CARE

Community Alcohol Response & Engagement

BALLYMUN - FINGLAS - NORTH DUBLIN

Community Alcohol Response and Engagement Pilot Project

Evaluation Report

Quality Matters

supporting improvement in social services

September, 2015

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CARE (Community Alcohol Response and Engagement)
A Cross Task Force initiative in collaboration with the HSE

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

FINGLAS CABRA
LOCAL DRUG & ALCOHOL TASK FORCE

rdatf
NORTH DUBLIN
Regional Drug & Alcohol Task Force

and partner sites

Ballymun Youth Action Project

Finglas Addiction Support Team

North Dublin Community Care Service

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Foreword

I am delighted to welcome this insightful and timely evaluation of the Community Alcohol Response and Engagement pilot project. This report provides great hope that through hard work, partnership and the creative use of our limited resources, we can develop innovative solutions in our communities.

Ireland has had a long and sometimes difficult association with alcohol and as a society, we must understand, accept and deal with the negative consequences that arise from our use and misuse of alcohol. It is projects like this one that will help to significantly and positively alter our relationship with alcohol. However such projects alone will not reduce the consumption of alcohol in general.

The measures provided for in the forthcoming Public Health (Alcohol) Bill will significantly reduce consumption and related harm. The measures arise from recommendations outlined in the *Steering Group Report on a National Substance Misuse Strategy* which was published in 2012. The introduction of this legislation sends a strong message to the public that as a Government, we are intent on reducing alcohol related harm. More importantly, it will protect public health, and over time, will reduce alcohol consumption at both individual and population level.

Alcohol is not an ordinary product and it is important that steps such as this project are taken to moderate the extent of its use in our society.

The interagency and community cooperation on this project has facilitated its success and I would like to take this opportunity to thank all those involved for their dedication and commitment.

Aodhán Ó Ríordáin TD
Minister for State for New Communities, Culture,
Equality and Drugs Strategy

Key Findings

Finding One: Highly Regarded Effective Programme

The CARE programme is highly regarded, and perceived to be an effective support for people with alcohol difficulties by clients, professionals involved in the programme and partner professionals. The CARE programme is in line with a range of local and national strategic goals in relation to community alcohol treatment. The CARE programme is regarded as having improved the quality and effectiveness of outpatient alcohol detoxification in pilot sites, ensuring clients and GPs are supported to engage in safer, appropriate detoxification regimens. Drawing heavily on existing skills, services and resources, the CARE programme is considered by its stakeholders to be good value for money in alcohol treatment provision. Given the rigorous governance and policy framework, the strong evidence base and the value for money and use of existing resources, many stakeholders consider the CARE model to be replicable for other areas.

Finding Two: Improved Outcomes for Clients

The case file analysis (of a random sample of 40 clients), which was supported by findings from client interviews and observations from professional interviews, found that significant progress was made by CARE clients in relation to their levels of alcohol use. It was reported that 82% (n=32) of clients who identified it as a care plan goal made a significant reduction in their alcohol use. Over half of the clients achieved abstinence (54% n=21), with over a quarter maintaining the abstinence they achieved[1] (28% n=11). In addition to this progress in relation to their alcohol use, it was also reported that clients who availed of CARE made progress in a number of other areas in their lives:

- 100% (n=14) of clients who identified 'improved physical health' as a care plan goal made positive changes in relation to this area
- 80% of clients who identified it as a goal were identified as having made improvements in relationships with their children (n=8)
- 75% (n=9) of clients who identified it as a goal were documented as having made positive progress in relation to illicit drug use
- Two thirds of clients who identified it as a goal (n=11) were reported to have made positive changes in their relationships with family or other close relationships
- Almost three-quarters of clients who identified their mental health as a care plan goal were reported to have made positive progress in relation to this (73%, n = 8)
- 50% of clients who identified it as a care plan goal (n=9) were reported to have improved their pro-social engagement

Finding Three: Positive Outcomes for Professionals and Improved Interagency Working

All professional groups consulted reported positive outcomes for their work including improved skills, knowledge or capacity of alcohol use and treatment, care planning and other relevant areas and improved capacity to provide services or refer to appropriate services for people with alcohol difficulties. The CARE programme has been successful in promoting effective interagency working relationships between clinical and psycho-social services, between community and statutory services, and across various health and social care disciplines.

[1] The duration of abstinence was not available

Finding Four: Rigorous Clinical Governance and Protocols

The CARE programme is a model provided in line with rigorously developed, evidence-informed protocols, the implementation of which is overseen by a robust statutory clinical governance structure, and a highly committed operational oversight group.

Finding Five: Need for Improved Outcomes Measurement and Data Management

While this evaluation shows considerable positive regard for the programme by stakeholders, and suggests that there were very positive outcomes for clients in relation to a number of issues, there was an absence of pre and post data collection measures that could robustly attest to changes made for clients, family members and professionals as a result of engaging with CARE. The absence of a coordinated client management IT system meant that at times, the work of clinical nurses was slowed down, and there were barriers to communication about clients by staff, and challenges in effective monitoring of client progress by the oversight group.

Finding Six: Potential for More Targeted Use of Resources and Need for Further Resources

While significant contributions to the programme were made by way of the use of existing resources (psycho-social support services, Task Force, oversight and clinical governance), there was ring-fenced funding for the clinical nurse specialists and the CARE Coordinator role. By the time the programme rolled out to the second and third pilot sites, the burden on the clinical nurse specialists became apparent and this limited service provision on all sites. As the project progresses, there is potential for a number of facets of the Coordinator role to be distributed among existing community roles and resources (e.g. including a clinical lead in each area and sharing administrative / managerial functions between partner services) and resources targeted at clinical nurse service provision hours. This alone will not ensure adequate service provision with existing resources across the three sites. There is a need for increased clinical hours, and due to waiting lists for access to psycho-social support in some areas, there is a need for increased availability of psycho-social support worker hours to meet demand for the service.

Finding Seven: Need to Strengthen and Clarify Certain Policies and Procedures

While staff working in CARE are strongly supported by management and confident in handling high risk situations, there remains a lack of clarity in some procedural issues. There is a need to review and clarify a number of policy and procedural issues, particularly around interagency communication, the key-working role and referral pathways, to ensure that the policy framework for the whole programme is robust and reflects the day-to-day reality of the programme.

Key Recommendations

Recommendation One: Continue the Programme and Pursue Funding to Expand and Evaluate Service Provision

This evaluation reveals a programme that is highly valued by all stakeholders, and considered to be an effective support for alcohol-using clients. This programme should be continued with a robust evaluation plan to articulate clearly the programme's impact for clients, family members and professionals. To ensure continuation and development of this service, the Steering Group should pursue additional funding to:

- Continue the provision of this service
- Improve psycho-social capacity through additional hours of psycho-social service provision to prevent the retention on waiting lists of clients motivated to change, and to prevent the use of clinical resources (nurse hours) for psycho-social service provision
- Extend clinical nurse specialist hours available in each site
- A core facet of the continuation of this service requires on-going GP and CNS hours. In line with the Review of Addiction Services in North Dublin (26), the Steering Group should negotiate with the HSE Addiction Service to provide GP and CNS supports for alcohol, as demonstrated to have worked effectively in this pilot.

Recommendation Two: Develop a Programme Manual

Building on rigorous work undertaken for the development of clinical protocols, develop a programme manual that outlines all facets of the service including:

- Vision, aims, model and approach
- Standards of training for professionals involved in service provision
- Supports provided to professionals involved in service provision
- Clinical governance standards and procedures
- Risk management
- Quality standards and procedures for non-clinical programme aspects
- Standards and procedures for interagency communications
- Outcomes and indicators for client progress
- Detailed guide to clinical and psycho-social service provision
- Information management and record keeping
- Referral pathways and criteria
- Programme promotion

This will support streamlined working within the existing programme, and support replicability for other Task Force / HSE areas considering replication.

Recommendation Three: Collect Pre and Post Measurements on Alcohol and Other Issues to Assess Change for Clients

To effectively assess changes occurring for clients through their engagement with CARE, collect measurements on alcohol use and other psycho-social domains at key points which may include initial engagement, mid-point, end of engagement and post-engagement. This will facilitate an understanding of areas where change is being affected and where it is not, which will inform improvement of supports to clients on an on-going basis, and establish the efficacy of the CARE programme. Outcomes, measures and tools should be collaboratively developed with relevant stakeholders (e.g. staff and clients) and used to inform data collection systems (see following recommendation).

Recommendation Four: Review and Improve the Use of Information Technology (eCASS) to Support Monitoring and Reporting of Outcomes

To support outcomes measurement, monitoring of client progress, reporting on client progress, and generally to support improved information processes and interagency communications, review and improve the use of the existing client management system used by psycho-social partners (eCASS). This review and improvement should ensure that CARE professionals and psycho-social partners can record and share streamlined information on CARE clients in a way that is efficient, enables monitoring of progress and change, enables collation of reported information across sites and supports simple, effective information management for the project. This means ensuring all systems are set up to record the same information and produce like reports, that all professionals are licensed to use the system (potentially for clinical nurse specialists to have access to the client management systems through psycho-social partner services), trained and supported to use it, and that programme policies and procedures reflect this.

Recommendation Five: Prioritise CARE Resources for Clinical Service Provision and Review Management Structures

There is duplication of management roles and potential for use of management resources for service provision. Review the existing coordinator role, potentially reallocating tasks and resources considering the following possibilities:

- Provision of Clinical Nurse Specialists with 1 nurse per site
- In line with the HSE Addiction Service review, the allocation of a Clinical Lead for each CHO area to support increased service provision/referrals as a result of increased CNS hours
- Allocation of Coordinator Responsibilities to CNS (clinical responsibilities), Task Forces (administration and operational line management duties) or other partner organisations

The Steering Group should review the Coordinator role and if choosing to remove this role, ensure all responsibilities are reallocated appropriately across other roles.

Recommendation Six: Clarify Policies and Procedures in Relation to Key Working Role and Client Related Communications

CARE and partner organisations should review existing protocols and agreements to develop clear, written protocols that clarify the following issues in relation to Key Working, and in relation to communications between partner organisations (psycho-social service providers) and CARE (clinical service providers):

- What the key working role is, who undertakes it, what basic agreed minimum standards are in place for CARE psycho-social support
- How this role is distinct from and complementary to the clinical role
- What information is collected at initial assessment and by whom (e.g. at first point of contact for a client who will be engaged with CARE)
- How this information is handed over and communicated when a second organisation is engaged in service provision to a client (e.g. from partner organisation to CARE or vice versa)
- What tools and templates are used to collect and share information on clients who receive CARE support, and agreed terminology for key facets of programme
- In what circumstances, how and when CARE and partner sites communicate with one another in relation to clients
- What the process is for interagency communication between CARE and partner sites where concerns arise in relation to service provision to CARE clients
- How communication with third organisations (e.g. GP or other health/social care provider) is managed

- What the process is for addressing concerns with work being undertaken by another professional involved in CARE
- How and whether CARE clients are prioritised for service provision in psycho-social services
- What support is provided to CARE clients who are on waiting lists

In addition to this, in order to support improved client working, the option of having the clinical nurse specialists connected into suitable team structures in partner sites, as relevant and appropriate and in line with available resources, should be explored, including:

- Relevant sections of team/client management meetings
- Client management systems (see recommendation 1)

Recommendation Seven: Review and Develop Promotion of the Programme and Engagement of Key Partners

Implement a formalised, systematic promotion strategy for the programme with all relevant partners to ensure that consistent, regular and appropriate information is reaching relevant gatekeepers and service providers. The strategy should address key areas of responsibility for promotion with clinical partners, strategic partners and community based social and healthcare partners. In addition to this, the strategy should consider renewed efforts to engage key clinical partners such as local hospitals and GPs.

Recommendation Eight: Plan for Evaluation of Broader Impact and Economic Impact of the Programme

It is clear from the evaluation that not only did the programme have significant impact on clients, but that there is an unexplored impact on families and concerned persons, as well as documented positive impact on the work of GPs, pharmacists and psycho-social support services. In continuing this programme, the Steering Group should consider steps that can be taken at an early point to support data collection at a later point for a wider impact and economic evaluation of the programme, including initial data from family members and professionals involved with or affected by the programme.

Chapter One:

Overview of the CARE Project

1 Chapter One: Overview of the CARE Project

1.1 About CARE

1.1.1 Programme Aims

Community Alcohol Response and Engagement (CARE) was a pilot community alcohol support project with the aim of providing a localised integrated care pathway with specific interventions for those presenting with alcohol problems in Ballymun, Finglas and the North Dublin Region. The purpose of the pilot project was to contribute to responses to alcohol problems in the community, and add to the development of an effective and responsive continuum of care. CARE was a cross-Task Force initiative made up of two local drug and alcohol task forces and one regional drug and alcohol task force collaborated in partnership with HSE Addiction Services and local partner psychosocial services to develop, implement and evaluate the programme. The stated aims and objectives of the CARE programme were:

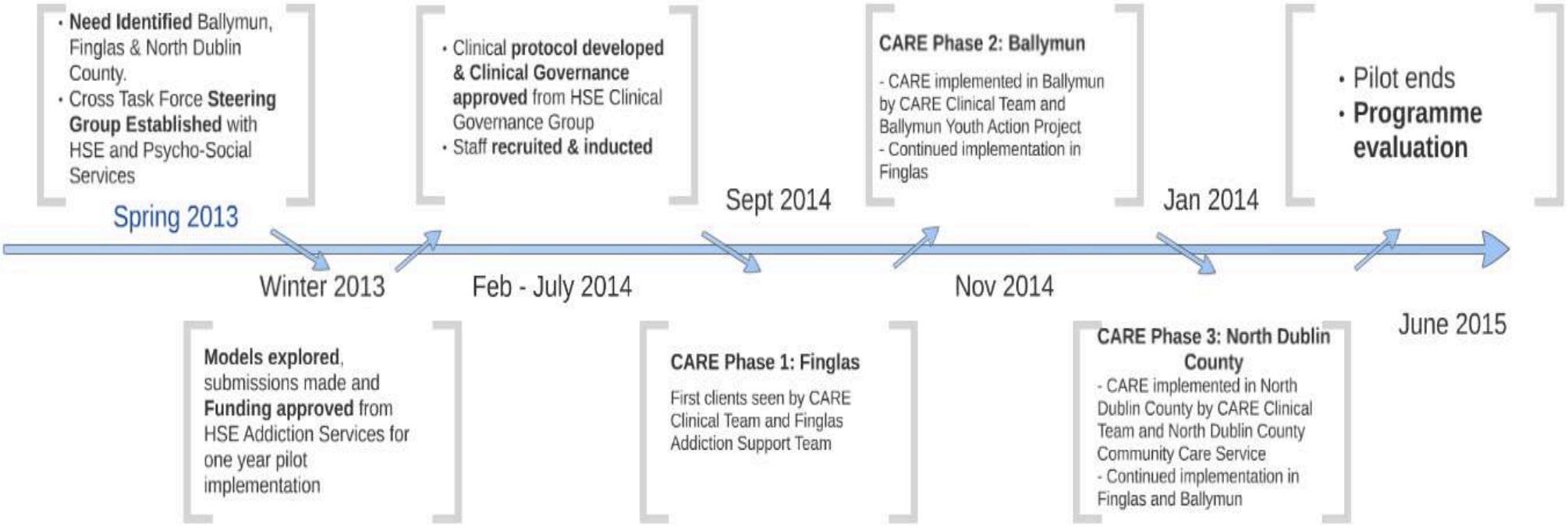
- To provide a local treatment and rehabilitation option for those at the early stages of addressing their problematic alcohol use;
- To engage and support those with alcohol problems/dependency issues who may or may not be accessing or presenting to drug services;
- To facilitate individuals to reduce and/or detox from problematic use of alcohol through a structured, non-residential process involving GP, clinical nurse specialist and a range of locally specialised addiction support services;
- To promote strong inter-agency and multi-disciplinary working in responding to alcohol use by operating in conjunction with and alongside community and primary/mental health care services.

As part of the pilot project, it was anticipated that an evaluation would assess its feasibility and its ability to effectively address its stated objectives at the end of its operational year. Implementation of the CARE pilot project over the 12 months will also inform the future direction and/or sustainability of the Project and contribute or influence other practices and policies in the area of alcohol treatment locally, regionally and nationally.

1.1.2 Programme Development and Implementation

In the months and years preceding the establishment of CARE in 2014, the lack of an integrated care pathway for problematic alcohol use, and the potential for local and regional drugs task forces to support responses to the issue, was identified nationally and given prominence on the agenda of relevant state bodies (34). Locally, it was identified as an issue requiring immediate response in each of the three Task Force areas in the years and months preceding the formal engagement in a cross-Task Force coordinated response, which was initiated in April 2013. The timeline on the following page details key milestones in the development of the programme between the initial embarking by partners to the completion of this evaluation, including the exploration of suitable models, the development of protocols and acquiring of clinical governance, and the recruitment of staff and phased implementation of the programme between September 2014 and January 2015 leading to a full implementation of all three sites up to June 2015. In developing CARE, the Project also drew on relevant information received from existing programmes such as the Dundalk Simon/Turas Alcohol Detox project, Coolmine Therapeutic Community (Alcohol Detoxification Project) and the Dublin Simon Residential Alcohol Detox Unit.

Figure 1: CARE Programme Timelines and Milestones



1.1.3 Roll Out Timeline and Allocation of Resources

As highlighted, Finglas was the first site to be piloted (September), followed by Ballymun (November) and North County Dublin was the last implementation site (January) with all sites running concurrently from January to June 2015. Referrals to CARE from North County Dublin before January were offered in either Ballymun or Finglas as site locations if willing to travel. CARE days available to each site were influenced by the phased implementation.

1.2 Model and Approach

1.2.1 Treatment Model

The CARE Programme was a community alcohol treatment programme, involving out-patient medical and psycho-social treatments tailored to the needs of individuals, who ranged from those with complex health and social needs to those with relatively low support needs. The programme was provided in line with the unique goals of individual service users, which could range from complete abstinence, through moderation management, to harm reduction of dangerous alcohol consumption levels. The range of supports available to clients is detailed in the following table:

Table 1: Range of Supports Provided to CARE Clients

Service	Method of Delivery	Approach	Provided By	Provided For
Screening and Assessment	Individual medical consultation	Clinical	Clinical Nurse Specialist	All service users
Specialist Referral	Individual consultation	Clinical & psycho-social	Clinical Nurse Specialist / CARE Coordinator	All service users who required it
Pre-entry support and preparation	Individual or multi-disciplinary professional support	Psycho-social	Clinical nurse specialist and/or psycho-social support worker	All service users preparing for community detox or residential alcohol support
Individualised care planning	Individual professional support	Psycho-social	Clinical nurse specialist and/or psycho-social support worker	All service users
Detox and withdrawal support[2]	Multi-disciplinary support	Clinical	Doctor, clinical nurse specialist, supported by local pharmacist and psycho-social support worker	All service users requiring this level of support
Treatment support and aftercare	Individual or multi-disciplinary support	Clinical & psycho-social	Clinical nurse specialist and/or psycho-social support worker	All service users who need it
Medication for Relapse Prevention	Individual medical support	Clinical	Doctor, pharmacy	All service users who need it and are suitable for it
Alcohol Awareness and Education Group	Group information programme	Psycho-social	Clinical nurse specialists	All service users who are interested, as well as family, community members etc.
Sober Skills Programme	Group support programme	Psycho-social	Psycho-social workers	All committed to maintaining sobriety for the duration of the programme
CARE Self Help Booklet	Printed Resource	Psycho-educational	CARE team	All service users

While psycho social supports were primarily provided by partner agencies FAST, BYAP and the North Dublin Community Care Service, in many cases other health, social care and/or

[2] It is important to note that detoxification is offered subject to clinical guidelines and medical assessment. Where a detox is not deemed appropriate for the referred person, onward referral and accompaniment into existing community based supports, including harm reduction services, is provided.

community organisations from the catchment areas were involved in the care plans or support systems for CARE clients.

1.2.2 Business Model

The pilot programme drew heavily on the use of existing local resources, with specific funding acquired for the roles of Clinical Nurse Specialists (2 part-time) and a CARE Coordinator (1 full-time). A total of €80,000 for the pilot programme was awarded by the HSE Addiction Services (Northern Area), with Ballymun Local and Alcohol Task Force providing the remaining monies through re-gifting from Ballymun Family Practice (38,000) and the task force Treatment and Rehabilitation Fund (8,000). The North Dublin Regional DATF purchased medical equipment required for the CARE team. A breakdown of spending follows:

Table 2: Project Costings

Items	Cost
Staff costs (Full Time Coordinator and 1FTE Clinical Nurse Specialist)	**€97,725**
Clinical Programme Costs	**€619**
Running Costs (e.g. insurance, evaluation and IT/development costs)	**€17,913.24**
Totals	**€116,257.24**

The following organisations contributed existing resources to the programme:

HSE Addiction Service (Dublin North City & County):

- Clinical governance for the programme
- Clinical lead for the programme
- Clinical supervision for the Clinical Nurse Specialists
- Contribution towards funding of medical supplies
- Steering Group Membership

Ballymun Local Drug and Alcohol Task Force:

- Employer for Care Coordinator and Clinical Nurse Specialists
- Operational management for the programme
- Project administration (steering group, interagency communications, evaluation etc.)
- Research and development for policies, protocols and pathways
- Steering Group membership

Finglas/Cabra Local Drug and Alcohol Task Force: was represented on steering committee by the manager of Finglas Addiction Support Team (FAST).

North Dublin Regional Drug and Alcohol Task Force

- Employer of North Dublin County Community Care Team
- Research and development for policies, protocols and pathways
- Funding towards purchase of medical equipment for CARE clinical team
- Organisation, supervision and funding of CRA training and accreditation for CARE CNS
- Steering group membership

Ballymun Youth Action Project, Finglas Addiction Support Team and North Dublin Community Care Service:

- Both FAST and the North Dublin Community Care Service were used as clinical sites for Project implementation in Finglas and North Dublin.
- HR support provided to the CARE team by Manager of FAST
- Psycho-social support worker hours in each of 3 services (key-working, counselling, family support, aftercare etc.)

- Design, development and delivery of group programmes by workers in FAST and Community Care Service
- Research and development of policies, protocols and programmes (management)
- Research and development of policies, protocols and programmes (front line staff)
- Steering group Membership

Dublin City Council:

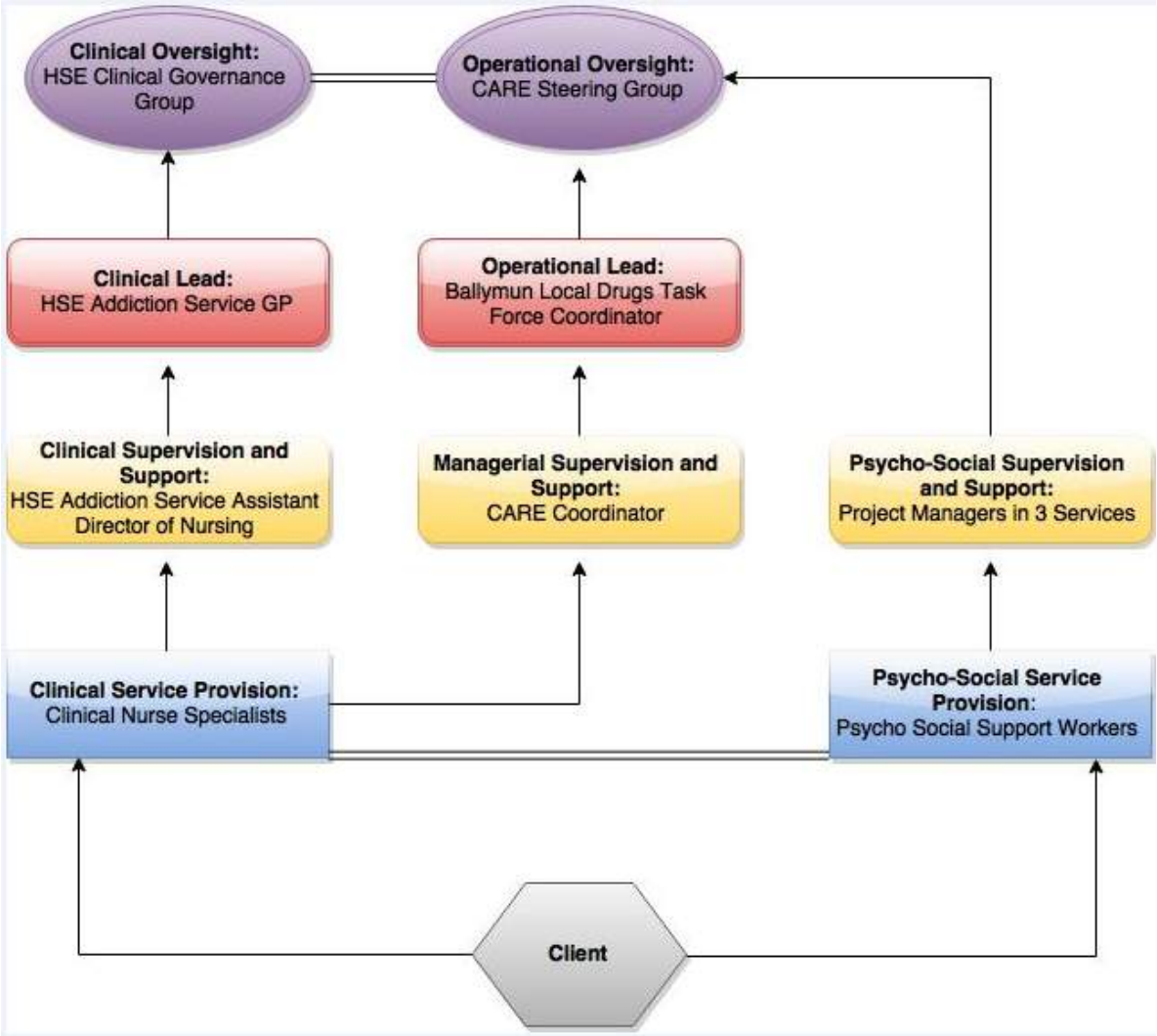
- In Ballymun, the clinical site was provided by Dublin City Council in Ballymun Civic Offices

1.3 Programme Structure

1.3.1 Overview of Programme Structure

The diagram below depicts the flow of responsibility in the CARE Programme. Note that this does not include reporting lines within individual organisations (for example, managers of psycho-social support services generally report to an internal Board of Directors, and the Assistant Director of Nursing reports to an Addiction Service Manager, though these internal mechanisms are not represented here). The diagram shows that the Clinical Nurse Specialists had both clinical and managerial reporting lines within the programme, which had oversight from both an operational group, and from the HSE Clinical Governance Group.

Figure 2: Organogram of CARE Programme



1.3.2 Governance and Management

Management

Ballymun Local Drug and Alcohol Task Force Coordinator: Responsibility for operational management of the programme was devolved to the Ballymun Local Drug and Alcohol Task Force Coordinator. Employment functions for the two Clinical Nurse Specialists and the CARE Coordinator was provided by the Ballymun Local Drug and Alcohol Task Force, which held clinical indemnity, public and employer insurance, responsibility for policies and procedures and general human resource functions for the team.

Care Coordinator: The role of the Care Coordinator was to act as the central point of contact in the project, leading on project promotion and coordination. The Coordinator's responsibilities initially were envisioned to be the coordination of care plans, detoxes and other general project management tasks although this role changed to some extent, which is detailed later in this evaluation.

Governance and Oversight

Operational Steering Group: Direction, oversight and monitoring of the programme was provided by a Steering Committee, consisting of stakeholders from the three programme delivery areas and HSE Addiction service. The Steering Group was responsible for the initial development of the project, including the achievement of funding and clinical governance, the development of protocols, as well as the direction and on-going monitoring of the project. The Steering Group worked in line with an agreed Terms of Reference and met at least monthly for the duration of the project, as well as for almost one year prior to implementation. The Steering Group formally reported on the progress of the pilot Project to the HSE Clinical Governance Group every three months.

Clinical Governance: The clinical governance for the project was designed in line with the HSE Quality and Patient Safety Standards Checklist for Clinical Governance and Guiding Principles(1). The clinical lead for the project was a GP within the HSE Addiction service with significant experience and expertise in addiction medicine and alcohol treatment. Clinical supervision for the Clinical Nurse Specialists was provided by the Assistant Director of Nursing in the Addiction service of the HSE. A detailed project overview was submitted to the HSE Clinical Governance Group. This document outlined the key steps of the project from engagement, referral, initial assessment, comprehensive screening, development, implementation and review of care plan and care plan objectives to on-going support and exit plan processes. The document included a number of key policy areas as appendices. The overall policy framework for the programme included policies developed in-line with HSE policy, relevant legislative or good practice guidelines.

- Management of Risks
- Data Protection and Record Keeping
- Protected Disclosures of Information
- Upholding the Dignity and Welfare of Patient/Clients and the Procedure for Managing Allegations of Abuse against Staff Members
- Incident Reporting and Investigation
- Infection control
- Medication management
- Use of CIWA scale in guiding treatment of alcohol detoxification patients
- Venepuncture policy
- Wound management policy
- Management of waiting lists
- Management of community alcohol detox

A service agreement with the HSE was completed for the project and included full details on the clinical and corporate governance structures and reporting arrangements of the project. This addressed areas such as:

- Leadership
- Quality and patient safety
- Management and reporting of risk, incidents and near misses
- Quality indicators
- Complaints procedures and client input
- Financial governance and reporting
- Insurance and indemnity

The Clinical Lead: The clinical lead was a GP from the HSE addiction service who was available on a weekly basis to provide detox assessments and prescribing and input on case management, as well as providing information and advice by phone to the team as required. The clinical lead also had a number of additional responsibilities relating to service provision issues such as referrals, as well as governance issues such as monitoring clinical health and safety issues.

Operational Oversight: It was agreed as part of the clinical governance arrangements that the CARE Project would use QUADS (quality standards in drug and alcohol services) and the protocols of the NDRIC framework. In psycho-social support services, it was agreed that all services would have QUADS standards in line with national policy, and staff would be accredited in the appropriate evidence-based models by the relevant accrediting bodies (for example, Addiction Counsellors of Ireland, Irish Association for Counselling and Psychotherapy etc.). Models used by services were evidence based such as CBT, CRA etc.
All of the partner community based psychosocial agencies provided services in line with the National Rehabilitation Framework (2010) and the 2011 National Protocols and Common Assessment Guidelines. The framework and protocols underpinned how the HSE Addiction Service, the clinical nurse specialists and the psychosocial services interacted with each other to support service users in CARE.

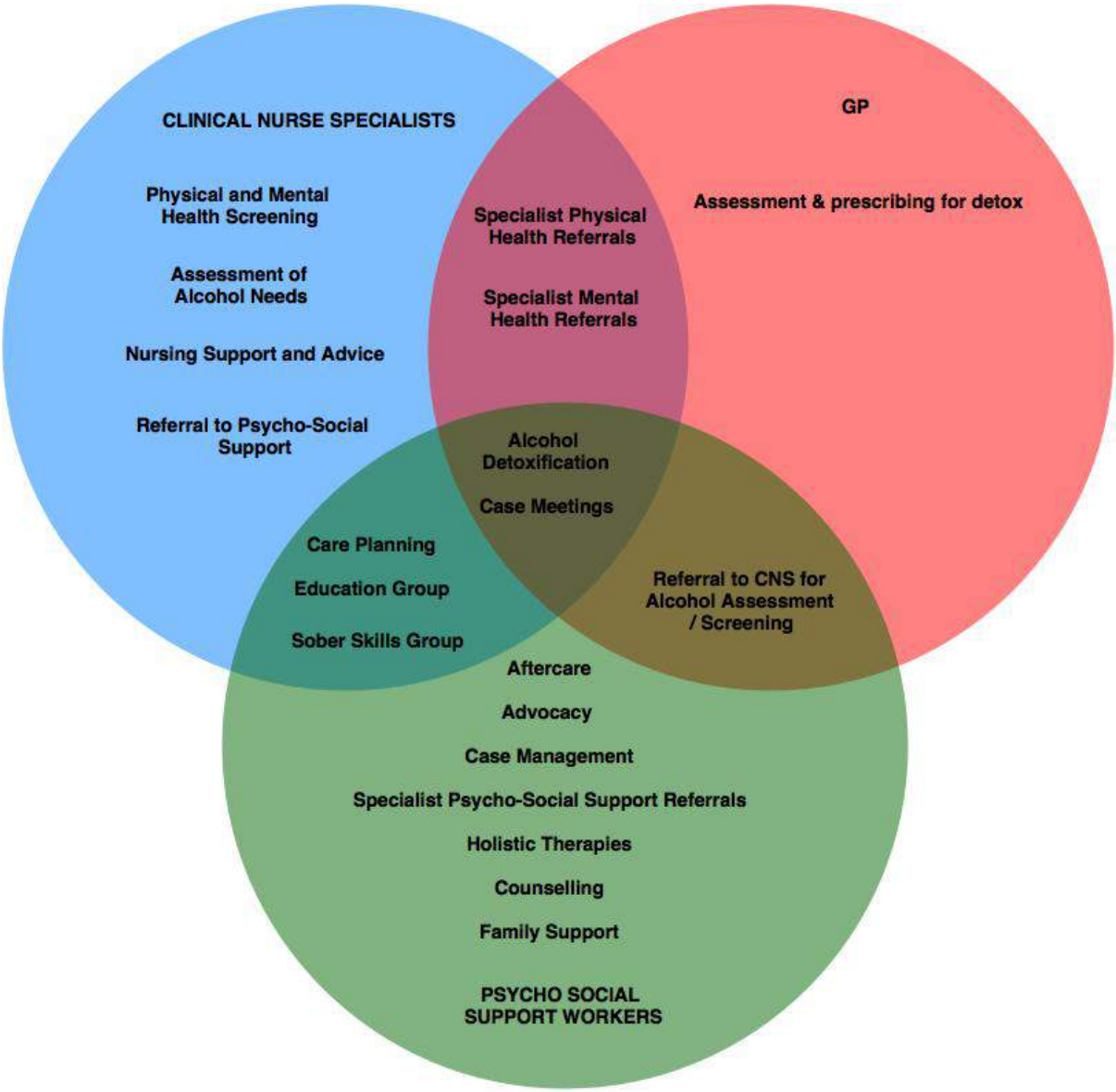
1.3.3 Service Delivery

Roles in Service Delivery: The diagram below depicts the domains of responsibility for each of the three key service elements of CARE; Clinical Nurse Specialists (CNS), GPs and Psycho-Social Support Workers. *This diagram does not depict a range of responsibilities undertaken by each role in relation to, for example, the extensive governance and support responsibilities of the clinical lead, but instead depicts only their responsibilities in relation to client service provision.*

CARE Coordinator: The role of the CARE Coordinator was to act as the central point of contact in the Project and to ensure that all of those in service provision roles were facilitated to work together in a coordinated fashion, supporting care planning and communication around clients in addition to programme promotion and development.

Clinical Nurse Specialist: The role of the clinical nurse specialist was to assess, plan, implement and evaluate individual person centred care within an agreed framework and in accordance with best practice and evidence and to actively participate as a multi-disciplinary team member in all aspects of service delivery.

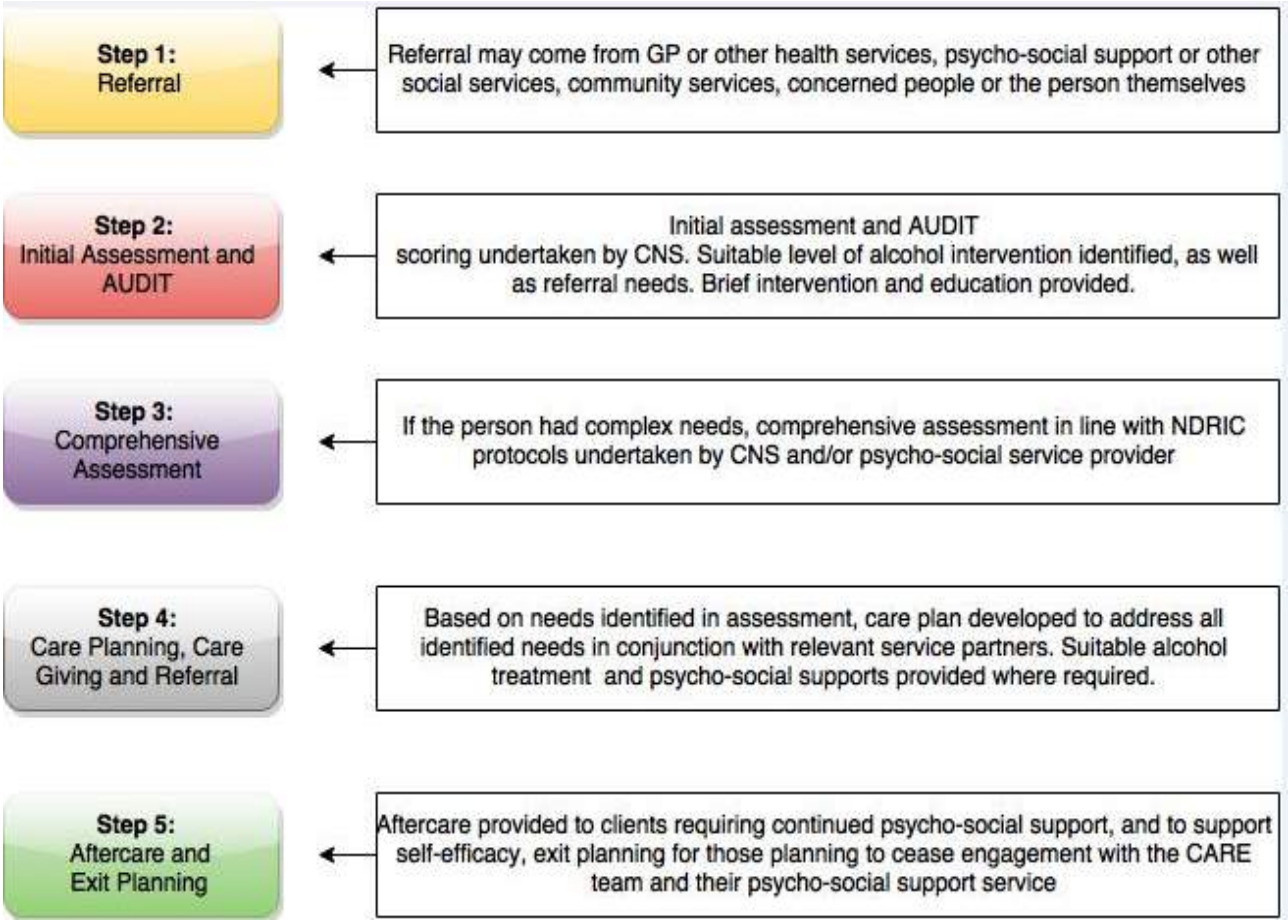
Figure 3: Domains of Responsibility for Key Service Providers in CARE



1.4 CARE Treatment Pathway

1.4.1 Overview of the Treatment Pathway

The figure below depicts the treatment pathway for CARE clients with an overview of each step in the process. This is followed by a detailed description of each step in the process.



1.4.2 Referral

Referrals to the programme came from a range of services including health, social, criminal justice and community services, as well as self-referrals. The inclusion criteria for CARE were:

- Clients living in or with connections to one of the three catchment areas: Finglas, Ballymun or North Dublin Regional Drug and Alcohol Task Force Area
- Over 18 years of age
- Have an identified need for the service (established through AUDIT score)
- In stable housing or working towards this with a service provider
- Where possible, that a significant other person would be available to support
- Where possible, the client's existing GP would be involved in their care

Individuals who were deemed unsuitable for CARE were those who, at the time, were:

- Complex poly substance users
- Significant comorbid physical or mental health issues
- History of significant physical or mental health issues
- Did not otherwise meet the criteria outlined above

1.4.3 Initial Assessment

The CNS conducted an initial assessment using the NDRIC endorsed initial assessment and the AUDIT assessment. Clients who scored less than 14 were given brief advice about their drinking, information such as the CARE self-help book, and advised to contact their GP or CARE project if they had any further concerns in the future. If additional risks were identified through screening, continued support was offered in some instances.

1.4.4 Comprehensive Assessment

If the client scored 15 or higher on the AUDIT assessment, a comprehensive assessment was undertaken which included an assessment of needs in relation to:

- Drug and alcohol use and history of adverse events
- Social circumstances
- Medication
- Physical and mental health concerns
- Risk screening
- Allergies and smoking history
- Other services involved in the person's care
- Client's goals

In addition to this, the CNS undertook basic physical health observations including height, weight, Body Mass Index, and respiratory rate. Where there was evidence of significant drinking, the CNS could recommend commencing the client immediately on Thiamine and Vitamin B.

1.4.5 Care Planning and On-going Support

Developing the Care Plan

A care plan was developed with clients whose score was above 15 on the AUDIT assessment and for whom a comprehensive assessment had been undertaken. The development of a care plan was a process in partnership with the client where goals were identified addressing alcohol, drug, physical, psychological, social and legal needs etc. A member of the CARE team was assigned to undertake care planning with the client, again in line with the National Protocols and Common Assessment Guidelines 2011. As illustrated in the evaluation section of this report, the responsibilities regarding care planning were at times undertaken by the CNS and at times undertaken by the psycho-social partners. For example in some instances, the service user will have been referred from the psycho-social service who may had already completed NDRIC endorsed assessment process and began development of a care plan with the client, one action of which would be a referral to the CARE project.

Medical Screening

Mental and physical health screening was undertaken by the CNS, who made appropriate referral to specialist services or the client's GP.

- Where clients presented with comorbid anxiety or depression, in-line with clinical guidelines, their alcohol misuse was treated first. If depression or anxiety continued after three to four weeks after abstinence from alcohol, then there is a need for treatment as per NICE guidelines for individual disorders.
- Independent of the alcohol detoxification assessments, if there was a significant comorbid mental health disorder or concerns with possible risks to self or others then the client was referred to the local community mental health team.

- If there were concerns about vitamin supplementation, particularly for high-risk clients, such as those who are street homeless or living in a hostel, then they may be reviewed by a Community GP or the CARE GP Specialist.

GP Liaison

Where consent was obtained the CNS informed the client's GP about their engagement in alcohol treatment and the CNS sought information from the GP on current active problems and medication the client was taking.

Blood Tests

Blood testing was required to identify physical health needs but not to be used routinely for identification and diagnosis of alcohol-use disorders. Routine blood testing by the clients' own GP was encouraged, including Full Blood Count (FBC), Urea and Electrolytes (U and E) and Liver Function Tests (LFT) including gamma glutamyl transferases (GGT). Where the patient was in urgent need of an alcohol detoxification or did not have a GP then this blood testing could be done at CARE.

Community Detox

Where detoxification was indicated as the most suitable form of treatment (after screening and assessment) a medical treatment for alcohol withdrawal was coordinated by a clinical nurse specialist and a GP. Where the client's GP did not have the capacity to undertake this, this clinical input was provided by the CARE Clinical Lead and Team. Following assessment and once a number of criteria was met, a treatment plan in line with the detoxification protocols for the programme was undertaken. This involved liaising with other medical services, developing a plan, providing sessional support to clients, and providing Librium detox. The detoxification model implemented was undertaken in line with international good practice on out-patient detoxification, as well as national guidelines on interagency working. The dosing regimen was responsive to the client, where a CIWA score was taken each day to determine levels of withdrawal symptoms and any required tapering of the Librium dosing. The risk of relapse, seizures and other complications during detoxification were discussed with the service user by both GP/CNS and key worker, and appropriate supports or alternative treatment options explored.

Referral to Inpatient Detox

Clients where community detoxification was not appropriate were referred for inpatient detoxification at a residential service. Some clients on presentation may require hospital detoxification and be referred as an emergency admission to the Acute Assessment Unit or to the Emergency Department. Both groups were encouraged to use and access community supports including aftercare.

Medication for Relapse Prevention

Clients who were completing a detox may have wished to promote the likelihood of continued abstinence by taking medication for relapse prevention. This was discussed between the client, their doctor and the CNS. All clients needed to have baseline blood tests before consideration of medication including Urea and Electrolytes (U and E) and Liver Function Tests (LFT), including gamma glutamyl transferases (GGT). Medications that could be prescribed at this point included Acamprosate or oral Naltrexone.

Psychosocial Supports

Ballymun Youth Action Project (BYAP), Finglas Addiction Support Team (FAST) and North Dublin Community Care Service provided a range of evidence-based psycho-social supports and interventions including cognitive behavioural interventions, community reinforcement approach, motivational interviewing, coping and social skills training, harm reduction interventions etc. Psychosocial workers in FAST and North Dublin Community Care Service

developed and delivered the Sober Skills Programme, while clinical nurse specialists facilitated the alcohol awareness programme. Interventions were provided based on needs identified in the comprehensive needs assessment. The supports provided by the psycho-social support workers varied from project to project, and indeed from person to person, depending on their support needs. In some instances, there was a waiting list for psycho-social support in the partner services. In these cases some clients were referred directly to the CARE Project to be key worked by the clinical nurse specialist. Both CNSs as part of their training for their role in CARE were trained in the Community Reinforcement Approach (CRA)(2). The range of psycho-social supports provided is detailed in Figure 3.

1.4.6 Promotion of the Programme

The promotion of the programme was led by the CARE coordinator and the Policy and Research Officer of the Ballymun Local Drugs Task Force, although informally all Steering Group representatives promoted the programme where possible at interagency events. Stakeholder groups who were targeted for promotion included GPs and other referrers, community and social services locally and the public, as potential clients or concerned persons. Methods of promotion included letters, phone calls and emails, presentations at professional meetings or workplaces and posters/ promotional packs.

1.5 Summary

The CARE pilot programme is a community alcohol treatment programme, provided by a cross-disciplinary team, engaging professionals from multiple partner agencies in supporting clients who wish to address problematic alcohol use. The programme provides tailored, individualised support in line with the client's own goals, providing a range of evidence-based supports that are in line with good practice guidelines and national policy for the provision of treatment to patients with drug or alcohol difficulties.

This section has outlined in detail how clients were assessed and treated, and how professionals providing supports as part of this programme were supported and monitored in their roles. This information will provide a useful reference for various facets of the evaluation to follow, which highlights where the programme was successful, what lessons were learned and how the programme and others similar can develop, grow and respond to the needs of people in the community requiring support with alcohol use.

Chapter Two:

Summary of Relevant Policy and Evidence

2 Chapter 2: Summary of Relevant Policy and Evidence

2.1 Overview

This chapter is a review of relevant literature and evidence in a number of key areas relevant to the evaluation of the CARE programme. This includes an overview of alcohol consumption, alcohol related harm and alcohol treatment in Ireland. It also includes a summary of key strategies, frameworks and reports in Ireland that outline recommendations in relation to alcohol treatment in Ireland. Finally, this chapter compiles evidence on key facets of the programme including alcohol treatment in a community setting, alcohol treatment by multi-disciplinary teams, psycho-social interventions for alcohol treatment, and the role of GPs and of key-working in relation to alcohol treatment.

2.2 Alcohol in Ireland

1.1.1 Consumption and Treatment

Alcohol has been described as playing a pervasive role in Irish social and cultural life, and as "embedded in our national identity" (3). Alcohol consumption per capita reached a peak in 2001 of 14.3 litres of pure alcohol per adult (persons over 15 years of age). Average alcohol consumption has declined from this peak by approximately 17% over the last decade, estimated at 11 litres per capita in 2014, an increase from an average of 10.73 litres in 2013(4). Irish drinkers have been ranked amongst the highest binge drinking nations in the EU27 (5)(6). A Special Eurobarometer study (2010), commissioned by the European Commission, found that Ireland ranked highest in terms of binge drinking (5 or more drinks on one drinking occasion) and the number of drinks generally consumed on a drinking occasion (7). Ramstedt and Hope (2005) estimated that 30% of men and 22% of women consumed more than the recommended upper limits of 21 standard drinks for men and 14 for women per week (8).

Alcohol treatment figures in Ireland[3] show that the total number of cases treated for problem alcohol use in Ireland increased from 7,940 in 2008 to a peak of 8,604 in 2011, which decreased in 2012 to 8,336 and to 7549 in 2013. The table below details the number of cases treated for problem alcohol use nationally and in each of the relevant local drug task force regions in 2012 and 2013. The table reveals an increase in those reporting residence in both Finglas Cabra and in North Dublin City and County(9).

Table 3: Treated Alcohol Use in Task Force Areas and Nationally

	Nationally	Ballymun LDTF	Finglas Cabra LDTF	North Dublin City & County RDTF
All cases 2012	8150	33 (0.4%)	78 (1.0%)	182 (2.2 %)
All cases 2013	7399	34 (0.5%)	100 (1.4%)	207 (2.8%)

People seeking treatment for alcohol use predominantly report alcohol as the only substance they use, however, polysubstance use is recorded for a significant minority. National data for

[3] These figures are from the National Drug Treatment Reporting System. There are limitations to these figures which should be borne in mind in interpreting treatment data. Firstly, this system reports unique episodes of treated alcohol use, rather than numbers of individuals presenting. This means that if a person presents with more than one treatment episode in a year, this will be recorded as more than one treatment episode. Secondly, it only records figures from those services who voluntarily return data to the central recording system, meaning this only presents treatment figures from some treatment services.

2013 shows that almost one in five (18.8%) of those treated for problem alcohol use also reported using at least one other substance which most commonly included cannabis, cocaine, benzodiazepines and ecstasy. In terms of treatment setting, most interventions provided in Ireland are done so in an out-patient setting, and far the most common alcohol treatment interventions provided are counselling (53% of cases), brief intervention (39% of cases) and education interventions (33% of cases)(9).

2.2.1 Alcohol Related Harm

Alcohol related harm in Ireland is estimated to cost the State €3.7 billion annually (3). There was a 92% increase in alcohol-related hospital discharges in Ireland between 1995 and 2004 (10), amounting to 117,373 bed days (2.9% of all bed days recorded that year) in 2004. A 147% increase in alcohol-related liver disease was recorded within the same study period (11). Alcohol has been implicated in between 25% and 40% of Irish Accident and Emergency admissions, with 23% of cases being recorded as acutely intoxicated. The prevalence of alcohol use disorders among victims of suicide is far in excess of the prevalence for the general population (12). Much research has been conducted which indicates that heavy consumption increases vulnerability to levels of mental ill-health (13). Alcohol is associated with mental health problems, including depressive episodes (11), sleep distortion (14), anxiety disorders (13), deliberate self-harm (alcohol was implicated in 37% of all reported cases of DSH in Ireland in 2013) (15), parasuicide, and suicide. This becomes all the more pertinent when it is considered that suicide is the leading cause of death in Ireland of males aged between 15 and 34 years of age (11). The World Health Organisation estimates an eight times greater risk of suicide in individuals abusing alcohol (World Health Organisation, 2004). Alcohol was implicated in over half of all suicides recorded in Ireland in 2008. In a study measuring the blood alcohol levels in individuals who had died as a result of suicide or injury in three counties in Ireland, Bedford, O'Farrell and Howell (2006) reported detection of alcohol in the blood of 55.5% of those who died as a result of suicide. They further reported that this was more likely in those aged less than 30 years (16).

Alcohol related harm has been documented in Irish research not only in relation to the drinker, but in relation to those around them including co-workers, family, friends and children (17). A literature review conducted by the National Advisory Committee on Drugs, '*Parental Substance Misuse: Addressing its Impact on Children',* highlighted that children whose parents abuse alcohol and drugs are more likely to experience psychological and social developmental difficulties, particularly in terms of attachment, self-regulation and stress responses; poorer quality of life and educational attainment, and were at greater risk of child substance misuse, earlier onset of use, and a shorter transition to dependency (18). The Growing Up in Ireland study highlighted that children growing up affected by parental substance misuse require additional support and intervention and advocated the development of parent-focused intervention programmes to prevent further harm to children in high-risk families (19).

2.3 National and Local Strategic Context

Although problematic alcohol use and its associated harms have been well documented in Ireland as illustrated previously, until recently, little progress was made toward the implementation of alcohol policy in Ireland (20,21). This was attributed to a number of factors, including the social partnership model of governance, the influence of the drinks industry and their involvement in consultation process around alcohol policy, and perception of successive governments of a lack of popular support for implementation of certain policies (22)(21). For the first time in 2009, alcohol was specifically targeted in the context of substance misuse by the Irish government, where a steering group was established to consider an alcohol misuse

strategy(23), and in 2013 the remit of Local and Regional Drugs Task Forces were extended to include alcohol as well as drugs. A number of local and regional strategies and reports have in recent years advocated for the provision of community based alcohol treatment from a multi-disciplinary, interagency model as part of a continuum of services, the efficacy of which would be supported by a focus on client outcomes. A summary of these recommendations are detailed in the table below:

Type	Title	Recommendation	Action/Implementation
National Strategy	Report of the National Substance Misuse Steering Group (24), 2012	Community based alcohol services should be provided by multiple disciplines and agencies	**Point 20:** While the HSE is key to the implementation of tier 3 and tier 4 specialist services, the voluntary and community sectors, the Irish College of General Practitioners, the Royal College of Physicians in Ireland, and the College of Psychiatry of Ireland also have key roles in their delivery.
National Strategy	Report of the National Substance Misuse Steering Group (24), 2012	Provide range of services including community based alcohol services	**Recommendation 1:** Develop a national recovery-based treatment and rehabilitation service built on quality standards which actively promotes and encourages early intervention to accessible services within the 4-tiered model approach based on integrated care pathways.
Local Strategy	Finglas Cabra Alcohol Strategy 2014(25)	Provide range of services including community based alcohol services	**Action 6.1:** Seek the provision of further community based alcohol treatment services for residents in the Finglas / Cabra area who require them
Local Strategy	Ballymun Alcohol Strategy	Provide range of services including community based alcohol services	**Objective 3.1**: Ensure a range of appropriate responses to engage those with problematic alcohol issues
Local Strategy	North Dublin Regional Annual Plan	To ensure that the North Dublin Community has seamless access to evidence based drug & alcohol supports	**Action: TR.3** Support set up of community based alcohol treatment programme. **Action: TR.3** Identify gaps and blocks to progression and access to services for drug & alcohol users in the Nth Dublin RDATF area.
Regional Report	HSE Addiction Services Review(26)	Provide range of services including community based alcohol services	**Recommendation 1:** Pathways be developed in the context of the four tiers …and where appropriate should encompass general care based in primary care settings through to specialist inpatient services.
Regional Report	HSE Addiction Services Review(26)	Community based alcohol services should be provided by multiple disciplines and agencies	**Recommendation 1:** care pathways should be highly integrated, drawing on multidisciplinary teams and

			external agencies requiring high levels of integration.
Regional Report	HSE Addiction Services Review(26)	Services should be provided by multi-disciplinary teams, locally, with a clinical lead in each area	**Recommendation 2:** Each locality team should have a manager and a lead clinician, both of whom report to the Dublin North City and County Addiction Service senior management team.
Regional Report	HSE Addiction Services Review(26)	Services should be outcomes focused and have an information management system to support this	**Recommendation 6:** The addiction service should be outcomes focussed with agreed outcome monitoring and performance management processes in place. The service needs to be clear about what outcomes it aims to achieve and develop the tools and processes (for all drug and alcohol problems), including an electronic data system to ensure service wide implementation.
National Report	Royal College of Physicians of Ireland Policy Group Report (27)	Community based alcohol services should be provided by multiple disciplines and agencies	**Recommendation:** We recommend that an integrated model of care be developed for treatment of alcohol-related health problems.
National Report	Royal College of Physicians of Ireland Policy Group Report(27)	Clinical guidelines for all disciplines should be developed	Clinical guidelines for treatment of alcohol-related health problems should be developed for healthcare professionals across all relevant sectors of the health and social care system
National Report	Royal College of Physicians of Ireland Policy Group Report(27)	Community based aftercare should be provided	Aftercare in the community should be supported particularly with respect to relapse prevention

In addition to these policy recommendations, and existing alcohol treatment provision, a number of local alcohol responses have emerged in recent years. Examples include:

- The National Community Mobilisation on Alcohol Project 2015: A pilot programme where 5 drug and alcohol task forces will develop collaborative community responses to alcohol in the form of local plans (28)
- The Turas Counselling/ Dundalk Simon Community Alcohol Detoxification Project: A pilot community alcohol detoxification project involving multi-agency, multi-disciplinary intensive support for people detoxing in the community (29)
- Addiction Response Crumlin Community Alcohol Support Programme: An alcohol reduction group programme for people wishing to address their alcohol use with psycho-social support (30)

2.4 Alcohol Treatment: Interagency or Multi-Disciplinary Approaches

The National Substance Misuse Strategy Report (24) advocated the adoption of a 4-tier model of rehabilitation service provision for alcohol, based on the promotion of early intervention and integrated care pathways, "where service delivery can be achieved through cross- and intra-sector collaboration within the HSE and between other statutory sectors in partnership with the community and voluntary sectors" (pp. 35 – 36). This document highlighted the need to broaden the focus of alcohol intervention and treatment to include the large group of individuals whose alcohol-related problems are less severe. Brief interventions may be appropriate in such presentations, and are effective for many. This report advocates that such interventions be delivered in general community settings by non-specialist, trained personnel and highlights that they are associated with positive treatment outcomes and cost effectiveness (31). Tier 3 services refer to the provision of a community-based specialist service delivered by a multidisciplinary team for more complex cases (4). The interventions provided include comprehensive assessment, care planned treatment, community detoxification, evidence based psychosocial therapies and liaison services for psychiatric and medical services. Tier 4 services refer to residential specialist treatment programmes delivered by a multidisciplinary team and providing more extended rehabilitative care (4).

This approach is supported in literature and national guidelines where specialist assessment and management of individuals presenting with alcohol use disorders may require interagency care planning and case management, depending on the severity and complexity of dependency (32) (33). Thus a comprehensive care plan with integrated care pathways, and appropriate communication and collaborative planning between service providers, is essential. A fully integrated approach is vital to ensure effective, outcome-based treatment (31). In this vein, British and Irish national guidelines advocate an interagency approach to treatment (34)(31), whereby the treatment offered by local service providers be based on pattern of need and capacity of the individual (34)(35).

2.5 Community Alcohol Treatment

Alcohol difficulties can be treated in out-patient, community based settings or inpatient settings. Factors determining the most suitable approach include the complexity of need, additional substance use, comorbid physical or mental health issues, history of previous treatment, and client preference(34). Community and out-patient settings are an appropriate treatment setting for clients and clients can effectively reduce alcohol use and alcohol related harm in out-patient settings. For example, there is extensive literature supporting the provision of alcohol detoxification in an out-patient setting, which when provided by a GP, with psycho-social support is an effective form of alcohol treatment (33) (34)(35)(36)(37). Guidelines from other jurisdictions such as the US (TIP 45) (32) and the UK (NICE) (36) advocate the provision of medication detoxification in combination with psycho-social supports before, during and after detoxification.

Community alcohol treatments have been shown to be cost effective; research in the UK with 742 clients revealed that the provision of out-patient therapeutic support saved about five times as much in expenditure on health, social, and criminal justice services as it cost(38) and significant cost effectiveness of alcohol interventions in primary care has been documented in the US (39). Community alcohol treatment is an accessible alternative for certain groups, for example women experience barriers in accessing treatment due to lack of childcare(40,41).

2.6 Psychosocial Interventions

2.6.1 Psycho-Therapeutic Interventions

There is evidence to support the effectiveness of a range of psycho-social supports for community alcohol treatment interventions currently provided including CBT (Cognitive Behavioural Therapy), CRA (the Community Reinforcement Approach), brief interventions and motivational interviewing.

Cognitive Behavioural Therapy (CBT) has been widely used in alcohol and addiction treatment and is considered as a highly effective treatment method for alcohol dependence(42). Research has shown that the combination of pharmacological and CBT treatment lead to significant reduction in alcohol related harm(43). Relapse Prevention has also been successfully implemented in the area of alcohol treatment. This approach of identifying and preventing high-risk situations for relapse has been effective(44). The use of Community Reinforcement Approach (CRA) has been successful in treating various types of substance dependence for over 35 years(45). There is evidence to suggest that the community reinforcement approach is highly effective (46–48). The first two studies by Azrin and colleagues found that the CRA is more effective in reducing drinking than Alcoholics Anonymous in hospitals, among alcohol-dependent patients in the United States. It was also reported that CRA had a positive impact on clients' family relationships and their employment(46,47). Finally, recent research in Ireland revealed significant decrease in alcohol use among patients provided with brief intervention and motivational interviewing interventions (49).

2.6.2 Group Interventions

The provision of group support for alcohol treatment may be a cost-effective and complementary service to individual support. A randomized clinical trial with 155 people found that similar positive outcomes were produced in both individual and group settings. The authors concluded that the group format can be used without decreasing treatment effectiveness, and may be more cost-effective (4). A meta-analysis of 23 studies comparing the effects of both treatment modalities, noted that group therapy can be used as an alternative to individual therapy under many different conditions (5).

2.6.3 The Role of GPs in Alcohol Treatment

Some research suggests that general practice is a major setting for the identification of alcohol problems in the general population(50) and research with GPs in Ireland has shown that the treatment of alcohol may place a considerable strain on GPs, who have cited barriers such as time constraints, a lack of available support and a lack of training as barriers to the provision of alcohol support(51). Other studies in Ireland have highlighted the need for increased capacity among GPs to support patients with dual diagnosis(52). A number of recent developments awaiting evaluation show the increased focus on the role of GPs in supporting alcohol users in primary care settings. Klimas and colleagues developed guidelines for GPs on the treatment of alcohol using substance misusers (53) and the training of GPs in the provision of brief interventions for alcohol use(54).

2.6.4 Key Working

Key working, which represents a Tier 3 (and upward) service, is a basic delivery mechanism for a range of key components. This may be provided in mainstream clinical services or in the community. The role of a keyworker is to match services to the individual, that is, to identify appropriate support services for individuals with more complex needs, and to support the individual on their rehabilitation pathway (24). Additional interventions that have been suggested within Irish guidelines (31) include; a community reinforcement approach, a comprehensive behavioural approach to treating substance-abuse problems based on the

belief of the role of environmental factors in influencing drug and alcohol-based decisions and behaviours; coping and social skills training; neuropsychological assessment; and self-help groups, using 'SMART' objectives to support individuals in addressing their issues and difficulties. Regular use of breathalyser readings may be useful in monitoring the amount of alcohol consumed and in assisting patients to reduce their use. Many services may only issue substitute prescriptions when the patient attains a certain low-level breathalyser reading, often set at the drink-driving limit. There is no evidence that this does reduce the amount a patient drinks but it may contribute to the safety of prescribing medication to patients who are dependent on alcohol.

2.7 Conclusion

The consequences and implications of alcohol misuse and disorders are endemic and far-reaching. A historic lack of leadership at national level has been negated by the development and implementation of local alcohol strategies, where the absence of suitable treatment options for people with alcohol difficulties was highlighted, and as evidenced by projects such as the CARE project, to some extent addressed. Providing support in the form of addiction services, dual diagnosis expertise and educational interventions to GPs may be an effective way to support primary care providers to work effectively with alcohol using patients. There is strong support in the literature for the provision of multi-disciplinary, multi-agency support at community level for people with alcohol issues which may or may not include pharmacological detoxification. Shared working between medical service providers and those with psycho-social support skills in the provision of community alcohol treatment is promoted as good practice for low-medium risk alcohol clients in international guidelines and literature.

Chapter Three:

Methodology

3 Chapter 3: Methodology

3.1 Approach

This research was a project evaluation, with the purpose of understanding the effectiveness of the CARE community alcohol support programme from the perspective of multiple stakeholders including clients, service providers and local policy makers.

3.2 Research Objectives

- To explore the extent to which the project was embedded in each site
- To explore the extent to which the project was delivering evidence based interventions in relation to problematic alcohol use.
- To ascertain and demonstrate the benefits that participation in the CARE Project has had for relevant stakeholders.
- To examine the extent to which CARE had contributed to the development of integrated practices, shared care pathways and referral/support opportunities at a local level in responding to alcohol use within services.
- To present key learning from the pilot project and make recommendations regarding the potential of this model and any adaptations to it.

3.3 Desktop Review

For the development of the client and service activity profile, as well as to achieve a number of key research objectives, the research team analysed project founding documents, protocols, and importantly, existing anonymised client data. Two databases were developed which were completed by CARE staff and psycho-social partners to support the case file review and audit of a random sample of client files.

3.4 Methodology, Sampling and Engagement

A mixed methodological approach was used to ensure engagement of as diverse a range of stakeholders as possible. The table below illustrates the method used, number engaged, sampling approach, outcomes of each method and a reference to where the engagement is explored in this evaluation report.

Method	**Number Engaged**	**Sampling**	**Outcome**	**Chapter**
Case File Review	105 clients	Whole population of clients	Overview of project activities	4
File Audit	40 clients	Randomly sampled representation of files from all sites	In-depth exploration of client outcomes	5
Client Interviews	6 clients	Purposive quota sampling to engage two clients from each pilot site	Review of experiences of some clients	5,6 &7
Professional Interviews: clinical workers	2 clinical nurse specialists	Whole population	Understanding of key issues from the perspective of clinical workers	6 & 7

Professional interviews: psychosocial workers	3 psycho-social workers; 1 from each site	Purposive quota sampling	Understanding of service provision from the perspective of psycho-social workers	6 & 7
Psycho-Social Survey	8 psycho social workers	Whole population of psycho-social workers who engaged with CARE	Understanding of service provision from the perspective of psycho-social workers	6 & 7
Professional Interviews: Management and Strategic	8 Management Professionals	Whole population of those in management/strategic role for the programme[4]	Understanding of programme development and monitoring	6&7
GP Survey	27 GPs	Purposive sampling of all GPs who referred, as well as targeted sampling of other GPs working in the pilot area.	Understanding of the impact of CARE on the related work of GPs (e.g. providing support for alcohol difficulties)	6&7
Pharmacist Survey	3 local pharmacists	Selective sampling of pharmacists who had worked with CARE	Understanding of the impact of CARE on the related work of pharmacists (e.g. provision of medication for detoxification)	6&7

3.5 Limitations

Quality of Data: The absence of pre and post data meant it was difficult to estimate the impact for clients either in terms of alcohol use or in other domains.

Family Members: Recruitment of family members proved difficult, and as family members were not direct clients of the organisations in most cases, it was not possible to understand the impact of the programme on family members using the existing recruitment and analysis methodologies.

Bias: Staff undertook the client case file analysis and this was not based on pre and post data collection, but drawn from the staff's own subjective perspective, either from memory or from written case notes/files.

Timeframe: Because the service was rolled out into one of the pilot sites for only 5 – 6 months at the time of the review, there was insufficient data from this site to provide as robust a picture of its effectiveness in all areas as in other pilot sites.

Chapter Four:

Profile of CARE Clients

4 Chapter Four: Profile of CARE Clients

4.1 Overview

This chapter provides a detailed profile of CARE clients. This profile includes demographic information, information on client risk in relation to alcohol use and related issues, and information on CARE and associated services availed of by the cohort of clients. This profile was created from a database developed for purposes of the report by the research team and the CARE team and completed by the clinical nurse specialists.

4.2 Key Note Regarding Interpretation of Data across Sites

The client profile reveals in many instances significant differences in numbers across the three pilot sites. This does not reflect a difference in demand for service or needs presenting, but reflects the phased implementation of the project including differences in project promotion, duration/days of provision and nature and extent of services available in each area.
Finglas was first site to be piloted (September 2014), followed by Ballymun (November 2014) and North County Dublin as the last implementation site (January 2015) with all sites running concurrently from January to June 2015. Referrals to CARE before commencement of the Project within an area were possible if a client was willing to travel. For example, seven clients within the Finglas implementation were from North County Dublin and four were from Ballymun. Likewise the Ballymun implementation included a referral from Finglas and North County Dublin.

4.3 Attendance Rates

4.3.1 Attendance Rate at Initial & Comprehensive Assessment

Altogether, 142 clients were referred to CARE, with 105 attending for initial assessment. The overall attendance rate for people who were referred to the programme at initial assessment was 74%. This ranged from a 71% rate of attendance at initial assessment in Ballymun to a 76% rate of attendance at initial assessment in Finglas and North County Dublin.
Of the 105 people who attended their first appointment, 104 people (99%) completed the initial assessment (one person was referred to A&E and received no further care), and 82 people (78%) completed a comprehensive assessment. There was little difference in these rates across the three sites.

4.3.2 Referral Source[5]

The majority of referrals who presented for initial assessment to the programme came from GPs, who were responsible for 40% of referrals (n=42) to the programme. The second most common referral source was the psycho-social partners, who were responsible for 34% of the referrals (n=36)[6]. The third source of referrals are categorised as other, and other referred in most cases to probation, another psycho-social provider or an allied health practitioner such as a nurse or social worker; in total 16 referrals were from an 'other' source (15%). In terms of self-referral, 11 people came through this route, 11% of the total population. Although a detailed breakdown of referral source by area is not provided due to the low numbers in some categories, an overview of the area-by-area breakdown is as follows:

- The lowest number of referrals in all three sites came from self or other and in all areas the highest referrals came from the psycho-social partner or the GP.

[5] Referrals analysed are only those 105 who progressed to an initial appointment with the CARE team.
[6] Only 23% of clients reported engagement in the previous three months with addiction services which raises a questions about whether there was a misinterpretation of certain information, for example whether clients regarded the psycho-social partner as an addiction service.

- Referrals from GPs were highest in Ballymun (64% of referrals came from GPs here) and lowest in Finglas (18%)[7].
- Referrals from the psycho-social partner were highest in Finglas (50%) and lowest in Ballymun (11%)

Table 4: Referral source

	GP N (%)	Psycho-social partner N (%)	Self N (%)	Other N (%)
Whole Programme (N=105)	42 (40%)	36 (34%)	11 (11%)	16 (15%)

4.3.3 Comparison of AUDIT-C Scores between Attenders and Non Attenders

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument. AUDIT C scores(55) were provided on referral for 112 people of the 142 referrals, of which 81 were attenders and 31 were non-attenders. Generally, a score of 4(men) or 3(women) indicates hazardous drinking, and generally the higher the score out of 12, the more likely it is that the person's drinking is affecting his or her physical or mental health.
A significant majority of those referred had AUDIT C scores of 6 or higher, meaning the majority of people referred were at a high risk of hazardous drinking or potentially alcohol dependency. Examining AUDIT C scores from referral information, there was no difference in alcohol risk levels between those who attended their first appointment and those who did not[8].

4.4 Gender and Age of CARE Clients

4.4.1 Gender of CARE Clients

The total number of people who attended an initial appointment with CARE from September 2014 to June 2015 was 105, with an almost even split of genders, 55 male (52%) and 50 female (48%).

Table 5: Gender breakdown of CARE clients for the whole programme

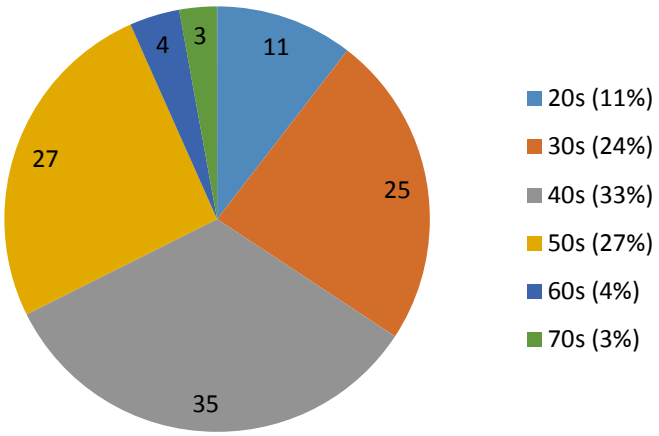
	Male / n (%)	Female/ n (%)
Whole programme (n= 105)	**55 (52%)**	**50 (48%)**

4.4.2 Age of CARE Clients

As illustrated in the graph below, the vast majority of clients were in their 30s, 40s and 50s with a smaller number in their 20s, and 7% in total in their 60s and 70s. The median age for CARE clients was 45 years, higher than the national figure of 40 years (56).

[7] It should be noted that in Ballymun the CARE clinical site was situated in the Civic Offices beside a number of GP practices.
[8] The audit c scores were compared for those who attended and for those who did not attend initial assessment using an independent samples t test, which allows us to compare means of AUDIT C scores between two groups.

Figure 4: Age of CARE clients for whole programme



4.4.3 Employment Status

In relation to the employment status at assessment, over half were unemployed (56%, n=57) while 35% (n = 36) were in employment which included CE schemes. The remaining 9% (n=9) were either students or retired. A significantly higher proportion of people were employed in the North County Dublin cohort (56%) than in Finglas (34%) or Ballymun (19%). The figures of employed clients in CARE is higher than that of cases of alcohol treatment reported nationally, where just 22% of alcohol treatment cases related to people in employment (56).

4.5 Profile of Needs and Risk

4.5.1 Summary of Risk

The table below shows the rates of people with comorbid mental health issue and/or polysubstance use.[9] Each of these factors increase the level of risk and complexity of need of the client cohort in the area, as well as a higher level of alcohol related risk with regard to AUDIT scores. The table reveals that many of the clients in CARE had complex needs; high risk in terms of their alcohol use, comorbid mental health issue and for a minority in terms of additional substance use.

Table 6: Summary table of risk

	% of all CARE clients	AUDIT Scores above 20	Comorbid mental health issue	Polysubstance use[10]
Whole programme	**100%**	**86% (n=86)**	**45% (n=47)**	**16% (n=16)**

4.5.2 AUDIT Scores

AUDIT[11] scores were taken for 100 CARE clients who attended initial assessment. The AUDIT contains three sections relating to consumption, dependence and alcohol related problems.

[9] Definition employed by CARE for the purpose of this research; comorbid diagnosis as a case where the person had received a formal diagnosis by GP or mental health service/specialist or was at the time of assessment on medication for mental health issues.

[10] This refers to the presence of other substances in urinalysis testing. DSM IV says polysubstance dependence is at least 3 substances, however for the purpose of this report, polysubstance refers to 2 or more substances.

An analysis by section was not possible for this report, however, the higher the overall score, the more problematic a person's drinking is indicated to be. Generally, AUDIT scores in the range of 8-15 represent a medium level of alcohol problems whereas scores of 16 and above represent a high level of alcohol problems. AUDIT scores of 20 or above are considered to indicate dependence and warrant further diagnostic evaluation and treatment(57).

Table 7: AUDIT scores for whole programme

AUDIT Score	Whole Programme
Less than 8	0 (0%)
8 - 15	7 (7%)
16 – 19	7 (7%)
20 – 30	55 (55%)
31 - 40	31 (31%)

4.5.3 Presence of Comorbid Psychiatric Disorders

At a whole programme level, 45% of people were reported as having a psychological comorbidity, with similar rates across all three sites. CARE defined a comorbid diagnosis as a case where the person had received a formal diagnosis by GP or mental health service/specialist or was at the time of assessment on medication for mental health issues. The percentages of people suffering from psychological disorders ranged from 42% to 48% across the three sites.

4.5.4 Use of Other Substances at Time of Referral

Screening for other substances was undertaken for 89 people. This was undertaken through urinalysis with the consent of the client. Of those who had urinalysis (n= 89), 51% of clients did not test positive for any other substance (n=45), 49% of clients (n= 44) tested positive, of the 89 clients who were tested, 16% of clients (n= 14) tested positive for two or more other substances.

In relation to the specific secondary drugs used, 37% of people tested positive for benzodiazepine (n= 33), followed by cannabis (n= 10, 11%) and cocaine (n= 6, 7%). No one tested positive for amphetamines and opiates.

Table 8: Number of people who tested positive by drug type

Substance	Positive Tests (n= 89)
Opiates	0 (0%)
Cocaine	6 (7%)
Methadone*	3 (3%)
Benzodiazepine*	33 (37%)
Amphetamine	0 (0%)
Cannabis	10 (11%)
Librium	2 (2%)
THC	3 (3%)

* Please note it is unclear whether this was prescribed or unprescribed medication

[11] The AUDIT is an alcohol screening tool, developed by the World Health Organisation (WHO) which identifies hazardous and harmful drinkers as well as alcohol dependence. Alcohol dependence as measured by AUDIT is consistent with the International Classification of Disorders 10 (ICD-10) definition(57).

4.5.5 Previous Reported Contact with Other Health and Social Services

Prior to their initial assessment in CARE, in the preceding three months, two thirds of clients (66%, n= 69) had no reported contact with other addiction, mental health or other relevant services. The service clients were most likely to report that they had been in contact with was an addiction service (23%), followed by 'other services' at 14%, while 6% reported that they had been in contact with mental health services.

Table 9: Contact with other services in three months preceding first CARE appointment

Contact with services	**N (%)**
Contact with addiction service	24 (23%)
Contact with mental health service[12]	6 (6%)
Contact with other services	15 (14%)
No contact with any other service	69 (66%)
Whole Programme (n= 105)	

4.6 Service Provision

4.6.1 Summary of CARE Service Provision Type

Of the 105 clients for whom an initial assessment was provided, 92 individuals (88%) also received psycho-social supports from a partner site. All clients included received both initial assessment and almost all clients received psycho-social support from a partner site, with the exception of 13 (13%) who declined this support or already had an alternative source of this support. The table below illustrates the services clients availed of across the whole programme.

Table 10: CARE service provision

Service Type	**Whole Programme (n= 105)**
Comprehensive Assessment	82 (78%)
Mental Health Assessment	67 (64%)
Physical Health Assessment	96 (91%)
Blood testing	66 (63%)
Urinalysis	89 (85%)
Mental Health Referral	23 (22%)
Physical Health Referral	32 (31%)
Referral to Residential Alcohol Services[13]	12 (11%)
CARE Detoxification	23 (22%)
Detoxification Support for Non Care Detox	20 (19%)
Alcohol Awareness Group	17 (13 clients; 4 family members)
Sober Skills Group	9 (6 CARE; 3 non CARE)

[12] Note this refers to contact with mental health services only, in the last three months only. This means clients who had been receiving mental health support from their GP are not included in this, nor are client's whose most recent contact with mental health services was more than three months prior to the time of assessment.
[13] This refers only to those who accepted an offer of referral and not those who were offered but refused a referral.

4.6.2 Comprehensive Assessment

Comprehensive assessments were undertaken for 82 (78%) of CARE clients. For all clients who undertook a comprehensive assessment, a care plan was developed based on care plan needs identified either with the CNS or with the psycho-social support worker.

4.6.3 Physical and Mental Health Assessments

The percentages in the table below indicate the clients who had physical and or mental health assessments undertaken. Physical health assessments were carried out for 91% of clients from the whole programme, while 85% of clients had undertaken urinalysis. A further 63% of participants had a blood test and 64% had a mental health assessment. CARE also worked with the clients GP regarding obtaining results if undertaken by GP.

Table 11: Health Assessments

	Mental Health	Physical Health	Bloods	Urinalysis
Whole Programme (N= 105)	**64%**	**91%**	**63%**	**85%**

4.6.4 Physical & Mental Health Assessment & Referrals

Of those who have attended the programme, 67 (64%) were reported as having had a mental health assessment and 23 of them were referred on for mental health service (34%). The number of people who were defined as having a comorbid psychological disorder was 47. Of this 47 clients, six were already engaged with MH services in the three months prior to initial assessment, and 41 were not. Of those who were not previously engaged, 23 were referred to Mental Health services as a result of their engagement with CARE. There was no information available on the progression or outcomes of these referrals.

In the overall programme, 96 (91%) people had a physical assessment, of which 30 (31%) were referred on to other specialist physical health services including liver/renal specialists, hepatology, in patient detox, A&E, GP specialist etc.

Table 12: Mental & physical health assessments and referrals

	Mental Health		Physical Health	
	Assessments	**Referrals N (%)**	**Assessments**	**Referrals N (%)**
Total	**67**	**23 (34%)**	**96**	**30 (31%)**

4.6.5 Psycho-Social Referrals & Groups

The majority of clients were referred to CARE partners (n= 88, 83%) and 26% (n= 27) referred to other psycho social services for key working, counselling and other supports etc. [14] Psychosocial services provided a range of evidence-based psycho-social supports and interventions including cognitive behavioural interventions, community reinforcement approach, motivational interviewing, coping and social skills training, harm reduction and relapse preventions techniques etc.

[14] Note this adds up to more than 100% because some clients may have been referred to multiple psycho-social supports

Two 4 week alcohol awareness programmes were delivered as part of CARE to clients and their concerned persons (if applicable) during the Finglas and Ballymun site implementations. All clients attending Ballymun and Finglas were offered this Programme. These sessions were also available for any referrals at that time from North Dublin County if they were willing to travel. However no programme could be delivered in North County Dublin within the pilot period as it was the last site to be implemented. In total, 17 people accessed this of which 13 were clients and 4 were family members. These programmes were delivered by the CNS's and CARE Coordinator.
A five week Sober Skills Group was also designed and delivered collaboratively by FAST and North Dublin Community Care Service. A total of 9 clients attended this group. This was also open to non-CARE clients from partner psychosocial services who met the criteria for inclusion (n=3). The criteria for the programme was that clients would commit to a period of sobriety for 5 weeks and that they could commit to attending the 2 sessions per week for the duration of the group. This was a skills based programme which covered a variety of topics; communication skills, values, problem solving, coping mechanisms etc.

4.6.6 CARE Detoxification

As part of the CARE Programme, alcohol detoxes were available to CARE clients across the 3 sites in addition to providing support for clients who were self-detoxing, preparing for residential detox or initiating a detox with or currently on a detox with their own GP.
In terms of a CARE detox, where detoxification was indicated as the most suitable form of treatment (after screening and assessment) a medical treatment for alcohol withdrawal was coordinated by the clinical lead (GP of HSE Addiction Service), CARE clinical nurse specialist and a pharmacy within the site location. Where there was a concerned person involved, they would also be a support for the client in terms of compliance of daily regime. A total of 23 clients were supported through a CARE detox, of whom 18 clients successfully completed detox while 5 clients disengaged from CARE detox prior to completion. One client successfully detoxed from alcohol and benzodiazepines. Of the 23 CARE detoxes, 13 were at the Finglas site and 10 Ballymun.

In some cases a CARE client may have initiated a detox in collaboration with their own GP and in such instances the CARE team provided support to the client as required but was not deemed to be a CARE detox. CARE supported clients in North Dublin to detox with their own GP but no CARE detox took place.

Table 13: CARE detoxification

	N (%)
CARE detox	23 (100%)
Completed CARE detox	18
Disengaged CARE detox	5
Pharmacological Treatment [15] (percentage of 105)	22 (21%)
Whole programme (N= 105)	

4.6.7 Summary of Client Profile and Risk

CARE provided services to a cohort of clients who were clearly indicated for specialised alcohol support. The complex range of needs presenting, including comorbid physical and psychological health issues, also highlights the importance of the provision of multi-disciplinary support with an emphasis on screening and referral to ensure appropriate support was accessed either from physical or mental health specialists, in-patient alcohol treatment

[15] Note that those on a pharmacological treatment may have also been clients who were undertaking a detox not initiated by CARE but their own GP.

services or from psycho-social support providers. Clients accessed a broad range of services provided by CARE and their partner organisations, and the adherence to treatment in the small cohort of community detoxification patients shows promising results for coordinated community alcohol detoxification.

Chapter Five:

Outcomes for Clients

5 Chapter 5: Outcomes for Clients

5.1 Introduction

This chapter presents the findings of a randomized case file analysis undertaken by CARE and partner site staff on client outcomes as a result of engaging with CARE (n=40). This section primarily provides an overview of client progress, based on the perceptions of staff, in relation to key care plan areas such as alcohol use, health, relationships and housing.

5.2 Case File Analysis for Outcomes

A random sample of 40% of client files that were opened between Sept 2014 and the end of April 2015 were examined. The sample was divided proportionately across the three sites.

Table 1: Number of client files analysed (total and by site)

Site	**N (%)**
Finglas	16 (40%)
Ballymun	14 (35%)
North County Dublin	10 (25%)
Whole programme	**40 (100%)**

The randomly sampled client files and a database on client outcomes were circulated to the CARE team and psycho-social partners to complete. They completed the database, which sought information on client outcomes in a range of domains drawn from the National Drug Rehabilitation Implementation Committee (NDRIC) guidelines, either from their case notes or from memory where case notes were not available[16]. Further information on methodology and limitations are discussed in Chapter 3 of this report.

5.3 Care Plan Goals Identified

All of the 40 clients in the sample had a care plan. Of these clients, only 20% (n= 8) of clients had alcohol as their sole care plan goal, while 80% of clients had multiple care plan goals.

As indicated in table two below, the majority of client files documented alcohol use as a goal (98%). This was followed by pro-social engagement as being the second most common goal recorded for clients (n= 18, 45%) and relationship with family members (n= 16, 40%) was the third most common goal identified.

Although still cited by at least a quarter of the sample of clients, relationships with children (25%) and housing (20%) were less commonly identified goals. Money and budgeting was the least commonly identified goal (n= 6, 15%).

In interviews with six CARE clients, all interview participants agreed or strongly agreed that working with CARE helped them to set realistic goals in relation to alcohol and other areas of their lives. All interviewees also agreed or strongly agreed that while working with CARE they made positive changes, both in their alcohol use and in other areas of their lives.

[16] No pre and post data on client outcomes was collected as part of the CARE programme care planning.

Table 2: Breakdown of client goals

Goals	Number of Clients Files where this Goal Was Identified (Total Sample = 40)
Alcohol use	39 (98%)
Pro-social engagement	18 (45%)
Relationship with family/partners	16 (40%)
Physical health	14 (35%)
Illicit drug use	12 (30%)
Mental health	11 (28%)
Relationships with children	10 (25%)
Housing	8 (20%)
Money and budgeting	6 (15%)

5.4 Progress towards Care Plan Goals

5.4.1 Understanding Progress towards Care Plan Goals

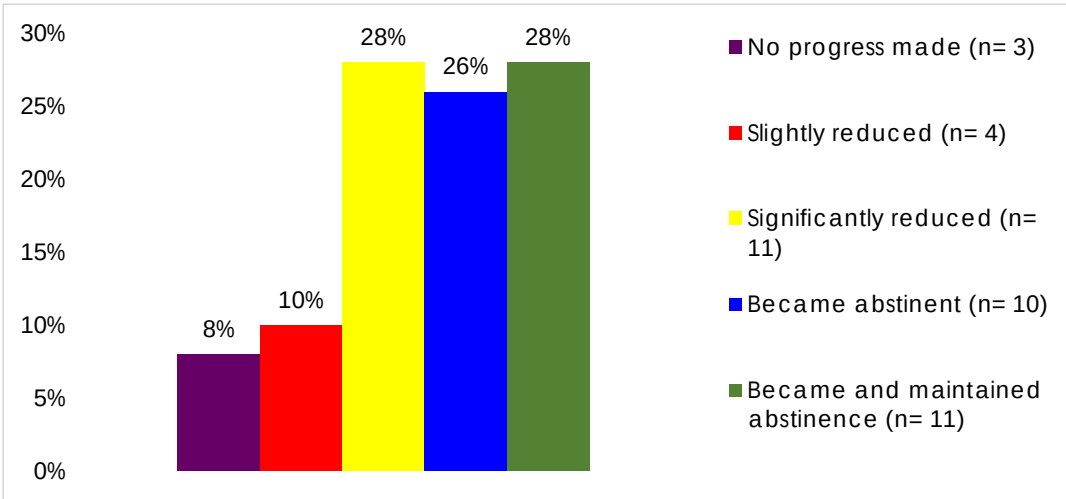
To complete the data on progress towards care plan goals, staff were provided with a database of goals for various care plan areas. Each goal had predetermined progress points, in line with common practice in care planning in the drug and alcohol sector in Ireland. Drawing on the Theory of Change methodology, client progress was marked at one point along the spectrum in each goal. This means that it was presumed that clients, where they achieved an outcome in relation to their goal, had also achieved all steps previously. For example, where a client reached the goal 'maintained abstinence' in relation to illicit drug use, it was presumed that they had also 'significantly reduced drug use' and 'achieved abstinence'.

5.4.2 Alcohol

Of the 40 clients randomly selected for this evaluation, all but one had alcohol reduction as a goal (n= 39, 98%). Of those, 92% (n= 36) made progress towards their goals, with 82% (n=32) either making a significant reduction in their alcohol use or becoming abstinent. Over half of the clients achieved abstinence (54% n=21), with over half of those maintaining abstinence[17] (n=11).

[17] The duration of abstinence was not available

Figure 1: Alcohol



Interviews with six clients also revealed that in relation to alcohol use, all client interviewees agreed or strongly agreed that working with CARE helped them to understand their alcohol use, and two thirds (n=4) of interviewees agreed or strongly agreed that they decreased problematic drinking as a result of working with CARE. Almost all clients agreed that working with CARE helped them to reach their goals in relation to their drinking. The positive impact of reducing alcohol use on day to day living is illustrated by one of the interviewees in the following quote:

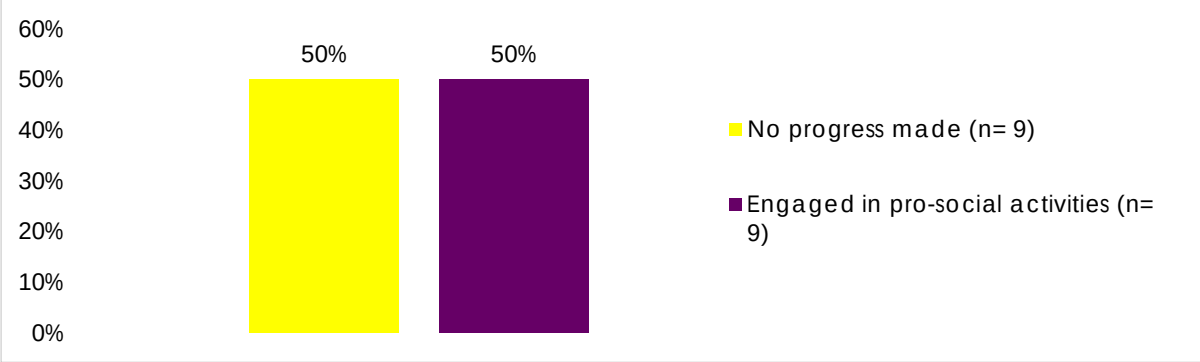
> *Without the hangover you wake up and think 'what are you going to do today?', 'how can you make it better?' - Or pick up the phone and ring the kids and see how they are - something small. Client 4*

In addition to this, there was also a high level of success in addressing alcohol use among the cohort of clients who undertook detox with support from CARE as noted in Chapter 4.

5.4.3 Pro-Social Engagement

Figure two indicates that the second most commonly identified care plan goal for clients was pro-social engagement; 18 people from the sample of 40 had identified pro-social engagement as a care plan goal (45%). Pro-social engagement refers to the ability to participate in social activities with peers, friends and others without the engagement being focused on or associated with alcohol consumption.

Figure 2: Pro-social engagement

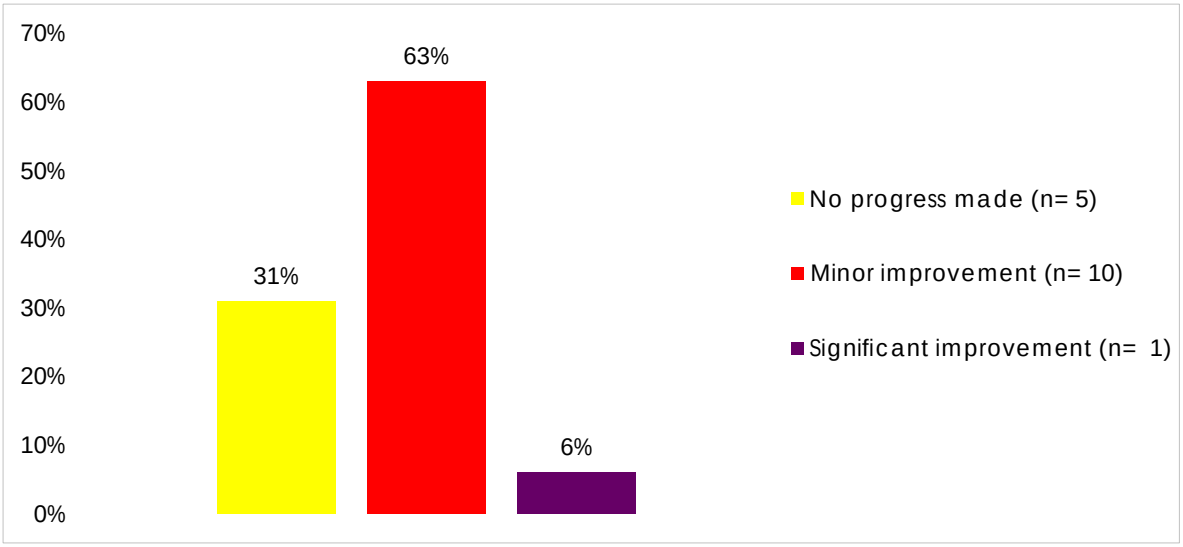


Half of the clients who identified this as a goal (n=9) made progress and engaged in pro-social activities.

5.4.4 Relationship with Family

There were 16 clients (40%) for whom improving their relationship with family or their partner was identified as a goal. Two thirds of these clients were successful in this care plan objective.

Figure 3: Relationship with Family



Of these 16 clients, 69% (n=11) made progress towards this goal, with 63% (n=10) noting a minor improvement. Five of these clients reportedly made no progress (31%) in relation to this area.

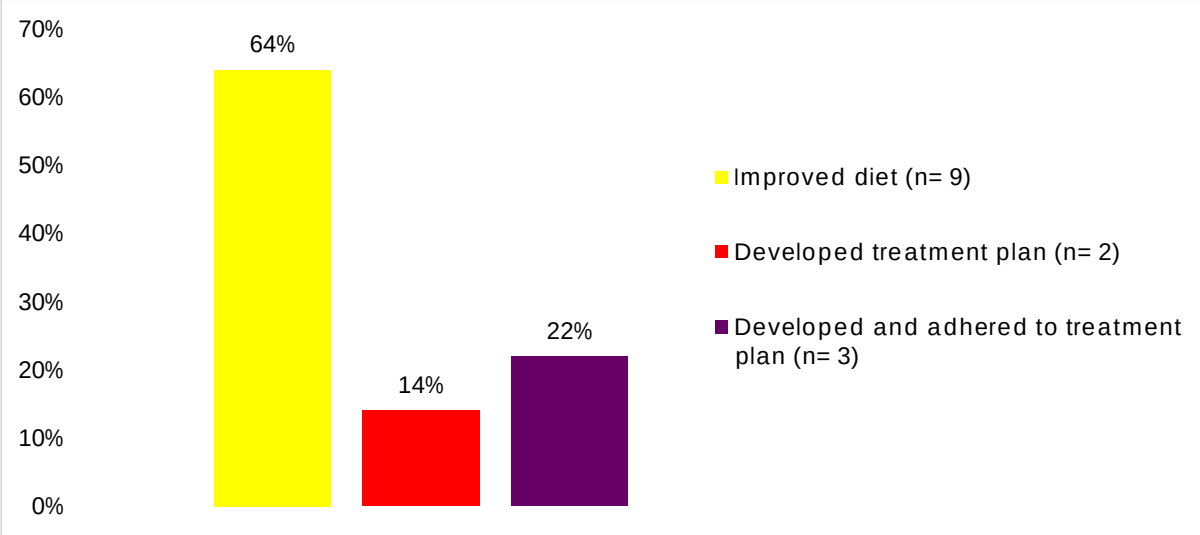
In interviews with clients, all client interviewees agreed or strongly agreed that working in CARE helped them to improve family and other close relationships. One client describes how their brother learned to help them with their drinking:

> *I could see that by the time the group finished, my brother knew the signs, he knew what was going on and was giving me warnings if he could see something going wrong, trying to tell me. So that was good. Client 1*

5.4.5 Physical Health

As indicated in Figure 4, 14 clients (35%) identified physical health as a goal area for improvement.

Figure 4: Physical health

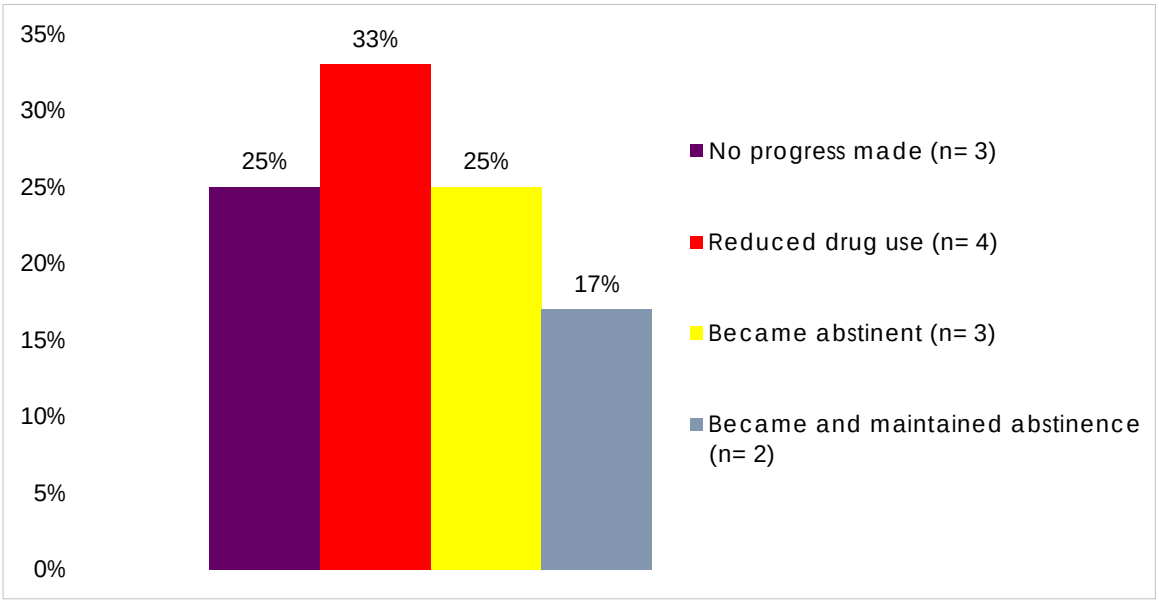


All clients who identified improving physical health as a care plan goal were reported as having made progress in relation to this. For the majority who identified this as a goal, the progress they made was an improvement to their diet (n= 9, 64%), while five others (36%) developed a treatment plan for their physical health with three of those adhered to this plan (22%).

5.4.6 Illicit Drug Use

Reduction in the consumption of illicit drugs was a goal for 12 clients (30% of the sample). As detailed in the previous chapter, 49% of the total population of CARE clients tested positive for at least one other substance. 33% of people who tested positive tested positively for benzodiazepines, whether these benzodiazepines were prescribed or illicit was not asked.

Figure 5: Illicit Drug Use

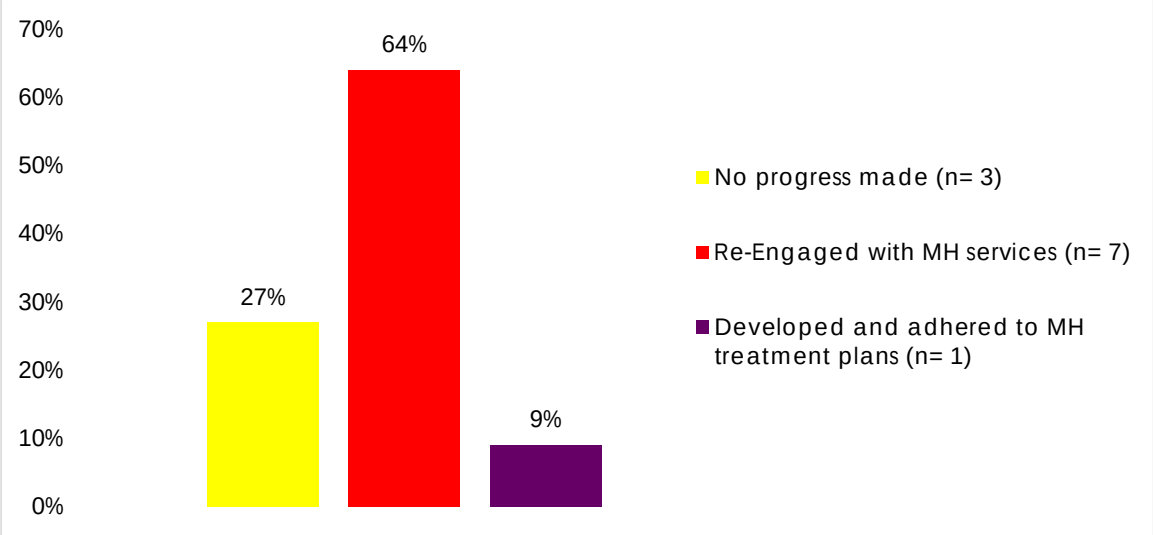


Of the 12 clients who had goals in relation to their illicit drug use, 75% (n=9) of these people made progress: 33% (n=4) reduced their drug use, 25% became abstinent (n=3) and 17% of clients (n=2) maintained abstinence, as illustrated in figure 5

5.4.7 Mental Health

As previously noted in Chapter 4, 45% of clients had a comorbid mental health issue when they began engaging with CARE and over one fifth (22%)of clients who came to CARE with mental health difficulties were referred to specialist mental health services by CARE. The case file analysis revealed that of the 40 sampled, 11 had identified mental health as a care plan goal (28%).

Figure 6: Mental health



Almost three-quarters of client files (73%, n = 8) where mental health care plan goals were identified showed progress in relation to this area, with 64% re-engaging with mental health services, and one person after engaging with services, adhering to their treatment plan. One client describes here how acceptance by workers helped him when he first presented to the service:

> *I found them very good because they were very understanding - I went in there like a total wreck and the way they were able to talk to me and understand me... Client 5*

5.4.8 Relationships with Children

Approximately one-quarter of the case files analysed identified improvements in relationships with their children as a goal (n= 10, 25%). Of these 10 clients, only two made no progress (20%), and 80% improved the relationship with their children (n= 8). One person described how they had jeopardized many facets of their lives but had managed to regain control after working with CARE:

> *Life is back in a structure now - I've kept my job, family. Client 3.*

5.4.9 Housing

Housing was a goal for 20% of clients (n= 8). 50% of these made no progress, while 50% either maintained their tenancy where it had been in jeopardy, or sourced new housing (n= 4).

5.4.10 Money and Budgeting

Money and budgeting was the least commonly identified goal for the clients (n= 6, 15%). No progress was made for the majority of clients (67%) with the remaining third of clients progressed on to make a financial management plan (n= 2, 33%).

5.4.11 Areas of Most and Least Progress

The area in which clients made the most progress, where goals were identified in these areas, was in alcohol reduction with 92% having made some form of progress, followed by improving relationship with children (80%), reduction in illicit drug consumption (75%) and the mental health goal (73%). It is important to bear in mind that these are proportions of those who identified a goal in this area, rather than proportions of the entire cohort. The areas in which the least progress was made were housing (50%), engagement in pro-social activities (50%), and money and budgeting goal (33%). However, it is important to note that this may indicate that some areas are significantly more challenging to make progress in (e.g. economic or structural barriers to increasing income or improving housing situation), rather than necessarily implying a lesser commitment by clients or staff to the goal.

5.5 Summary

The analysis of client files indicates that clients who were supported by CARE made significant progress in relation to their alcohol use, with the majority of clients achieving abstinence and a significant amount maintaining abstinence as a result of their commitment and the support received through the CARE programme. In addition to serving their primary function of supporting adults in the community in relation to their alcohol use, the CARE team and partner organisations also supported clients to make progress in relation to a number of other areas in their lives including physical and mental health, illicit drug use, and relationships with family and children.

Chapter Six:

Professional Outcomes and Programme Structures

6 Professional Outcomes and Programme Structures

6.1 Overview

This chapter provides perspectives from multiple stakeholder groups on the effectiveness of the framework of support underpinning the CARE programme including policies and procedures, management support and governance and oversight. It also provides perspectives on structural issues such as programme accessibility, promotion and external communications. The second part of this chapter highlights two key outcomes identified by various professional groups that they have enjoyed as a result of engaging with or working in the CARE programme.

6.2 Terms Used to Describe Participants

Psycho-social workers: this refers to staff of FAST, North Dublin Community Care Team and Ballymun YAP who were involved in providing psycho-social supports to clients of CARE. There were 13 psycho-social worker participants in total.

Clinical workers: this refers to the two clinical nurse specialists who provided CARE services to clients. There were two clinical worker participants in total.

Manager: this refers to those in a management role involved in the programme and includes the CARE Coordinator, the Clinical Lead, managers of psycho-social support services and all who sat on the Steering Group in a strategic role. There were eight manager participants in total.

CARE Professionals: this is an umbrella term for all of the above professionals. There were 23 professional participants in total.

GPs: this refers to those GPs who completed surveys for the evaluation

6.3 Supporting Structures for the Programme

6.3.1 Policies and Procedures

Clinical and psycho social workers (n=15) were asked to indicate their level of agreement with a number of statements relating to policies and protocols, in order to understand the extent to which the existing framework supported them in their work[18]. Generally, both the clinical and the psycho-social support workers were confident about the policies that underpin their work with CARE and procedures in key risk areas:

- **Child protection and suicide:** There was almost unanimous agreement among all frontline workers that they knew what steps to take in the case of a client presenting with suicidal ideation, or in the case of a child protection concern. Only one person who answered questions in relation to these areas was not confident about how to manage a child protection concern in the context of CARE.

- **Induction and Policies:** 87% of people (n=13) agreed that there are a range of policies and procedures underpinning their work, and 73% (n=11) of people agreed that they understood the range of policies and procedures underpinning their work. Three people (25%) disagreed that they understood the range of policies underpinning their

[18] As well as bespoke policies and procedures, clinical staff in CARE used the HSE National and Addiction Service Policies, Procedures, Protocols and Guidelines and any new PPPGs developed by the CARE clinical team had to be signed off by the HSE Addiction Service Clinical Governance Committee.

work in CARE and two people (16%) disagreed that their induction adequately prepared them for their work in CARE.

6.3.2 Management Support for Front Line Staff

There was a strong perception of management support 87% (n=13) of front line workers (psycho-social and clinical) agreed that they feel adequately supported by their management to undertake their work. 93% (n=14) of front line workers felt that if there was something they were unsure how to do that was associated with CARE, there was someone they could ask. In the first case, two people neither agreed nor disagreed; one of the clinical team felt their time could have been managed better. In the second case, again one person neither agreed nor disagreed.

6.3.3 Resolution of Issues

A significant majority (93%, n=14) felt that if there was a problem with issues such as policies and procedures in CARE that they would know who to bring this to, only 58% (n=7) of psycho-social workers felt that if there was a problem with another professional in CARE that they would know who to bring this to (the clinical workers were confident in this area).

6.3.4 Governance and Oversight

It was generally accepted by all those respondents in a management/strategic role that the Steering Committee was highly effective, and crucial to the success of the project's development. This is illustrated in the following quote:

> *The Steering Committee was the helicopter view and look at the bigger picture. We established it and then provided oversight. Without the steering committee it wouldn't have happened.* Manager 2

A number of key factors in the success of this facet of the programme were identified by Steering Group members:

- Appropriate representation: that all professional and strategic groups with an interest in the project and role in its governance were a part of the Steering Group, including HSE addiction services (six people)
- Hard working: everybody who was a part of the Steering Group worked hard, undertook tasks between meetings and completed them (five people)
- Range of experience: that there was the requisite broad range of experience around the table to provide the needed knowledge and skills to develop and oversee the programme (four people)
- Focus on effective clinical governance: that there was a rigorous process for developing and having protocols approved, and that there were professionals of suitable capacity to take clinical leadership on the programme (three people)
- Enthusiasm: that all Steering Group members were enthusiastic about and committed to the programme (three people)
- Task Force administrative support: the policy and research officer from the Task Force facilitated the smooth and productive running of the steering group (three people)
- Shared vision for the programme: that all present in the Steering Group were committed to the same ultimate goal for the establishment and success of the programme (two people)
- Clarity in roles for each person on the group, commitment to issue resolution and a strong sense of teamwork (one person each)

The importance of the protocols is captured in the following quote:

> *The structures were great; the fact that the documents in relation to treatment pathway protocols were clear. The tools, assessments and time-frames were done, were clear, and well thought through and then it was implemented. People knew where they stood. It was all planned and structured very well. If people were contemplating community detox, there was a rigorous framework there. Even for people in pre-contemplation or people well passed detox, there was a response that was clear for them. The work to create that and the follow through on implementation was vital.* Manager 4

Some of the successes attributed to the Steering Group are highlighted by these quotes:

> *Having the research officer coordinating all of the meetings, gathering and collating research and all of the other information was huge. She would have taken on a lot of the work that otherwise would have fallen to the steering group.* Manager 3

> *It wasn't a talking shop, we were working and there were actions. We developed the treatment protocols and clinical governance. A lot of people put a lot of energy and time into it. Having a real, live steering group had a huge impact on the project.* Manager 4

6.3.5 Accessibility of Referral Process

Almost all clients agreed or strongly agreed that CARE was easy to access. 93% of GPs who reported referring to the Programme (n=15) said that CARE is accessible. 81% of GPs (n=13) said that the referral process is clear, however, 3 GPs rated this as neutral or poor.

> *So far the service has been able to offer help very promptly when a patient presents, catching an opportunity for intervention which is missed if there is a long delay. "Localness" of the services makes initial engagement easier for people.* GP3

One worker in a managerial role highlights here how being in a pilot phase, and having a skilled team supported accessibility of the programme:

> *We provided quick access: as we were a new service, we didn't have any waiting list. We'd get a referral from a GP and people were seen within a week. We'd encourage the GP to call from their office, we'd speak to them immediately and schedule an appointment, there was no back and forthing with letters. There were waiting lists in Ballymun and North County Dublin, but the clinical team could provide bridging support in the wait for psycho-social and get the clinical support – bloods and medical.* Manager 8

6.3.6 Programme Promotion

While considerable efforts were undertaken by the CARE team to promote the programme as highlighted in Chapter One, it is possible that this may not have been as effective as hoped. Almost one third of GPs (n=8, 29%) said that they had not referred to CARE because they did not know about the programme. The issue was also highlighted by a client who says they did not hear about the range of supports available. One psycho-social worker also felt that the lack of referrals from other services suggested that enough people did not know about it, despite a presumed widespread need for such a service.

6.4 Outcomes for CARE Professionals, GPs and Pharmacists

6.4.1 Improved Ability to Provide and/or Refer to Services Locally

85% of GPs (n=23)[19] felt that the CARE project is important or very important for supporting people with problematic alcohol use in their area and 94% (n=16)[20] of GPs who reported referring said that the availability of CARE had improved their capacity to support patients with alcohol use. Likewise, 92% psycho-social workers (n=12) agreed that *CARE has made working with alcohol users easier in our area or organisation* was very or somewhat true, while one person did not feel this was true. Likewise, all three pharmacists who responded to the survey noted that they had an improvement in their sense of professional confidence in providing services when working with CARE patients as opposed to other patients.

6.4.2 Improved Internal Skills or Capacity

Professionals from all groups; clinical, psycho-social and managerial, highlighted the importance of the learning they gained from the CARE project. 13 professional participants in interviews highlighted how their own knowledge and skills or that of their team had benefitted from the joint working approach including:

- Reflecting on and clarifying own approach, methods, tools and techniques
- Improved understanding of appropriate supports for alcohol users
- The learning from developing the two alcohol awareness Programmes and the motivational group support programme (Sober Skills)
- Conducting needs assessments and developing treatment plans
- Learning to use the Community Reinforcement Approach (CRA)

> *One of the staff was involved in alcohol awareness programme and we can now take that mode and run it, same with the motivational group. We can implement them quickly and easily. Coming up with it and designing it was very helpful.* Psycho-Social Worker 13

> *Yes it has enhanced my skills in relation to making individualised treatment plans and assessing needs in relation to motivation, preparation... Whatever point they came in, there was a way around it, and the way around it was always having a wraparound support... learning about the importance of continued psycho-social support and also a quick re-entry to medical support from us if they need it. It has opened my eyes up to see the importance of psycho-social and medical working together.* Clinical Worker 1

In surveys, 94% of GPs (n=16)[21] said that the availability of CARE had increased their knowledge or skills around alcohol, generally.

6.5 Summary

The CARE programme is a model provided in line with rigorously developed, evidence-informed protocols, the implementation of which is overseen by a robust statutory clinical governance structure, and a highly committed operational oversight group. Staff working in CARE feel they are strongly supported by their management, and are working with a range of effective and appropriate policies to support their work. Staff working in CARE are confident in how to manage high-risk issues in line with organisational policy. All professional groups consulted reported positive outcomes for their work including improved skills, knowledge or capacity of alcohol use and treatment, care planning and other relevant areas, as well as

[19] In total, 27 GPs responded to postal surveys. However, only 16 of these had had engagement with CARE and were asked additional questions, which explains the two different n= figures for GPs in this section
[20] 17 GPs responded to this question
[21] 17 GPs responded to this question

improved capacity to provide services or refer to appropriate services for people with alcohol difficulties.

There is a need to review and clarify a number of policy and procedural issues and ensure that the policy framework for the project reflects the day-to-day reality of the programme, and that all staff involved are clear on key issues such as criteria for referrals, and steps for managing concerns with other professionals involved in CARE. Generally, clients and GPs perceived the programme to be accessible, however, there is a need to review communication channels between CARE and GPs to ensure clarity on referral pathways and other communications. GPs and other stakeholders highlighted a need for more information about the programme to be available.

Chapter Seven:

Thematic Analysis: Programme Strengths and Challenges

7 Thematic Analysis: Programme Strengths and Challenges

7.1 Overview

This chapter presents a thematic analysis of the strengths and challenges of the CARE programme from the perspective of all stakeholder groups. This information was gathered from the interviews with professionals and clients, as well as surveys with psycho-social workers, GPs and pharmacists.

7.2 Programme Strengths

7.2.1 Professional Confidence in Programme Effectiveness

All professional respondents and clients felt that CARE was effective:

- Most clients scored their overall experience with CARE as an 8 or above out of 10, with one client scoring a 6. The average score was 9
- All clients interviewed agreed or strongly agreed that they would recommend the programme to a friend in similar circumstances to them
- 100% of psycho-social workers and clinical workers (n=15) agreed with the statement "*Clients I work with have made positive changes in their lives as a result of engaging with CARE"* and they identified a range of domains in which they observed improvements for their clients including alcohol use, family relationships, communication skills and improved mental health
- 100% of those who had an opinion on the impact on families, most likely to be those psycho-social staff who worked with family members, said the statement "*Care has had a positive impact on the lives of families of our clients'*
- 94% of GPs (n=15) said that CARE was effective in helping patients to reduce alcohol consumption and 86% of GPs (n=14) said that CARE was effective in helping patients to improve other outcomes
- 68% of GPs (n=11) said that patients had made significant positive changes in their lives as a result of working with CARE, and a further 13% (2 GPs) said that patients had made minor positive changes in their lives as a result of engaging with CARE

> *I'd tell them to keep up the good work and don't change anything basically. I know it's probably rare that they get thanked for the work they do - that's what I don't like, you get people that go behind the scenes to help people with addictions and they don't get recognised, they get no thanks for it. I'd be lost without the care and being looked after. Client 6*
>
> *This project has changed a lot of clients and their family lives that don't have the opportunity to go into residential.* Psycho-Social Worker 7
>
> *[A patient was] not drinking. Feeling more positive about the future and less isolated.* GP13

In addition to this, in interviews, three professional respondents highlighted the importance of CARE as a high-quality evidence-based service.

7.2.2 Promoting Effective Interagency Working in Pilot Communities

While most CARE professionals were modest in their measurement of the impact of CARE on interagency working with addiction and mental health services, 50% of GPs[22] (n=7) said there had been an improvement in their working relationships with psycho-social support services, 29% (n=4) said there had been an improvement with the addiction service and 14% (n=2) said there had been an improvement with the mental health service. Psycho social workers also noted improvements: 62% (n=8) with clients GPs, 59% (n=7) with other psycho-social support services, 46% (n=6) with HSE addiction services, and 33% (n=4) with HSE mental health.

In interviews, the majority of professionals who participated in interviews highlighted the positive impact the CARE programme had on interagency working between the CARE clinical team and partner sites, and between project partners and other organisations in the community. Sixteen professionals discussed this, highlighting issues such as:

- Improved capacity to provide specialised group support
- The significance of a cross Task Force initiative involving HSE addiction services
- Improved relationships with GPs in the community and shared working with them
- Being able to send clients to another discipline (e.g. from clinical to psycho-social) with continuity and shared care
- Psycho-social services across Task Force areas working together
- Lack of duplication of work
- Ability to manage waiting lists more effectively, meaning that the clinical CARE team could provide bridging support to people waiting for psycho-social support

The following quotes illustrate some of the ways in which interagency working was seen as a strength of this programme:

> *[Bringing the HSE Addiction Service and Community Services together] seemed like a very easy and amicable move ... it was almost too good to be true, the positive relationships. The support from the managers of the psycho-social support services was very important. They gave those from their services working on the psycho-social the leeway to establish that themselves. There seemed to be great relationships between the psycho-social services too. In terms of inter-agency working, it was a very positive experience all round.* Manager 5

> *The link between CARE and the other organisations is noticed by clients, which in turn makes the client feel cared for and supported through a variety of people.*
> Psycho-Social Worker 9

Interagency working was also seen as a benefit from the perspective of local pharmacists. All pharmacists reported improved communications with the clinical team and client's GPs where the patient was engaged in a CARE detox.

7.2.3 Providing Improved Community Detoxification

In interviews, ten of the professionals highlighted that an important development that arose from CARE was the improvement in the provision of alcohol community detoxification services in the area. Many who discussed it highlighted that prior to CARE, many clients and GPs were undertaking detoxes and struggling to do so effectively in the absence of structured support. Through CARE, both clients and GPs were provided with targeted, tailored clinical support to promote safer and more effective detox, as illustrated by the following quote:

> *The usual thing was that we would have tried to contact the GP with a letter or email of support and they would have engaged in a Librium detox. The most we could usually do*

[22] 14 GPs responded to this question

was see them once a week when they were on a Librium detox. They would try to lock themselves indoors for two weeks; that was the format of a detox plan. I don't think it was very successful for people we worked with. The fear of inability not to drink was so high, it was better to lock themselves away. Psycho-Social Worker 13

The role of the nurses in helping GPs and patients to identify appropriate treatment, detox or other, is illustrated in this quote:

The nurses' professionalism in communicating with the GPs had a big impact, for example for one particular person, the doctor had tried Librium detoxes with them a couple of times. [With CARE] the nurse and the doctor discussed the case, options etc. which resulted in better management of risk: that person ended up doing an inpatient as it wasn't safe for him. Manager 7

All clients who rated detox, rated it as good or very good, and as previously illustrated, there was a high rate of successful detox among the cohort of clients that undertook CARE detoxes:

They would ring up to see how I was doing. I found it brilliant because I couldn't do the detox on my own - I just kept going back out drinking when I tried at home on my own - I needed that support. Client 5

Two of the three pharmacists felt that providing detoxes under CARE had benefits compared to their previous experiences, noting improvements in compliance, appropriate dosing and their own capacity to monitor the detox. Two of the three pharmacists felt the risk associated with alcohol detoxification was better managed with CARE patients than with other non-CARE patients.

However, one worker felt it was important to highlight a concern with the detox model:

I didn't see as much preparation for detox as I thought there was... it was an earlier selling point of the programme. My sense is that there were a number of reasons, one being that the clients weren't at a stage where they were ready to prepare. Another reason why that may have happened was that, in order for someone to do a supervised detox, they would have needed to attend the service on a daily basis, it's really difficult to get that commitment. Psycho-Social Worker 3

7.2.4 Meeting Identified Need and Strategic Objectives

A number of professional respondents highlighted the need for this service in the pilot sites. Six people highlighted a general lack of alcohol support services both locally and nationally:

The first time we did the SAOR training, we developed a leaflet on signposting and realised that there were few realistic options; just residential support really. There was little available in the community that could be locally accessible, where people wouldn't have to get childcare, arrange for someone to mind their homes. Manager 6

Services available for people with alcohol issues are far behind what's available for drug users. It's a bit dated. Psycho-Social Worker 13

Limited resources available apart from AA which doesn't suit everyone GP14

Three people highlighted a lack of capacity amongst local GPs, who were generally perceived to be the only community based support for people with alcohol issues:

As things stand right now, general practice are all feeling very stressed and strained, and working harder for less money. Many doctors just don't go there with addiction; they feel they have limited knowledge and no resources to deal with those problems. When you work in general practice, having a counselling service available to work with your clients, it's very reassuring, to have that multi-disciplinary support system is wonderful. Manager 5

There was also an identified need for structured out-patient detox supports. Two people highlighted the poor practices that were prevalent, anecdotally, in outpatient or community detoxification, and one person highlighted the absence of dual diagnosis supports.

In terms of policy and strategy, those in a strategic or management role highlighted that addressing alcohol misuse and expanding the range of support services to include community based treatment was enshrined in each of the three pilot sites either in work plans or strategies, as well as in a number of national strategies including the Alcohol Strategy, the National Rehabilitation Framework, national standards for nursing, data collection and programme quality management, and in a recent review of HSE addiction services in the region.

7.2.5 Expanding Treatment Options to New Client Group

For many of the services involved in this programme, particularly the psycho-social services and the Task Forces, their client group had traditionally been primarily opiate users and users of other illicit substances. Although there has been a shift at strategy and policy level towards supporting alcohol users, and although many of the services had been providing support to poly-substance users including those with alcohol difficulties, for a number of professionals in this programme, the expansion of treatment services to a new cohort of service users was important. Four people named the positive development of an expanded client group as a result of CARE, as illustrated by this comment:

People who wouldn't have traditionally come into our service were coming through the door, through a more neutral route…. It allowed for that transitioning into an addiction service for those who might otherwise have been outside of it. Links happened into our service that wouldn't have otherwise happened. People that no addiction services were accessing, people that GPs were reluctant to engage with (e.g. opening a can of worms), were now receiving support. Manager 4

7.2.6 Providing Value for Money

Given the programmes' extensive reliance on existing resources in the community for the provision of psycho-social support, governance and oversight, it was felt by a number of professionals that the value for money aspect of the programme was a key strength. Five professionals highlighted this:

It was a cross task force initiative and given our lack of funding and resources, there was a clear benefit in collaborating with our partners on this initiative, and for the HSE, having 3 areas receive the service was a good way of increasing treatment numbers, and providing services in an area that didn't have them previously. Manager 3

7.2.7 Replicability of the Programme

All of those professionals (six people) who were invited to discuss the replicability of the programme felt that it is a replicable model:

I haven't seen anything so successful. If I had the resources in the morning I would have nurses out in all the communities to do this work. It's been fantastic. Manager 1

Yes, very much so. I think it could be replicated in any of the HSE areas, very easily. The protocols and structure are there to be used. As long as there are quality services to provide the psychosocial supports and an appropriate clinical governance structure in place. Manager 3

7.2.8 Specific Facets of the Programme

Clinical Support

All clients rated their support from the medical team as very good:

They are very helpful. They listen to people. I find them very good to deal with personally. Client 6

A participating GP also referred to the support provided to their patient following an inpatient detox;

One patient who had completed inpatient detox has done well as she has been well supported afterwards by CARE. GP4

This was also a facet of the service highly regarded by professional interview respondents; nine people discussed the importance and value of the clinical service highlighting issues such as:

- The professionalism of the clinical team
- Their cultural fit with the psycho-social services and how personable they were with clients and staff alike
- The importance of their role in enhancing the credibility of the service to local medical providers and to clients
- The importance of screening both in promoting client well-being and engaging clients in treatment
- The improvement their role brought to community detoxification
- Their expertise in mental health and dual diagnosis in the absence of such specialisations in the community

The involvement of the clinical nurse specialist(s), and not only that but the multi-disciplinary team. Having them on site was invaluable. Having the clinical nurse specialist come to that meeting, just for our mutual clients / potential referrals, there was no preciousness and it was very client focussed. This made communication easy, it enhanced client outcomes. Manager 2

Individual Psycho Social Supports

All clients in interview rated the support from their key worker as good or very good, and all of the frontline clinical staff likewise highlighted the value of the psycho-social partners in the provision of the CARE service, as illustrated in the following quotes:

The two guys I was dealing with were extremely good. I have to say the counsellor was a person that sort of showed an awful lot of interest, very professional - after a while you wouldn't see an hour and a half slipping in. He opened me up to a lot I didn't see. The other guy, the psychiatric nurse, was a really caring guy too. I have made professional friends - when I was in [residential service] the counsellor made it his business to come in and visit me …it was over and above the call of duty. Client 4

Provision of trained counselling and support to patients apart from AA. Very good service. GP13

They're brilliant. We had really good positive feedback from the clients about the psycho-social supports. We also felt that there was a quick feedback into us if someone needed our support after we had discharged them.
Clinical Worker 1

Alcohol Education and Information Sessions and Sobriety Skills Groups:

All clients who rated these groups, rated them as good or very good. Three professionals noted these groups as an important strength of the whole programme:

The motivational group in Finglas was great… after they had done their detox and were sober and wanted to stay sober. Feedback from that was fantastic. People really did like that. Clinical Worker 2

Aftercare and Onward Referral

All clients who rated aftercare, rated it as good or very good, and almost all client interviewees agreed or strongly agreed that at the end of their time with CARE, the staff helped them to find appropriate onward support:

They suggested I get inpatient care and how right they were. It was very good because they more or less laid it on the line that I wouldn't be able to do this myself - they supported me all the way. I didn't realise how bad they could see things that I couldn't see. There was always a one on one with the counsellor. I definitely want to get back there because the one on one skills are really good. Client 3

7.3 Programme Challenges

7.3.1 Time, Resources and Waiting Lists

The impact of a lack of appropriate resources for the project on clients and staff was a concern raised by nine professionals. The types of concerns relating to this referred to:

- The strain that trying to provide the service across three sites put on staff and clients
- A bottleneck in some psycho-social support services which meant that clients had to wait, or the clinical team had to provide bridging psycho social support, which in turn delayed their capacity to provide timely clinical support
- The considerable resources required for consistent promotion of the programme with GPs
- Not being able to run groups in all areas

The waiting lists in the different psycho-social support services… that's everywhere at the moment unfortunately. If you miss the window for working with someone with an addiction issue, you may miss it and they won't come back. Clinical Worker 2

This was reinforced by a participating GP;

It needs to be resourced so that there is not a long waiting list to access an appointment with CARE. GP5

Two clients highlighted the impact of either waiting lists or lack of clinical hours on the accessibility of the programme:

It should be more accessible, there should be more people trained up to help them with what they're doing. Client 6

Maybe have a permanent nurse or keyworker in our area - because sometimes I would have to wait for them to come back from one of the other two places they work in. Client 2

7.3.2 Data Collection and Information Management

Nine professionals representing clinical, psycho-social and managerial all highlighted a concern with data collection and information management in the programme. The types of concern included:

- The need to use pre and post measurement scales to measure outcomes in substance use, personal development and other relevant issues
- Delays or confusion on care plans and progress as a result of a lack of a suitable IT system
- Time wasted on hand writing notes for the clinical team
- Challenge in being able to effectively monitor the programme without access to accurate data on client progress

In terms of data collection, recording and outcome measurement in the future it would be useful to use TOPS (pre and post) and a client information system such as eCASS. There wasn't always clarity on the information collected centrally and what was happening in the projects. Manager 3

7.3.3 Communications

Concerns regarding communications were highlighted by six respondents from the managerial, clinical and psycho-social cohorts. The types of concerns included:

- Poorer communications in Ballymun compared to Finglas due to less effective structures and constrained resources as clinical site was not embedded in psychosocial service in Ballymun unlike other 2 sites
- Difficulty in contacting nurses when they were working in other pilot sites
- Lack of clarity and communication around referrals

There was also a concern highlighted regarding external communications by one professional person who noted:

There were some communication challenges; GPs were not always clear about the role we did. Clinical Worker 2

This concern was supported by surveys with GPs: while 69% said that the communications with the CARE clinical team was good or very good, over one quarter, 26% (n=4), rated this as neutral or poor.

Reports from CARE staff to GP on patients could improve GP6

7.3.4 Allocation of Resources for Coordination

While the role of the coordinator was generally felt to be of considerable importance to the programme, as highlighted previously there were significant concerns about the allocation of time and resources to front-line service provision. Four professionals identified a concern that resources were used for management tasks that in hindsight could have been distributed across existing or clinical roles, with the resources freed up to provide much-needed further nursing hours:

The most important facet of this service was the front line interventions provided by the CNS. There was great clinical supervision and support for the CNS via the HSE Assistant Director of Nursing and the GP. With the limited funding… [We could] refocus

management/coordination costs to increase direct frontline provision for service users. Manager 3

7.3.5 The Role of Psycho-Social Partners and their Staff

While there was considerable confidence about clinical protocols and interventions, there was concern about the role of psycho-social partners, the role of the key-worker, and the confusion in the distribution of psycho-social work across the CARE team and the psycho-social partners. Six professionals discussed a lack of clarity around the key working role:

> *On reflection having absolute clarity on key working role and what it entails would be useful as it was quite different across the three areas. I don't think it impacted on the client, but on the interagency working and communications.* Manager 8

> *The protocols were not strong enough on the keyworker role. You assume everyone is thinking the same as you and you figure out five months down the road that they're not. There were different ideas about what the psycho-social services were doing and what their commitment was.* Manager 2

Two of the respondents urged caution in being overly prescriptive about the key-working role, highlighting the importance of the availability of a variety of approaches for psycho-social work.

7.3.6 Lack of Clarity on Certain Programme Aspects

While there was general confidence in the policy suite underpinning the programme, six professionals discussed a lack of clarity around other aspects of the programme (as opposed to key-working highlighted previously). This included:

- Lack of clarity in referral pathways between the nurses and psycho-social projects
- Lack of clarity on certain language and tools used
- Lack of clarity on the timetable for roll-out (this particularly impacted on the team in North County Dublin)
- Lack of clarity in the organisation of the group programmes

> *There was a lack of clarity around it all. We didn't know the levels of risk for people we were referring in...There was no criteria laid out… I think there was a lot of confusion from the get-go and I don't know if that confusion ever fully left us... A little bit more consultation might have saved some confusion.*
> Psycho-Social Worker 3

> *We weren't clear about the best way for us to refer in and out of CARE. Not everyone needed CARE and we didn't have to send them round the houses if they didn't need CARE... I think I'm clear but I'm not sure how clear the rest of our team are and if they feel the same as me.* Psycho-Social Worker 12

7.3.7 Programme Instability

Five professionals highlighted the negative impact the lack of clarity around the future of the programme had on those involved in it:

> *It feels like we sold this project and now we're taking that away and that doesn't feel great.* Clinical Worker 2

> *It was a significant and fruitful intervention. From our perspective as a service, this is something that works. People were very disappointed when we felt it may not continue. The only negative impact is the ending of it… it has sapped energy if we feel it isn't*

going ahead. People are puzzled and disillusioned as to how something that works well could be pulled. Manager 4

One client also noted a concern with this:

You don't know if your care is going to continue as it's only a year project that they're hoping to extend. Client 3

7.3.8 Organisation of Nurses Time

While the lack of time and resources was clearly a concern, there was also a concern, expressed by four professionals, about the use of or organisation of nurses' time. In particular, it was felt that changing locations and being spread across three sites, and the travel requirements that go with this, was a poor use of the nurse's time:

The three locations, trying to manage appointments, travel was stressful. Because we were job sharing it was hard to get a handover between the two of us. We worked more than we were paid for to be in the project, but it didn't affect our other work, we did it after work in our own time. Clinical Worker 1

7.3.9 Organisation of the Roll Out

It was generally felt by those who discussed it that trying to launch a pilot programme in three different sites was ambitious, but in retrospect did have some negative consequences. Four professionals discussed the negative impact this had and mentioned issues such as:

- The withdrawal of resources from FAST, the original pilot site, and the impact this may have had on clients
- Promoting the programme in the other pilot sites, the subsequent delay, and then having to manage the expectations of clients and professionals in the absence of a programme
- The allocation of resources of North County Dublin to the development of a group that was never rolled out there

I am aware that the service only became available here much later than the other two areas, but I personally was reluctant to try to sell it to my clients on any level other that for screening and support. This is unfortunate. The NDRDTF region is vast and we are seeing a high level of alcohol related harm and individuals presenting for support without aggressively marketing our service. I believe that a project like CARE, adequately resourced and funded could provide solid outcomes for a large number of people, but each aspect of the service needs to be available. Psycho-Social Worker 1

7.3.10 Impact on Other Service Provision

While for the most part, professionals said that CARE did not have any negative impact on their work, two participants did highlight how they felt their client work had been impacted by engaging with CARE:

I lost a lot of time for client work when supporting the group. In one way it was beneficial for me, but it was taking me away from one-to-one work with clients. It probably had a bit of an impact on the team... both myself and a colleague were off working in new projects and left us down staff. You nearly feel a sense of being disloyal. Psycho-Social Worker 3.

7.3.11 Buy In

While most key agencies were very committed to the programme, two professionals noted concerns in getting buy-in. One person highlighted how it was a shame that the hospitals had not been successfully engaged as a referring partner:

It would have been good to have the general hospital involved, to have referrals from them, as we know they were discharging people from A&E with 5 day Librium detoxes. We did make an effort but it did not prove fruitful. Manager 6

Another professional highlighted that in some areas it was particularly challenging, political and resource intensive to engage GPs in the programme, and this was not successful in many cases.

7.4 Summary

The CARE programme is highly regarded, and perceived to be an effective support for people with alcohol difficulties by clients, professionals involved in the programme and partner professionals. The programme is in line with a range of local and national strategic goals in relation to community alcohol treatment. CARE has been successful in promoting effective interagency working relationships between clinical and psycho-social services, between community and statutory services, and across various health and social care disciplines. It is regarded has having improved the quality and effectiveness of outpatient alcohol detoxification in pilot sites, ensuring clients and GPs are supported to engage in safer, appropriate detoxification regimens. Diverse professional groups regard the CARE programme as having expanded the treatment catchment for existing services, engaging community members who had not previously engaged with treatment services. Drawing heavily on existing skills, services and resources, the CARE programme is considered by its stakeholders to be good value for money in alcohol treatment provision. Given the rigorous governance and policy framework, the strong evidence base and the value for money and use of existing resource, many stakeholders consider the CARE model to be replicable for other areas.

As is common with community health initiatives, it was felt that there were insufficient resources to cater to the needs of all who required the support of the programme and this was felt by clients, front line providers and those in management positions alike. It was also felt that the resources that were made available were stretched thinly across the three areas and this had an impact on communications between staff, and waiting lists for clients; many felt that time could have been managed better and resources more efficiently allocated to promote client access and outcomes. Although there were robust protocols and a strong policy suite underpinning the programme, there remained a number of areas where clarity was lacking, in particular around referrals and the role of psycho-social support workers and services. The circumstances surrounding the roll out, specifically the lack of clarity about the future of the programme, meant many front line workers could not be confident about the availability of various facets of CARE to their clients. Finally, many professionals agreed that in the future, the programme will benefit significantly from improved data collection systems supported by a suitable IT system.

Chapter Eight:

Recommendations

8 Chapter 8: Recommendations

Recommendation One: Continue the Programme and Pursue Funding to Continue and Expand Service Provision

This evaluation reveals a programme that is highly valued by all stakeholders, and considered to be an effective support for alcohol using clients. This programme should be continued with a robust evaluation plan to articulate clearly the programme's impact for clients, family members and professionals. In Ireland, alcohol users are a community that has remained largely underserved compared to those requiring opiate-focussed support. CARE provides an important service that was not previously available for community members experiencing alcohol difficulties, and facilitates GPs and psycho-social workers who support alcohol users to partner in the provision of care for their clients that is effective, comprehensive and well-coordinated. The model of interagency working at all levels in CARE, from front-line service provision to clinical and operational monitoring and oversight, has shown how the effective use of existing skills and resources in statutory and community and voluntary addiction services, combined with a ring-fenced investment in skilled psychiatric nurses, results in the provision of a tailored, effective community alcohol support programme to those who need it. CARE provides a vital service and fills a gap in the continuum of care for alcohol users, by providing out-patient, community based specialised support to those who do not required intensive in-patient addiction treatment. To ensure continuation and development of this service, the Steering Group should pursue additional funding to:

- Continue the provision of this service
- Improve psycho-social capacity through additional hours of psycho-social service provision to prevent the retention on waiting lists of clients motivated to change, and to prevent the use of clinical resources (nurse hours) for psycho-social service provision
- Extend clinical nurse specialist hours available in each site
- A core facet of the continuation of this service requires on-going GP and CNS hours. In line with the Review of Addiction Services in North Dublin (26), the Steering Group should negotiate with the HSE Addiction Service to provide GP and CNS supports for alcohol, as demonstrated to have worked effectively in this pilot.

Recommendation Two: Develop a Programme Manual

Building on rigorous work undertaken for the development of clinical protocols, develop a programme manual that outlines all facets of the service including:

- Vision, aims, model and approach
- Standards of training for professionals involved in service provision
- Supports provided to professionals involved in service provision
- Clinical governance standards and procedures
- Risk management
- Quality standards and procedures for non-clinical programme aspects
- Standards and procedures for interagency communications
- Outcomes and indicators for client progress
- Detailed guide to clinical and psycho-social service provision
- Information management and record keeping
- Referral pathways and criteria
- Programme promotion

This will support streamlined working within the existing programme, and support replicability for other Task Force / HSE areas considering replication.

Recommendation Three: Collect Pre and Post Measurements on Alcohol and Other Issues to Assess Change for Clients

To effectively assess changes occurring for clients through their engagement with CARE, collect measurements on alcohol use and other psycho-social domains at key points which may include initial engagement, mid-point, end of engagement and post-engagement. This will facilitate an understanding of areas where change is being affected and where it is not, which will inform improvement of supports to clients on an on-going basis, and establish the efficacy of the CARE programme. Outcomes measures and tools should be collaboratively developed with relevant stakeholders (e.g. staff and clients) and used to inform data collection systems (see following recommendation).

Recommendation Four: Review and Improve the Use of Information Technology (eCASS) to Support Monitoring and Reporting of Outcomes

To support outcomes measurement, monitoring of client progress, reporting on client progress, and generally to support improved information processes and interagency communications, review and improve the use of the existing client management system used by psycho-social partners (eCASS). This review and improvement should ensure that CARE professionals and psycho-social partners can record and share streamlined information on CARE clients in a way that is efficient, enables monitoring of progress and change, enables collation of reported information across sites and supports simple effective information management for the project. This means ensuring all systems are set up to record the same information and produce like reports, that all professionals are licensed to use the system (potentially for clinical nurse specialists to have access to the client management systems through psycho-social partner services), trained and supported to use it, and that programme policies and procedures reflect this.

Recommendation Five: Prioritise CARE Resources for Clinical Service Provision and Review Management Structures

There is duplication of management roles and potential for use of management resources for service provision. Review the existing coordinator role, potentially reallocating tasks and resources considering the following possibilities:

- Provision of Clinical Nurse Specialists with 1 nurse per site
- In line with HSE Addiction Service review, the allocation of a Clinical Lead for each area to support increased service provision/referrals as a result of increased CNS hours
- Allocation of Coordinator Responsibilities to CNS (clinical responsibilities), Task Forces (administration and operational line management duties) or other partner organisations

The Steering Group should review the Coordinator role and if choosing to remove this role, ensuring all responsibilities are reallocated appropriately across other roles.

Recommendation Six: Clarify Policies and Procedures in Relation to Key Working Role and Client Related Communications

CARE and partner organisations should review existing protocols and agreements to develop clear, written protocols that clarify the following issues in relation to Key Working, and in relation to communications between partner organisations (psycho-social service providers) and CARE (clinical service providers):

- What the key working role is, who undertakes it, what basic agreed minimum standards are in place for CARE psycho-social support
- How this role is distinct from and complementary to clinical role
- What information is collected at initial assessment and by whom (e.g. at first point of contact for a client who will be engaged with CARE)
- How this information is handed over and communicated when a second organisation is engaged in service provision to a client (e.g. from partner organisation to CARE or vice versa)
- What tools and templates are used to collect and share information on clients who receive CARE support, and agreed terminology for key facets of programme
- In what circumstances, how and when CARE and partner sites communicate with one another in relation to clients
- What the process is for interagency communication between CARE and partner sites where concerns arise in relation to service provision to a CARE clients
- How communication with third organisations (e.g. GP or other health/social care provider) is managed
- What the process is for addressing concerns with work being undertaken by another professional involved in CARE
- How and whether CARE clients are prioritised for service provision in psycho-social services
- What support is provided to CARE clients who are on waiting lists

In addition to this, in order to support improved client working, the option of having the clinical nurse specialists connected into certain structures in partner sites, as relevant and appropriate and in line with available resources, should be explored, including:

- Relevant sections of team/client management meetings
- Client management systems (see recommendation 1)

Recommendation Seven: Review and Develop Promotion of the Programme and Engagement of Key Partners

Implement a formalised, systematic promotion strategy for the programme with all relevant partners to ensure that consistent, regular and appropriate information is reaching relevant gatekeepers and service providers. The strategy should address key areas of responsibility for promotion with clinical partners, strategic partners and community based social and healthcare partners. In addition to this, the strategy should consider renewed efforts to engage key clinical partners such as local hospitals and GPs.

Recommendation Eight: Plan for Evaluation of Broader Impact and Economic Impact of the Programme

It is clear from the evaluation that not only did the programme have significant impact on clients, but that there is an unexplored impact on families and concerned persons, as well as documented positive impact on the work of GPs, pharmacists and psycho-social support services. In continuing this programme, the Steering Group should consider steps that can be taken at an early point to support data collection at a later point for a wider impact and economic evaluation of the programme, including initial data from family members and professionals involved with or affected by the programme.

Chapter Nine:

References

9 References

1. National Clinical Programmes Model of Care Development Checklist Governance for Quality and Safety [Internet]. [cited 2015 Jul 28]. Available from: http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Clinical_Governance/CG_docs/NCPchecklistclgov.html
2. Meyers RJ, Villanueva M, Smith JE. The Community Reinforcement Approach: History and New Directions. J Cogn Psychother. 2005 Jul 1;19(3):247–60.
3. Long J, Mongan D. Alcohol consumption in Ireland 2013: analysis of a national alcohol diary survey. Health Res Board Dublin. 2014;
4. Alcohol Action Ireland. Alcohol Treatment Systems and Services. Position Paper. Alcohol Action Ireland; 2007.
5. Joint Committee on Health and Children. Report on the Misuse of Alcohol and Other Drugs. Dublin. :2012.
6. World Health Organisation. European Status Report on Alcohol and Health. WHO Cph. 2010;
7. Special Eurobarometer 331. EU citizens' attitudes towards alcohol. Eur Comm. 2010;
8. Ramstedt M, Hope A. The Irish drinking habits of 2002: drinking and drink-related harm in a comparative European comparative perspective. J Subst Use. 2005;10(5):273–83.
9. Health Research Board. Treated problem alcohol use in Ireland: figures for 2013 from the National Drug Treatment Reporting System. 2015.
10. Burns M. Alcohol: A Key Public Health Issue. Work Notes. 2009;60:18–24.
11. Mongan D, Reynolds S, Fanagan S, Long J. Health-related consequences of problem alcohol use. Overv 6 Dublin Health Res Board. 2007;
12. Foster T. Dying for a drink. Global suicide prevention should focus more on alcohol use disorders. Br Med J. 2001;323:817–8.
13. Mental Health Foundation. Cheers? Understanding the relationship between alcohol and mental health. Ment Health Found. 2006;
14. Junghanns K, Horbach R, Ehrenthal D, Blank S, Backhaus J. Chronic and high alcohol consumption has a negative impact on sleep and sleep-associated consolidation of declarative memory. Alcohol Clin Exp Res. 2009;33(5):893–7.
15. Griffin E, Arensman E, Corcoran P, Wall A, Williamson E, Perry I. National Registry of Deliberate Self Harm Annual Report 2013. Cork: National Suicide Research Foundation.; 2014.
16. Bedford D, O'Farrell A, Howell F. Blood alcohol levels in persons who died from accidents and suicide. Ir Med J. 2006;99(3):80–3.
17. Alcohol Harm to Others in Ireland [Internet]. [cited 2015 Feb 10]. Available from: http://www.hse.ie/eng/services/Publications/topics/alcohol/ah2o.html
18. Horgan J. Parental Substance Misuse: Addressing its Impact on Children. A Review of the Literature. National Advisory Committee on Drugs; 2011.
19. Owens S. What do we know about parenting? A review of the findings from Growing Up in Ireland and the Prevention and Early Intervention Initiative. Department of Children and Health; 2013.
20. Hope A, Butler S. Changes in consumption and harms, yet little policy progress. Trends in alcohol consumption, harms and policy: Ireland 1990 – 2010. Nord Stud Alcohol Drugs. 2010;5:479–96.
21. Butler S. Obstacles to the Implementation of an Integrated National Alcohol Policy in Ireland: Nannies, Neo-Liberals and Joined-Up Government. J Soc Policy. 2009;38(2):343–59.
22. O'Keefe C. Coalition criticised for lack of alcohol action. Irish Examiner. 2015 Apr 28;
23. Mongan D. Steering Group launches report on a national substance misuse strategy. Drugnet Irel. 2012;41:1–2.
24. Department of Heaalth. Steering Group Report on a National Substance Misuse Strategy. Department of Health; 2012.
25. Finglas Cabra Local Drugs Task Force. Reducing Alcohol Related Harm in Finglas and Cabra in 2014: A Community Mobilisation Strategy. Dublin; 2014.
26. Pilling S, Hardy R. Review of the Dublin North City and County Addiction Service. Dublin: PIRC/UCL;
27. Royal College of Physicians. RCPI Policy Group on Alcohol; Reducing Alcohol Health Harm Policy Statement. Dublin: Royal College of Physicians; 2013.

28. Alcohol Forum | National Community Action on Alcohol Project [Internet]. [cited 2015 Sep 1]. Available from: http://af.mannadev.com/national-community-action-on-alcohol-project/
29. Turas Counselling » Community Alcohol Detox [Internet]. [cited 2015 Sep 1]. Available from: http://www.d1225600-55736.cp.blacknight.com/how-we-can-help/community-alcohol-detox/
30. Dermody A, Gardner C. Choose to Change: Addiction Response Crumlin Alcohol Reduction Programme Evaluation. Dublin: Addiction Response Crumlin; 2014.
31. Byrne S. Costs to Society of Problem Alcohol use in Ireland. Dublin HSE. 2010;
32. Substance Abuse and Mental Health Services Administration (SAMHSA). Detoxification and Substance Abuse Treatment: A Treatment Improvement Protocol (TIP) Series, No. 45. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006.
33. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence | Guidance and guidelines | NICE [Internet]. [cited 2015 Feb 10]. Available from: http://www.nice.org.uk/guidance/cg115
34. Department of Health (UK). Models of Care for Alcohol Misusers (MoCAM). www.dh.gov.uk/publications. 2006;
35. Raistrick D. Managment of Alcohol Detoxification in Day E (ed). Clin Top Addict R Coll Psychiatr Lond. 2007;
36. NICE Pathways. Alcohol-use disorders pathway; Assisted alcohol withdrawal. National Intitute for Health and Care Excellence; 2015.
37. Raistrick D. "Management of Alcohol Detox" Clinical Topics in Addiction: Updates from Advances in Psychiatric Treatment Treatment by Ed Day. 2007 Aug 1;
38. Team UR. Cost effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). BMJ. 2005 Sep 8;331(7516):544.
39. Solberg LI, Maciosek MV, Edwards NM. Primary Care Intervention to Reduce Alcohol Misuse: Ranking Its Health Impact and Cost Effectiveness. Am J Prev Med. 2008 Feb;34(2):143–52.e3.
40. Ashley OS, Marsden ME, Brady TM. Effectiveness Of Substance Abuse Treatment Programming For Women: A Review. Am J Drug Alcohol Abuse. 2003 Jan 1;29(1):19–53.
41. Copeland J. A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours. J Subst Abuse Treat. 1997 Mar;14(2):183–90.
42. Morgenstern J, Longabaugh R. Cognitive–behavioral treatment for alcohol dependence: A review of evidence for its hypothesized mechanisms of action. Addiction. 2000;95(10):1475–90.
43. Balldin J, Berglund M, Borg S, Månsson M, Bendtsen P, Franck J, et al. A 6-months controlled naltrexone study: Combined effect cognitive behavioural therapy in outpatient treatment of alcohol dependence. Alcohol Clin Exp Res. 2003;27(7):1142–9.
44. Irvin JE, Bowers CA, Dunn ME, Wang MC. Efficacy of relapse prevention: a meta-analytic review. J Consult Clin Psychol. 1999;67(4):563.
45. Meyers RJ, Roozen HG, Smith JE. The community reinforcement approach: An update of the evidence. Alcohol Res Health. 2011;33(4):380.
46. Azrin N. Improvements in the community-reinforcement approach to alcoholism. Behav Res Ther. 1976;14(5):339–48.
47. Hunt GM, Azrin NH. A community-reinforcement approach to alcoholism. Behav Res Ther. 1973 Feb;11(1):91–104.
48. Miller WR, Meyers RJ, Hiller-Sturmhofel S. The community-reinforcement approach. Alcohol Res Health. 1999;23(2):116–21.
49. Klimas J, Field C-A, Cullen W, O'Gorman C, Glynn LG, Keenan E, et al. Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users: Cochrane review. Drug Alcohol Depend. 2014;(140):e106.
50. Holden J, Tatham D, Wooff E. Delay pattern analysis of 368 patients with alcohol problems in one general practice. Eur J Gen Pract. 2007;13(2):55–9.
51. King R, Roche E. The Management of Alcohol Abuse by GPs [Internet]. Irish College of General Practitioners; 2010. Available from: https://www.icgp.ie/assets/56/B15A6513-19B9-E185-83692E370EF9FA6B_document/Alcohol_27.pdf
52. Byrne H. The role of mental health service (psychiatrists) and primary care services (GPs) in their treatment of dual diagnosis: a comparative study. [Internet] [ma]. Dublin Business School; 2006 [cited 2015 Sep 1]. Available from: http://www.drugsandalcohol.ie/4403/
53. Klimas J, Cullen W, Field C-A, Problem Alcohol/Drug Use Guideline Development Group. Problem alcohol use among problem drug users: development and content of clinical guidelines for general practice. Ir J Med Sci. 2014;183(1):89–101.

54. Klimas J, Lally K, Murphy L, Crowley L, Anderson R, Meagher D, et al. Development and process evaluation of an educational intervention to support primary care of problem alcohol among drug users. Drugs Alcohol Today. 2014;14(2):76–86.
55. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. The alcohol use disorders identification test. Guidel Use Prim Care. 2001;2.
56. Health Research Board. Treated problem alcohol use in Ireland: figures for 2013 from the National Drug Treatment Reporting System. 2015.
57. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. The alcohol use disorders identification test. Guidel Use Prim Care. 2001;2.

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