefore be interpreted with caution. This is encouraging as it suggests that males and females in need are accessing treatment at broadly similar rates. A significant discrepancy in PSURs for males and females would have been cause for further investigation.

5.2 Service availability

Chapter 3 addressed the research objective to assess the availability of services and the specialist alcohol treatment sector in Scotland was described in detail. The 149 services were analysed in terms of sector, tier, alcohol and drug focus and history.

One interesting element of the findings, in light of this research’s focus on the impact of additional resources was the formation of a number of new specialist alcohol treatment services and reconfiguration of others in 2010 and 2011 (although there were a number of service developments throughout the 2000s). The local delivery landscape was reformed during this period influenced by a number of factors, most notably the introduction of the A11:HEAT target, the publication of Changing Scotland’s Relationship with Alcohol: A Framework for Action and the additional investment towards tackling alcohol misuse that accompanied the Framework for Action. The Framework aimed to improve local service delivery and accountability with additional funding provided specifically to improve the identification, support and treatment of people misusing alcohol and the building of capacity in specialist alcohol treatment and care services. The survey findings and the views expressed in the case study areas support the proposition that the aims of the additional resources have been addressed by service commissioners and planners. The new and reconfigured services established in 2010 and 2011 were distributed across Scotland. Post 2009, reconfigured services have outnumbered new services.
Staffing and the role of the third sector were two other interesting aspects of the review of service availability which are considered in more detail below.

5.3 Growth of the third sector

Consultees from service providers and commissioners in the three case study areas identified the growth of the third sector as a key development since 2008. At a national level the providers’ survey showed that third sector services represented 44.6% of all services in 2012; differences in survey methods meant it was not possible to compare this figure with the SANA figure from 2006/07. However, the views of service providers and commissioners in the case study areas reported in chapter 4 highlighted that third sector services were an integral part of the local delivery system supporting a considerable number of individuals. It also suggests that third sector views about the possible impact of HEAT Target H4 in focusing resources on the statutory sector may not have materialised.

The view that there has been a growth of third sector provision links with the Scottish Government’s policy to encourage the sector’s delivery of public services. The overarching approach to the third sector’s role is outlined in an Action Plan (Scottish Government31) which aimed to open markets to the sector, provide support for organisational growth, and invest in skills, learning and leadership in the sector. The specific benefits perceived from the involvement of the third sector in health and social care services was outlined in an evidence paper produced in 2011 (Scottish Government32). The evidence paper identifies that third sector providers can bring expert knowledge of local needs and preferences, as well as a flexible and economically efficient organisational structure which can help service users to take control of their own health and social care outcomes. The views reported in chapter 4 suggest this is occurring, to a degree, in specialist alcohol treatment services in the three case study areas.

5.4 Data collection and availability issues

As highlighted previously, the quantitative elements of the research were limited by a number of data collection and availability issues.

The response rate of 87.2% compares favourably to a response rate of 84.5% for the SANA study and an alcohol needs assessment in England which achieved a response rate of 55.7% (Drummond et al10). The response rate was only achieved after the researchers invested an extensive amount of time pursuing non-responders; the support of the Research Advisory Group, Scottish Government and the ADPs to further encourage response, on more than one occasion, was welcomed by the researchers and led directly to additional responses. Services identified competing demands on their time and difficulty gathering the information as the main barriers to completion. Specific attention was given to securing data on the number of individuals in treatment during 2012 and it was clear from the survey process that the availability of this information varied greatly between services. Many services provided information for the various stages of support from referral to discharge as well as being able to breakdown the information by the protected characteristics whereas other services could only provide limited information or in the
case of 13 services no user data at all. For some services collating this information from their existing records was straightforward whereas for others it was a time-consuming exercise involving support from monitoring, research or database management colleagues and in some cases cross-referencing information with case files. Concerns about the representativeness of the data provided on the number of individuals referred, assessed and discharged and the reliability of estimates for missing data extrapolated from these figures resulted in them not being included in this report.

In chapter 2 it was noted that services record considerable information on service users including their name, date of birth, postcode, Community Health Index number, gender, ethnicity, and whether they have a disability as part of the DATWT monitoring process. It was also noted that service users can choose not to share this information outside the service and ISD data showed that a quarter of cases submitted to the DATWT database in 2012 were anonymous. This figure varied across Scotland from 100% in one ADP to 0% in another – in other words services in some areas were not reporting any of this data whereas in other areas information was being submitted for all service users. This level of variation suggests that some services were not recording or submitting this information as well as service users choosing to have their case recorded anonymously. This situation meant that individual identifiers could not be used to extract information from the DATWT database on individuals rather than cases.

The limited availability of data on the protected characteristics was also apparent in the survey of providers undertaken as part of this study. Analysis of the protected characteristics was an aim of this study however the limited availability of such data was highlighted in chapter 3. This limited availability included gender, age and ethnicity as well the other protected characteristics. The Equality Act 2010 places an obligation on statutory providers to avoid discrimination against a person with a protected characteristic and it encourages providers to take positive action to help people with a protected characteristic where they are under-represented, at a disadvantage or have particular needs. The limited availability of information on users with a protected characteristic among specialist alcohol treatment services is an issue which may merit further attention from service providers and commissioners, as well as policymakers. This is an important issue as research has been undertaken to assess differential levels of alcohol consumption and access to services by issues such as age, gender and ethnicity for example.

The calculation of a PSUR for England used information from the National Drug Treatment Monitoring System which records individuals accessing tier 3 and 4 interventions. Ideally this information would have been available for Scotland from the DATWT database however a survey was required for the reasons previously outlined and this created additional demands on services, leading some to question whether the information was already available. Service providers and NHS ISD commit considerable time to recording, reporting and analysing DATWT information. The ability to generate information on individuals in treatment from a national database – broken down by the protected characteristics – would enhance the benefits of the database in the future.
The development of the national Drug and Alcohol Information System (DAISy) led by NHS ISD should address the data weaknesses encountered during this research. Improved data gathering on specialist alcohol treatment services would benefit future alcohol needs assessments.

5.5 Outcomes

Scottish Government policy in general and alcohol treatment specifically, has adopted an increasing outcome-focus since the 2007 Spending Review. The Building Better Health Outcomes work undertaken by NHS Health Scotland and the Scottish Government included specific work on alcohol which culminated in the Outcomes Framework for Alcohol\(^1\). This formed part of the work to inform the Scottish Government's consultation document and the subsequent Framework for Action. The benefits of an outcome-focused national reporting system and Scottish Government commitment to developing such a system have previously been reported (Scottish Government\(^{11}\)). In 2013, the Scottish Government developed seven core outcomes for ADPs including individual recovery and services (Scottish Government\(^{33}\)).

The case studies demonstrated that an outcome approach was evident in services of services with staff and service users talking in terms of achieving goals. Staff also highlighted the tools used to capture the recovery journey and the time expended in recording the information. However, the reporting and analysis of this outcome information at both the ADP and national level was limited. DAISy will include outcome data and this should lead to a focus on the impact of services on those in treatment as well as reporting on the numbers referred and in treatment.

5.6 Take-up of treatment by some dependent drinkers

There was a view among alcohol treatment staff and service users in the case study areas that there are many individuals who either do not recognise their need for treatment or are reluctant to access support. This is supported by the PSUR figure of 1:4.3 which shows that approximately three-quarters of alcohol dependent individuals did not access treatment in 2012.

While the qualitative research identified some examples of innovative work to reach service users as well as preventative activities, it was acknowledged by many staff that their main focus was to meet the HEAT Target/Standard for referrals leaving little scope for additional work to increase the reach of services. If the national ambition is to increase the take-up of treatment by dependent drinkers some thought should be given to the resource and policy implications of achieving such a change.

Staff in case study areas 1 and 3 highlighted lengthy waiting times for residential detox services, during which they struggle to keep service users motivated. While not available at the ADP level, the national waiting times information for the quarter ending 30 September 2012 support this view – 38% of ongoing waits for residential

\(^1\)www.healthscotland.com/OFHI/alcohol/content/tools.html
detoxification and rehabilitation services had been ongoing for six weeks or more, a far higher percentage than for any other service type.

5.7 Referral routes

Chapter 4 highlighted differing views on referrals among staff and service users. Staff across the three case study areas identified a range of referral routes including GPs, hospital-based Alcohol Liaison Nurses, partner agencies and self-referrals. On the other hand, some service users described poor experiences of signposting from NHS services including GPs and A&E. These contrasting views and experiences are particularly relevant given the introduction of HEAT target H4 and the implementation of ABIs in primary care, A&E and antenatal care settings since 2008. The target was met in 2011 and an evaluation of the process found that ABIs had generally been embedded in these priority settings although the reach and impact of the initiative was mixed across Scotland (NHS Health Scotland17). Staff views suggest that referrals are emanating from GPs and A&E settings – although no direct link to ABIs was highlighted – however the views of some service users indicate that their experiences vary. Research in England found that referral rates from A&E and GPs were low and concluded that they should be more active in identifying and referring drinkers who need treatment (National Treatment Agency for Substance Misuse34).

The case study consultations also highlighted that changed referral models, such as the establishment of drop-in centres, may have unintended consequences, both positive and negative, and there may be merit in undertaking evaluation activity to identify the impact of such developments. For example if GPs alter their practice from making direct referrals to signposting service users to treatment providers, individuals may ‘fall through the net’ if follow up processes are not established.

5.8 Development of the alcohol treatment workforce

Workforce development was frequently mentioned in discussions with interviewees about changes to the delivery of alcohol treatment and service redesign or reconfiguration. Many staff described ‘learning on the job’ and outlined the broad range of skills required in their work, emphasising the importance of interpersonal skills; some managers suggested that additional resources, particularly an increase in time dedicated to skills development, would lead to more effective delivery of treatment and support. Linked to this, there was a recurring theme about the reluctance of some NHS staff to expand their roles in terms of activity related to recovery. This suggests there is potential for further work to enhance skills and achieve a culture change in attitudes among the workforce. There was no reference to the Alcohol and Drugs Workforce Statement (Scottish Government35) although some of the issues raised during the interviews in the case study areas are reflected in the Statement. For example, the Statement emphasises the need for service providers to demonstrate a commitment to workforce development, it also identifies a need to develop competence, skills and expertise to assess and treat specialist cases.
5.9 Service user involvement

Commissioning staff, service managers and staff suggested a shift in the ways services undertake assessment and planning, moving beyond the traditional model of providing services to those in treatment, towards working in partnership with individuals in recovery. There was also repeated mention of service users’ important role in the co-production of service design. This shift aligns with national policies and publications such as the Quality Alcohol Treatment and Support report (Scottish Government[^11]) which highlights the positive impacts of increased service user engagement.

Linked to this managers and staff highlighted an increase in peer-led recovery initiatives noting that they provide an additional resource that is welcomed by many service users and staff. While their enthusiasm for these approaches was noted there is limited research pertaining to how they link to the specialist alcohol treatment services covered by this research – there may be issues relating to the sustainability of some of the locally established initiatives as well as potential risks associated with the delivery of recovery support by peers, for example support from people who are not fully trained, or lack of continuity from those who undertake the delivery of peer support (such as withdrawal of support due to relapse or ill health).

5.10 Services for people affected by Alcohol Related Brain Damage (ARBD)

One of the gaps raised by managers and staff was an increasing awareness of people affected by ARBD and the limited availability of treatment for this group as highlighted in chapter 4. Such views align with recent research that notes ‘because of the diagnostic problems, patients not being aware that they have the condition, variability of presentation, poor levels of awareness in clinical settings and the stigma associated to ‘self-inflicted’ alcohol-related disease, few data exist relating to the size of the problem’ (Royal College of Psychiatry[^4]). These findings suggest there may be scope for further research to identify potential demand for treatment by people affected by ARBD in Scotland with additional work to assess gaps in the availability of services and interventions to support this group.

At present people affected by ARBD may be receiving support from agencies that do not have a detailed knowledge of their condition and or treatment, resulting in missed opportunities to identify ARBD patients and deliver appropriate and targeted interventions to aid their recovery. Some staff suggested that social services for older people may be using resources to deal with issues that would be better tackled by alcohol treatment and recovery services. More generally, limited availability of ARBD services links to a wider issue of historic gaps in needs assessment and limited information as to the range and nature of alcohol treatment provision across Scotland. It is acknowledged that efforts are being made to improve needs assessment exercises and changes to service commissioning processes are also being implemented.
5.11 Capacity

The capacity assessment exercise established that direct service user contact accounted for approximately a third of the time staff spent on alcohol-related activities in the two case study areas. Slightly more time was spent on supporting activities which did not involve direct contact with the service users such as case notes and discussions with referral agencies.

The level of direct contact with service users in both case study areas was less than those found in a capacity exercise undertaken in another ADP area using the Demand, Capacity, Activity and Queue (DCAQ) tool (Scottish Government36). In this area the rate of direct contact with service users was found to be approximately 50%. The DCAQ process is more comprehensive than the methods employed in the two case studies and the results will be more reliable, for example the DCAQ exercise covers 12 weeks and the breakdown of time is more detailed.

Service capacity figures were presented in chapter 4 of 225 individuals for Area 1 and 249 individuals for Area 2. The figures were based on an assumption that individual service users received 26 hours of support on average which was informed by discussions with the services. Variation between services in the average amount of time per individual service user would need to be taken into consideration in any future exercise to estimate service capacity and the ratio of capacity to demand.

The capacity assessment exercise was intended as a means of assessing the feasibility of the exercise. The lessons learnt were therefore of interest to the study commissioners. In three ADP areas which initially expressed interest in the case studies, the capacity assessment exercise was cited as a factor in their decision not to take part. The services in these areas were concerned about the time commitment, duplication with local capacity assessment work and possible negative reactions to the exercise among staff heightened by local tendering or health and social care integration. While staff who took part in the exercise in the two participating areas found it straightforward and used a mixture of paper-based and electronic methods to enter their data there were some challenges in gathering timesheets after they had been completed. During interviews some staff also expressed a view that the capacity assessment task was ‘another addition to their workload’; three staff members in Area 2 did not complete their time sheets. The capacity assessment findings were also affected by the long-term absence of one member of staff in Area 1. There was also some doubts about the reliability of the capacity information provided by one staff member who acknowledged they had completed their timesheet retrospectively based on their memory and diary.
6. Conclusions

This research assessed the availability, demand and utilisation of specialist alcohol treatment services following the additional Scottish Government resources that accompanied *Changing Scotland’s Relationship with Alcohol: A Framework for Action*. It also considered the feasibility of assessing the capacity of specialist alcohol treatment services and an assessment exercise was subsequently undertaken in two case study areas. The research was an important element of the extensive ongoing MESAS programme led by NHS Health Scotland. The findings of the research will be of interest not only to the Scottish Government and NHS Health Scotland who commissioned the study but to the 30 ADPs and 149 specialist alcohol treatment services delivering tier 3 and 4 interventions across Scotland. It is also hoped that the findings are of benefit to individuals who use specialist alcohol treatment services.

The study involved a comprehensive mixed methods approach of quantitative and qualitative research. A survey of specialist alcohol treatment services delivering tier 3 and 4 interventions gathered information on service availability and individual service users. The survey gathered information on demand in the form of individuals in treatment which was required for the estimation of the PSUR that was a key objective of the study. Crucial information on need was gathered from the 2012 SHeS which was required to complete the PSUR estimate. Interviews were undertaken with service commissioners, providers and users in three case study areas; in addition a capacity assessment exercise was piloted and undertaken in two of the three areas.

The study found that 149 specialist alcohol treatment services – of varying size and type – provided tier 3 and 4 interventions across Scotland. The services supported almost 32,000 individuals in 2012. SHeS data showed that 3.1% of adults in Scotland were possibly alcohol dependent which equated to almost 138,000 individuals, although it is acknowledged that the SHeS data likely underestimates the prevalence of alcohol dependence. The PSUR was estimated to be 1:4.3 while sensitivity analysis to address limitations with the prevalence estimate resulted in a range of PSUR figures up to 1:8.3 if alcohol dependence was 6% of the adult population. While it was not possible to compare the 2012 PSUR figures to a previous estimate in Scotland reported in the SANA study, this research has established a baseline from which future change can be measured. Comparison with historic data from England – subject to data caveats – suggests that a greater proportion of alcohol dependent adults in Scotland were accessing treatment in 2012. The Scottish figure also compares favourably with international standards where access of 1 in 5 was regarded as high and 1 in 10 as low.

Having established that a capacity assessment exercise was feasible the research established that direct service user contact accounted for approximately a third of the time staff spent on alcohol-related activities in the services in the two areas where staff took part in the exercise. Lessons were learnt from the exercise which could be applied if it is repeated in other areas or on a national level; the lessons related to barriers to participation and the application of the capacity assessment tool. In-depth interviews with service commissioners, providers and users in the three case study areas identified the positive impact of the additional funding that
accompanied the Framework for Action. Overall, a wide range of developments were reported including additional staff, an increased focus on recovery and preventative work, changing referral routes and service pathways, convergence with drug treatment services, growth of the third sector, positive relationships between stakeholders, increasing service user involvement, and peer-led recovery services. The interviews also identified ongoing issues including service gaps, service planning, staffing, demand and missed appointments. These issues are important as barriers and facilitators to the future development of specialist alcohol service availability. A number of the issues raised in the case study areas reflected the recommendations contained in the Quality Alcohol Treatment and Support (QATS) report (Scottish Government11).

The research has shown that a range of specialist alcohol treatment services delivering tier 3 and 4 interventions was available across Scotland in 2012. The additional investment and resources has enabled them to support approximately a quarter of those in need. Engagement of a greater proportion of alcohol dependent adults will be informed by learning from the barriers and facilitators identified in this report.
Appendix 1

Research Advisory Group

Andrew McAuley    NHS Health Scotland
Fiona Myers       NHS Health Scotland
Rebecca Sludden   NHS Health Scotland
Dr Lesley Graham  NHS National Services Scotland Information Service Division
Iain MacAllister  Scottish Government Health Analytical Services Division
### Appendix 2

**Capacity Assessment**

**To be completed by managers and staff involved in assessment/treatment not administrative staff**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Job title:</th>
<th>Week commencing:</th>
<th>Contracted weekly hours:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>See Guidance for more detail and examples of the activities in each category</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td><strong>Direct contact with service users</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>For example assessment, case review with service users, and the delivery of support, activities or treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other service user related activities (not involving direct contact with the service user)</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including administration associated with the service user such as case notes, meetings with referral agencies, supervision, case review without service user present, and supporting ‘significant others’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Supporting activities</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including general admin such as timesheets, travel, staff meetings, and training/CPD</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong> (please specify)</td>
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<tr>
<td><strong>Total</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Appendix 3

**Services**

**Table 8: Specialist alcohol treatment services in Scotland in 2012 (n)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>149</td>
</tr>
<tr>
<td>Aberdeen ADP</td>
<td>2</td>
</tr>
<tr>
<td>Aberdeenshire ADP</td>
<td>10</td>
</tr>
<tr>
<td>Argyll &amp; Bute ADP</td>
<td>7</td>
</tr>
<tr>
<td>Ayrshire (East, North and South Ayrshire ADPs)</td>
<td>4</td>
</tr>
<tr>
<td>Borders ADP</td>
<td>3</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway ADP</td>
<td>3</td>
</tr>
<tr>
<td>East Dunbartonshire ADP</td>
<td>3</td>
</tr>
<tr>
<td>East Renfrewshire ADP</td>
<td>1</td>
</tr>
<tr>
<td>Edinburgh ADP</td>
<td>8</td>
</tr>
<tr>
<td>Fife ADP</td>
<td>5</td>
</tr>
<tr>
<td>Forth Valley ADP</td>
<td>2</td>
</tr>
<tr>
<td>Glasgow City ADP</td>
<td>40</td>
</tr>
<tr>
<td>Highland ADP</td>
<td>13</td>
</tr>
<tr>
<td>Inverclyde ADP</td>
<td>2</td>
</tr>
<tr>
<td>Lanarkshire ADP</td>
<td>6</td>
</tr>
<tr>
<td>Mid &amp; East Lothian ADP</td>
<td>4</td>
</tr>
<tr>
<td>Moray ADP</td>
<td>2</td>
</tr>
<tr>
<td>Orkney ADP</td>
<td>1</td>
</tr>
<tr>
<td>Outer Hebrides ADP</td>
<td>7</td>
</tr>
<tr>
<td>Renfrewshire ADP</td>
<td>6</td>
</tr>
<tr>
<td>Shetland ADP</td>
<td>2</td>
</tr>
<tr>
<td>Tayside (Angus, Dundee and Perth &amp; Kinross ADPs)</td>
<td>13</td>
</tr>
<tr>
<td>West Dunbartonshire ADP</td>
<td>2</td>
</tr>
<tr>
<td>West Lothian ADP</td>
<td>3</td>
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</tbody>
</table>
In treatment

Table 9: Estimated number of individuals in specialist alcohol treatment services in Scotland in 2012 (n and %)

<table>
<thead>
<tr>
<th>Area</th>
<th>Estimated individuals in treatment</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland(^1)</td>
<td>31,796</td>
<td></td>
</tr>
<tr>
<td>Aberdeen ADP</td>
<td>973</td>
<td>3.1%</td>
</tr>
<tr>
<td>Aberdeenshire ADP(^1)</td>
<td>1,453</td>
<td>4.6%</td>
</tr>
<tr>
<td>Argyll &amp; Bute ADP</td>
<td>492</td>
<td>1.5%</td>
</tr>
<tr>
<td>Ayrshire (East, North and South Ayrshire ADPs)</td>
<td>1,917</td>
<td>6.0%</td>
</tr>
<tr>
<td>Borders ADP</td>
<td>779</td>
<td>2.5%</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway ADP</td>
<td>1,059</td>
<td>3.3%</td>
</tr>
<tr>
<td>East Dunbartonshire ADP(^1)</td>
<td>476</td>
<td>1.5%</td>
</tr>
<tr>
<td>East Renfrewshire ADP</td>
<td>393</td>
<td>1.2%</td>
</tr>
<tr>
<td>Edinburgh ADP(^1)</td>
<td>1,635</td>
<td>5.1%</td>
</tr>
<tr>
<td>Fife ADP</td>
<td>2,037</td>
<td>6.4%</td>
</tr>
<tr>
<td>Forth Valley ADP</td>
<td>177</td>
<td>0.6%</td>
</tr>
<tr>
<td>Glasgow City ADP(^1)</td>
<td>7,831</td>
<td>24.6%</td>
</tr>
<tr>
<td>Highland ADP</td>
<td>1,050</td>
<td>3.3%</td>
</tr>
<tr>
<td>Inverclyde ADP</td>
<td>821</td>
<td>2.6%</td>
</tr>
<tr>
<td>Lanarkshire ADP(^1)</td>
<td>4,736</td>
<td>14.9%</td>
</tr>
<tr>
<td>Mid &amp; East Lothian ADP(^1)</td>
<td>342</td>
<td>1.1%</td>
</tr>
<tr>
<td>Moray ADP(^1)</td>
<td>420</td>
<td>1.3%</td>
</tr>
<tr>
<td>Orkney ADP</td>
<td>--</td>
<td>-</td>
</tr>
<tr>
<td>Outer Hebrides ADP(^1)</td>
<td>581</td>
<td>1.8%</td>
</tr>
<tr>
<td>Renfrewshire ADP(^1)</td>
<td>2,244</td>
<td>7.1%</td>
</tr>
<tr>
<td>Shetland ADP</td>
<td>154</td>
<td>0.5%</td>
</tr>
<tr>
<td>Tayside (Angus, Dundee and Perth &amp; Kinross ADPs)(^1)</td>
<td>1,519</td>
<td>4.8%</td>
</tr>
<tr>
<td>West Dunbartonshire ADP</td>
<td>302</td>
<td>0.9%</td>
</tr>
<tr>
<td>West Lothian ADP</td>
<td>296</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Notes:
Data provided by 117 services via the survey.
Where all services in an area provided data the above figures are the totals reported, adjusted for inter-service referral.
In other areas (marked with \(^1\)) the above figures include estimates for services that did not provide this data.
No data available for Orkney ADP.
References


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All hyperlinks accessed 17 October 2014.