DAFS is a dedicated service to assist those affected by a loved ones problematic drug or alcohol use. Operating in the 5 counties of Gwent, South Wales, it has been developing integrated treatment pathways for concerned others and piloting new data collection systems. This interim report reviews progress to date in these two key areas.

A Review of Outcomes in DAFS

Outcomes of concerned others in an integrated treatment pathway.

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Contents

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The outcomes in this report are wholly reflective of the commitment and professionalism of the team. Not only do they show a deep attention to the clinical approach to their clients, but their continued openness to the evolution of their service is rare and striking. Recognition must go to Karon Edkins for her original work and to the Service Manager, Mike Blanche, for not only creating a vital service but for working so hard in its furtherance. We remain indebted to the commissioning teams across Gwent-including Newport, Caerphilly, Blaenau Gwent, Torfaen and Monmouthshire for their continued financial support. They were courageous in backing an innovative approach and have continued to support the work of the project for which we are deeply grateful.

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Introduction

Drug Alcohol Family Support (DAFS) is a dedicated service that offers assistance to those affected by a loved one's drug or alcohol use, which operates across the five counties of Gwent. This geographical area covers a wide range of urban and rural communities as well as exhibiting significant regional variance in poverty and affluence. Historically the DAFS service offered generic counselling and a mutual aid support group to those affected by a loved one's problematic drug or alcohol use. In 2004 it was the host site for the initial feasibility trial of the Parents and Carers Training (PACT) programme. This was a skills based treatment approach that synthesised key findings from a number of treatment models for concerned others. The original PACT programme was twelve weeks in length and offered concerned others the opportunity to:

- Get an unmotivated loved one into treatment
- Support a loved one in treatment
- Reduce the stress on the concerned other
- Improve the quality of life of the concerned others

The initial feasibility trial of PACT involved one worker who held a case load of PACT clients and counselling clients. In the PACT arm, 100 per cent of concerned others were successful in motivating the loved one into treatment compared to 20 per cent in the counselling service. These promising results has led to the implementation of the PACT programme as a distinct treatment intervention within DAFS ever since. This allowed for greater experience in applying the programme and the development of the approach. The DAFS team contributed extensively to a review of the PACT modality in 2008-2009, culminating in the publication of a revised clinical manual in 2010. In 2009, a partial Service Level Agreement was formalised for the DAFS service across the five counties of Gwent which lead to a review of its current services and structure. This report outlines the progress that has been made in implementing these changes during this period and the resulting clinical outcomes.

Changes to the PACT treatment modality, as well as the integrated treatment pathway, has meant that DAFS have undertaken a significant period of transition in the last 12 months. This has included the development of both a specialised integrated treatment pathway specifically for concerned others and new data collection systems. The new integrated treatment pathway was developed in April 2010 in order to create a treatment system that was able to capture not only the hopes and aspirations of concerned others but one that reflected their clinical journey. In order to achieve this, the treatment pathway was shaped by feedback and the *in vivo* experience of concerned others. This 'outcome informed' approach differs from evidenced based models of practice. Evidence based models require the testing of treatment modalities in randomised control trials in highly manualised approaches. The challenge for organisations is to then replicate these treatment modalities to a very high fidelity in everyday treatment settings. In comparison, an outcome informed approach reviews each client's treatment response and identifies patterns in outcome. Where patterns are detected, treatment programmes can evolve to address any identified weaknesses to achieve optimum outcomes in everyday settings. As such, the outcome informed approach reviews feedback and the reported experiences of concerned others in the treatment system and analysed

specific patterns of client's responsiveness. Based on this information, it was a hoped that a pathway could be designed that accounted for the natural journey of concerned others in treatment rather than imposing a treatment structure upon them.

In parallel to this, new data collection systems were implemented to measure the impact of these changes and the outcomes of the service. This was particularly important because the evolution of an outcome informed treatment structure relies heavily on accurate data, particularly in regards to treatment responsiveness. The findings outlined in this paper spans this transition of services and trials of new data collection systems that informs this but with a caveat. Initially a new paper based data collection system was devised to capture core data, but in practice, this had limitations. This led to the development of a bespoke IT solution that is currently being refined. As a result, the time frames differ in some of the samples as data is drawn from the initial trial period when the paper system was used and the later IT data collection. Time periods are stated throughout and can be considered at this stage as 'sampling periods' rather than a complete data set. These sampling periods are therefore reflective of data collection system used and have not been selected for any other reason.

Integrated Treatment System

The implementation of a new integrated treatment pathway has expanded the range of treatment options at DAFS. Previously, concerned others had set treatment options. This included an un-facilitated peer-led mutual aid group, structured counselling or the 12 week PACT programme. Whilst triage assessments were used, there was no comprehensive assessment. This meant that concerned others' wider needs would not necessarily be identified at the outset of treatment. Furthermore, consistent feedback from clients suggested:

- Many clients did not want structured one-to-one or group interventions but preferred briefer contact. These clients ended up in the counselling service but dropped out having achieved what they wanted. However, this looked like non-treatment completion in clinical outcomes.

- Some concerned others did not want to complete the entire PACT programme. Whilst they found elements of the programme useful, some of the goals of PACT did not feel relevant for them. Once they had achieved their goals they may have prematurely exited the service. Again, this looked as if they have not completed treatment when they were satisfied that their own personal goals were achieved.

- A small minority of clients lives were chaotic or the concerned other experienced additional levels of complexity such as mental health problems. These concerned others' lives were more unmanageable at presentation making it less likely that they were able to benefit from structure interventions until their own lives were stabilised. This suggested a case management model may be more appropriate for them.

To account for this feedback, significant changes were introduced to the treatment system in order to address these challenges. The entry point into treatment would

always occur through a Brief Intervention service that would offer 1-3 sessions, including triage. For those wishing to enter into structured treatment options, a concerned other specific comprehensive assessment tool was also introduced. The PACT programme was restructured into a menu of options. This would allow concerned others to select their treatment goals from the four options of PACT and focus on those most relevant for them. Case management was to be included for clients who needed more general assistance than PACT or counselling could offer. The mutual aid group was maintained unchanged for the concerned others that wanted peer support. (Data is not currently collected on the mutual aid programme.) The new treatment pathway was implemented in June 2010 (see figure 1).

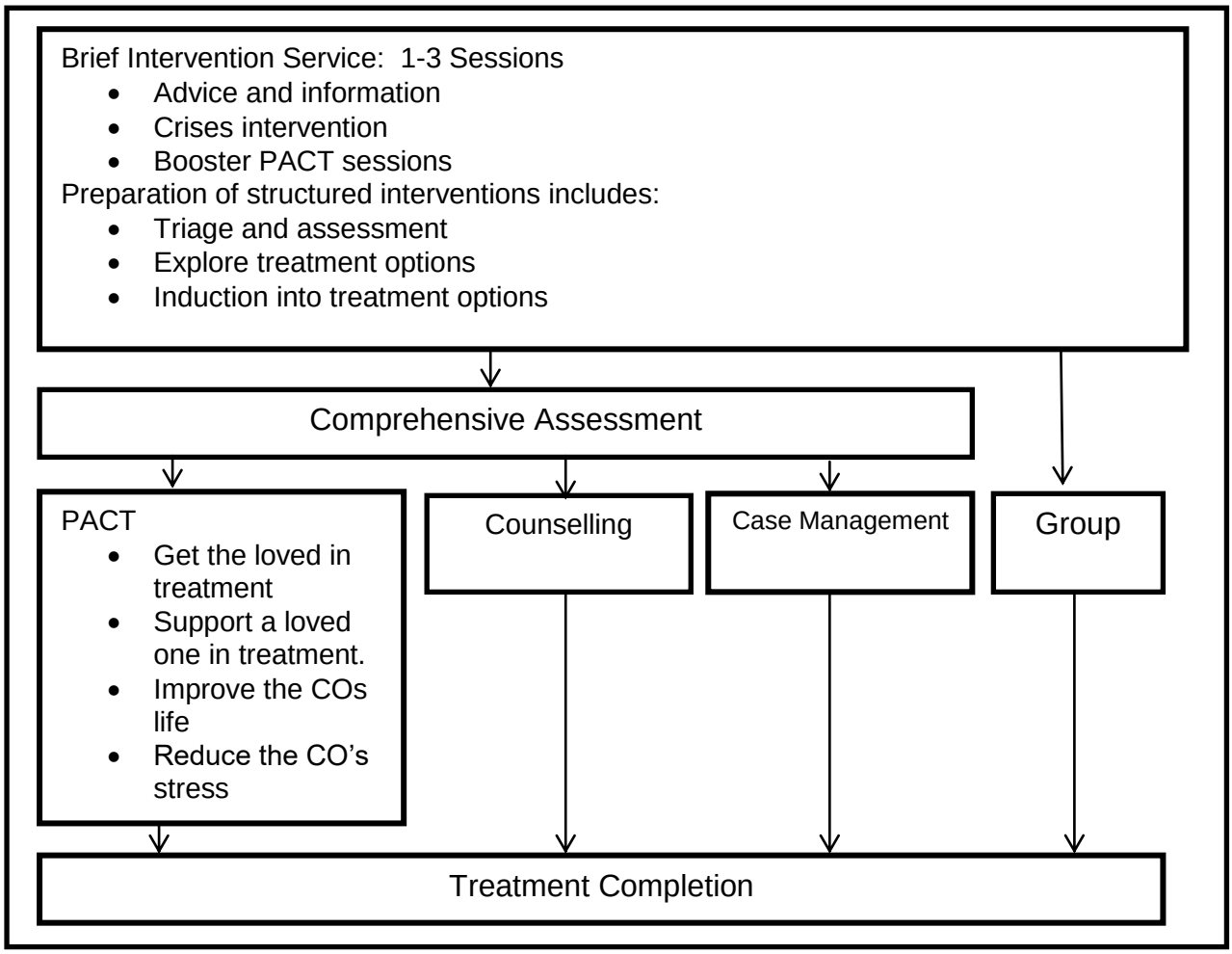


Figure 1: Integrated Treatment Pathways for Concerned Others

Brief Interventions

The first significant change to the DAFS treatment pathway was the inclusion of a Brief Intervention service. This would offer concerned others 1-3 sessions to consider their own needs and review the treatment options available to them. The brief interventions service would offer:

- Triage and assessment
- Explore treatment options
- Induction into treatment options

It was also recognised that many concerned others wanted advice and support without necessarily entering into structured support for themselves. Therefore, besides preparation for treatment entry, the Brief Intervention service would also provide time-limited interventions. It was anticipated that some concerned others may be seeking:

- Advice and information
- Crises intervention
- Booster PACT sessions

Staff would monitor whether concerned others presented with any other needs within the Brief Intervention service to review whether its scope needed to be widened. Currently, no wider aspirations have been reported for the service.

Between the 1st of July 2010 and 31st December 2010, DAFS offered 110 Brief Interventions to concerned others. The majority of these Brief Interventions were for information and advice. A total of 90 concerned others sought this guidance with 22 of these individuals subsequently seeking structured treatment. A further 14 clients sought assistance with crises intervention. Despite the crises prompting them to seek professional help, only 3 of these clients subsequently entered into structured treatment. Finally, 4 clients sought assistance with booster sessions. The low re-uptake of booster sessions suggests that the skills of the PACT programme appear to be acquired and maintained post treatment.

The introduction of the Brief Intervention sessions suggests that a significant number of clients have found the assistance that they required within these 1-3 sessions. This is reflected in the Failed to Attend (FTA) rates. The FTA rate for their initial Brief Intervention sessions is 34.5 per cent. This figure accords with general research findings that 65 per cent attendance is a good clinical average. The FTA rate for those who attended their first appointment in the Brief Interventions service is low (under 5 per cent). This suggests that the interventions are meeting the needs of concerned others in a very short time frame. The vast majority of concerned others achieved their goals in the Brief Intervention service without recourse to structured treatment. Whilst the initial FTA rate of 34.5 per cent is comparable to other services, this may be a suitable target to lower with promotional literature which is currently under development.

Comprehensive Assessment

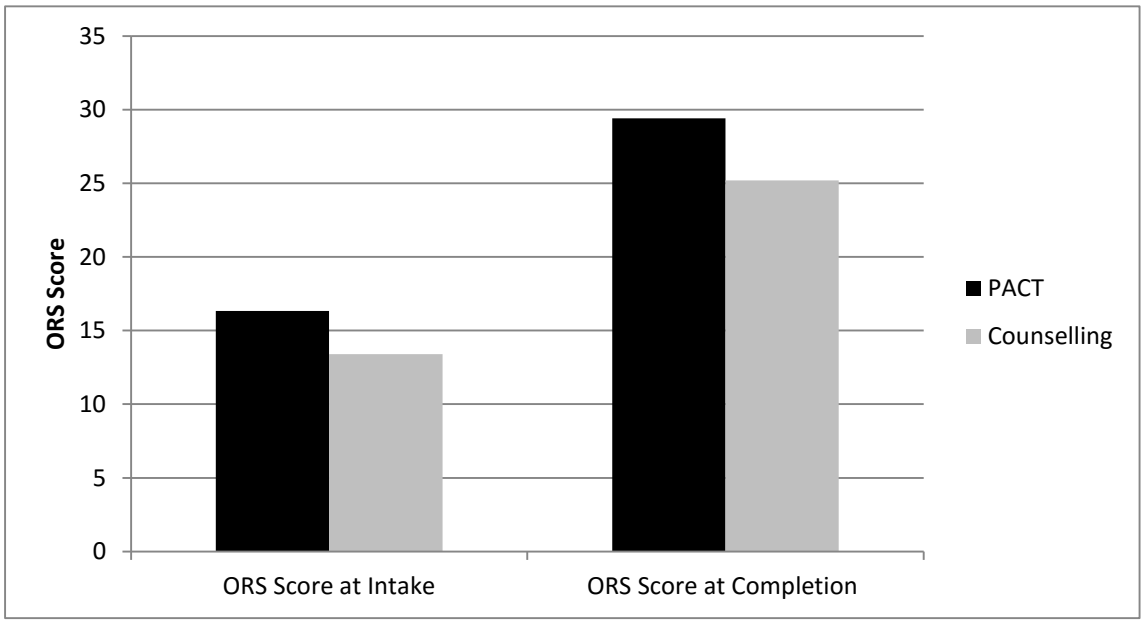
The comprehensive assessment has been introduced to all clients who enter into structure treatment options and has achieved 100 per cent coverage. Initially, the staff team raised concern regarding the length of time it took to conduct the assessment. Comprehensive assessments of concerned others are challenging as the needs of two individuals are being assessed: the concerned other and the loved one. The team spent considerable time reviewing the comprehensive assessment and its application. It was agreed that it would not be conducted in the first Brief Intervention session which would be used to allow the concerned other to tell their story and ventilate their stress regarding their situation. This then allowed for greater focus on the assessment process in a subsequent session. As staff increased in

confidence in using the tool, assessment times have diminished considerably, with many being completed in under 1 hour.

One key finding in the application of the comprehensive assessment tool is the relevance of assessing dependency in the loved one. The comprehensive assessment tool triangulates key features of the loved ones consumption that include 'substance,' 'pattern of consumption' and 'key symptoms of dependence' in order to gauge the severity of the drug or alcohol problem. Interestingly, the team's assessments show that there is a very strong relationship between these three variables when assessing depressant substances such as alcohol and opiates but it is not strong for other substances such as cannabis and cocaine. This is exactly what would be expected as physical dependence tends to be limited to depressant drugs. This offers a high degree of confidence that the comprehensive assessment tool is able to accurately detect severity of problem use in a loved one.

Structured Interventions

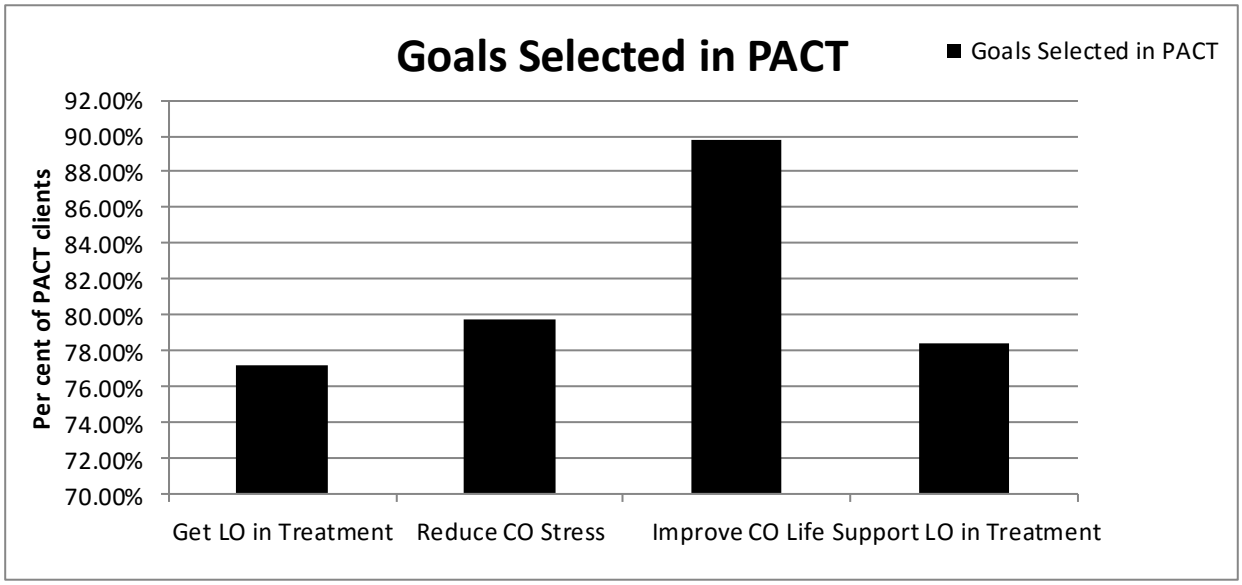
During the period 1st July -31st December 2010, the numbers in structured treatment were 114. The rate of take up for the PACT service was slightly higher with 63 clients and 51 clients entering into structured counselling. The FTA results were similar across the board, with a rate of 3.1 per cent in PACT and 5.5 per cent in counselling. Clinically validated outcome tools were also adopted to measure change.



Graph 1: Average intake and completion scores for ORS amongst treatment completers (1st July 2010-1st March 2011) n=114

Further adaptions to the PACT programme have included the 12 week programme being sub-divided into a menu-style approach, where clients can select treatment goals that are most relevant to them. The PACT goals have been separated and can be delivered in a menu style. Clients may select which options may be most appropriate for them. Reviewing these changes amongst the PACT clients in treatment from the 1st July -31st December 2010, 69 per cent of them chose all four

treatment goals of PACT. In comparison, only 12.6 per cent chose one single treatment goal. This suggests that menu approach is not relevant to all concerned others but has proved useful to a smaller minority of concerned others. Overall, 'Improving Their Own Life' appears to be specifically important to concerned others (see graph 2). The latest feedback from concerned others and the staff team is that Planned Termination (the concerned other wishes to separate from the problem user) is increasingly a goal sought by concerned others at the outset of treatment and should be included as an additional PACT treatment goal.



Graph 2: Per Cent of CO Requesting Specific PACT Goals (1st July 2010-1st March 2011)

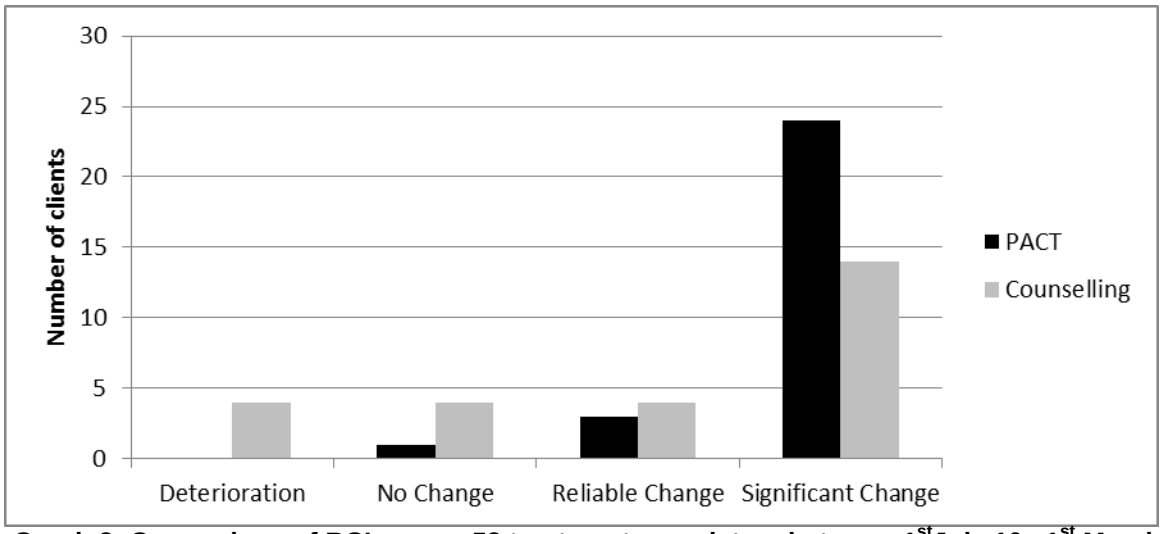
Outcomes

Outcome data is available for the time period 1st July 2010-1st March 2011. Data is only calculated on individuals on completion of treatment as the final ORS score is necessary to establish the significance of the changes that have occurred. The number of concerned others completing the PACT programme during this time is 28. The number completing counselling during the same time frame was 25. In collecting outcome data it is important to recognise that the individual scores are not the whole picture, rather it is the significance of the client scores. For example, how does a client scoring very low on an outcome measure who makes some improvement in treatment compare with a client who scores in a mid-range at treatment entry who subsequently makes substantial benefit? The significance of change is what is important and this is identified using a Reliability Change Indication. This calculates whether a client experiences:

- **Deterioration:** The client has worsened during their treatment.
- **No Change (Null Hypothesis):** The client experiences no change in their treatment – some clients may show some sign of improvement but this may be natural remission.
- **Reliable Change:** The client has improved and this improvement can be attributed to the treatment that they have received.

- **Clinically Significant Change:** The client has experienced the highest level of change and their social functioning is akin to those that do not require professional help.

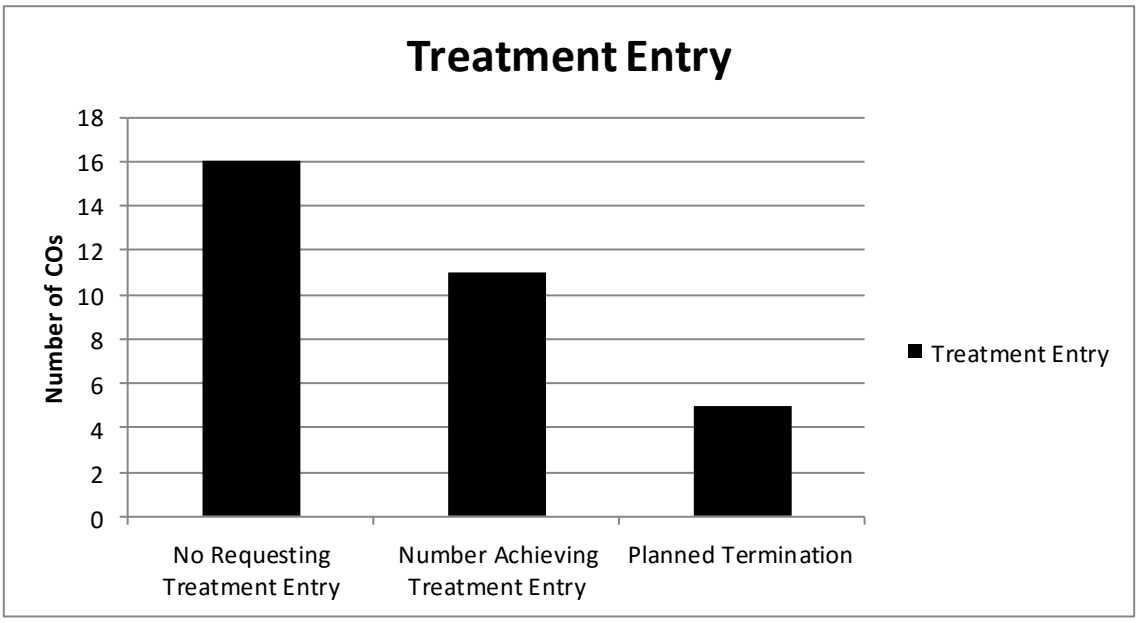
Conducting the Reliability Change Indication on ORS scores of concerned others in treatment show a higher range of outcomes for PACT clients compared to those in counselling. Not only did PACT clients fair better in treatment, they were also less likely to deteriorate or experience no change than those in counselling (see graph 3). In the PACT client cohort, 85.7 per cent of concerned others achieved clinically significant levels of change: the highest possible rate of change in treatment. In comparison, 56 per cent of clients in counselling achieved the same range.



Graph 3: Comparison of RCI scores 53 treatment completers between 1st July 10 –1st March 11

PACT clients n=28 Counselling n=25

PACT has additional goals other than the improvement in the concerned others life. Namely, assisting the concerned other to motivate an unmotivated loved one into treatment. Not all concerned others request this as a treatment goal in PACT. Amongst the 16 clients requesting treatment entry as a goal during the period 1st July-31st Dec 2010, 11 subsequently got their loved one into treatment (68 per cent) (see graph 4). This is in comparison to 3 loved ones entering treatment in counselling (21 per cent). In addition, 7 concerned others amongst the PACT treatment completers were successful in separating from the loved one in comparison to the counselling arm were 5 concerned others terminated their relationship.



Graph 4: COs Requesting Treatment Entry in PACT (n=16) 1st July 2010-31st Dec 2010

Recommendations

Considering the progress that has been made to date, a number of areas require more attention in the continuing development of the service.

- The IT system does require further refinement with RCI scores appearing to be miscalculated in some cases. The excel spread sheet should be replaced with a data-base system. The organisation should be in position soon to report on whole treatment population.

- Case management take up needs to be reviewed in order access the benefits of this system over time.

- CES-D Depression Scale scores have been under used and should offer more clarity in service over time.

- Pre-treatment literature could be further developed in an attempt to reduce initial FTA's.

- Peer support group has not been reviewed in detail and could be developed further.

Conclusion

DAFS have made significant advances in their own treatment provision in the last 12 months as well as having advanced models of practice with those affected by a loved one's use as a whole. These organisational structures have been seen as a model of good practice and have been implemented across other counties in England. The brief intervention service has been very successful in offering a lower tier of support for concerned others as well as operating as an effective gateway to structured interventions. The high outcomes in structured treatment may be a

product of better filtration, with concerned others having the time to make informed decisions regarding the most appropriate treatment pathway for themselves. The overall outcomes are very high for both PACT and counselling with PACT showing an advantage. Differences in initial ORS baseline scores might suggest that concerned others with higher support needs may be opting for counselling as opposed to PACT. Greater utilisation of CES-D Depression Scale scores in future analysis may or may not support this finding. Alongside the development of an integrated treatment pathway, improved data collection has revealed the impact of these services on those seeking help who consistently show significant gains from this service. The menu options of the PACT programme has also proved very helpful for a smaller minority of clients whose treatment requirements are narrower in range. In conclusion, the DAFS service not only provides an important service to an under-served treatment population but also does this with a very high degree of therapeutic success.