Evidence Briefing 2: Key Themes

This briefing provides detail on the ten key themes which underpin the successful delivery of alcohol and drug preventative approaches outlined in subsequent evidence briefings in the GGC Alcohol and Drug Prevention Framework. These themes can be considered when developing, implementing and monitoring all alcohol and drug prevention initiatives and services.

Reducing stigma	Asset-based and person-led approaches
Workforce development	Evidence-informed
Harm reduction	Whole systems approach and person-centred
Multiple risks and how they interact	Trauma Informed Practice
Health inequalities and deprivation	Community empowerment

Reducing stigma

Stigma encompasses negative stereotypes which lead to individuals or groups being marginalised or discriminated against[1]. Sentiments of shame and disapproval can surround alcohol and drug use across society.

It has been found that when compared with people suffering from **substance-unrelated** mental health issues, alcohol-dependent persons are[2]:

- Less frequently regarded as mentally ill
- Held much more responsible for their condition
- Provoke more social rejection and more negative emotions
- Are at particular risk for structural discrimination.

Stigma is harmful in that it can create **barriers for individuals to access support, advice and treatment** in relation to alcohol and drugs. Certain groups can be more likely to experience stigma in relation to alcohol and drug use. For example, there is overall less acceptance of women's drinking, and women who drink are "more likely to be portrayed negatively compared to men"[3].

In addition, individuals can experience stigma in relation to alcohol and drugs when **applying for jobs**. Although employers are willing to consider supporting existing staff who develop addictions, "they are much less willing to recruit people with an existing history of dependence"[4].

The reduction of stigma should underpin all approaches to alcohol and drug prevention. This can include[5]:

- Improving understanding amongst the general public about dependency and recovery to reduce fear and blame
- Workforce training and development to improve service responses for those who are accessing support
- Addressing the legislative and administrative barriers which reinforce stigmatisation such as unlawful Criminal Records Bureau checks and the exclusion of ex-offenders
- Empowering those recovering from substance use to challenge language used and reporting in the media
- Improving community participation and contact with those in recovery, as it has been shown that those who have "closer contact with people with a history of drug problems have more positive attitudes towards them".

Asset-based and person-led approaches

An asset-based approach involves "**mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits**"[6]. Asset-based approaches can increase self-esteem and reduce social isolation[7]. They are based on the notion that recognising individual strengths, as well as establishing supportive social networks and engaging in positive activities in the community[8], can support recovery.

Assets can be grouped into[9]:

- **Individual assets** eg resilience and self-esteem
- **Community assets** eg social networks and community cohesion
- **Organisational or institutional assets** eg employment security, safe housing and political participation.

The role of practitioners implementing alcohol and drug prevention initiatives / services would be to help individuals, communities and organisations to realise the full potential of assets and support their mobilisation to overcome challenges identified in individuals' own lives and local areas.

Preventative approaches which are person-led ensure that individuals are empowered to make decisions about their own alcohol and drug use and recovery. It has been shown that individuals are often well placed to articulate what would help them personally to move to and sustain recovery[10].

Workforce development

The continuously evolving landscape of alcohol and drug use means that **sustained staff training and development** must underpin all approaches to prevention. Some examples of relevant staff training to increase the effectiveness of alcohol and drug prevention include:

- Baseline of basic alcohol and drug knowledge
- Delivering brief interventions
- Law and policy around the sale of alcohol
- Delivering workshops and educational programmes around alcohol and drug use and multiple risk
- Trauma Informed Practice
- Reducing stigma around alcohol and drug use and treatment
- Increasing knowledge of at-risk groups eg older adults, LGBTI+ populations and those with ACEs
- Providing support and treatment for individuals taking New Psychoactive Substances (NPS)
- Preventing opioid overdose eg with Naloxone.

Evidence informed

It is inevitable that some preventative approaches will have a greater body of evidence supporting their implementation than others. As innovative interventions emerge, it may take some years before it is possible to fully evidence their impact. In addition, the complex nature of alcohol and drug use means that it can sometimes be difficult to establish causal connections between interventions and changes in substance use.

Despite these limitations, **decision-makers and frontline practitioners can usefully utilise research which has demonstrated that certain interventions are more (or less) successful than others in prevention**. For example, studies into the effectiveness of alcohol and drug programmes have shown that "attempts to scare pupils are found to be ineffective or even increase the likelihood of substance use" and therefore school-based programmes should not attempt to induce fear, shock or guilt[11].

When designing staff training programmes; policy and legislation; and educational programmes, planners and practitioners should ensure that proposed approaches are informed by the most current and robust evidence base.

Harm reduction

The theme of harm reduction recognises that a valid aim of alcohol and drug interventions is to reduce the "relative risks" associated with their use[12]. Harm reduction is a core theme for prevention as it recognises that in cases where it is not possible to entirely prevent or stop substance use, **there are benefits for individuals; health and social care services; and wider society in limiting substance-related harm.**

Harm reduction is linked to person-led approaches in that it is designed to help people "define and reach their own goals" regarding alcohol or drug use, without "presupposing that they have a specific goal in mind" eg abstinence[13].

While harm reduction can underpin all preventative approaches, specific initiatives include[14]:

- Preventing drug-related deaths eg with take-home Naloxone
- Responding to outbreaks of bacterial infection
- Improving the sexual and reproductive health of people who use alcohol and drugs
- Reducing instances of binge drinking and the harm related to this.

Whole systems approach and person-centred

Person-centred approaches are those which allow for the personalisation of support and services around **individual needs**. In other words, being person-centred is about "focusing care on the needs of the person rather than the needs of the service"[15].

This personalisation works most effectively when various services are flexible and work together through a **whole systems approach** to assess and respond to the holistic needs of the individual. This requires effective partnership working and collaboration. There are many challenges to partnership working including differences in priorities, lack of management buy-in, poor communication and funding issues however effective multifaceted outcome focused approaches can be successfully achieved through:

- Clearly defining roles and responsibilities from the outset
- Agreeing shared priorities
- Increasing the knowledge of practitioners about service landscapes; and streamlining referral processes
- Effective information sharing and clear channels of communication
- Forums for joined-up service planning and the development of aligned goals.

For example, in the case of treatment for alcohol and drug dependence, it has been found that if individuals are to sustain their recovery, they need to be linked in with "a range of appropriate support services, including family and peer support, mental health, stable housing and especially access to employment, training or education opportunities"[16].

When designing and commissioning alcohol and drug preventative interventions, a level of flexibility is essential to allow for the tailoring of policy and programmes to the unique circumstances of the individual.

The Scottish Government recently committed to driving forward a whole systems approach through their public health reform programme, with the publication of the National Public Health Priorities[17]. These aim to make the best use of collective resources, encouraging ownership from the 'whole system' of public services to improve the public's health and reduce health inequalities.

Multiple risks and how they interact

Preventative initiatives for alcohol and drug use should consider that **people often experience multiple intersecting risks and vulnerabilities**.

At risk groups include (see Evidence Briefing 4):

- Those with mental health problems and / or behavioural disorders
- People experiencing or at risk of deprivation, poverty and homelessness
- LGBT+ people
- Prisoners and persons with convictions
- Care experienced children and young people (see Evidence Briefing 6)
- Young people (see Evidence Briefings 5 and 6)
- Those with family alcohol and drug use (see Evidence Briefing 6).

The prevalence of intersecting risks and vulnerabilities means that **effective interventions will support a person in multiple areas simultaneously** eg addressing mental health problems or insecure housing, *alongside* alcohol and drug use. **Services need to consider wider family, social group and community context**, including addressing family poverty and disadvantage and intergenerational poverty issues. This is often achieved through whole system and person-centred approaches (see Evidence Briefing 4).

When planning and implementing alcohol and drug interventions, it is good practice to include those from the targeted at-risk group to ensure the intervention is more likely to be meaningful and effective.

In addition**, initiatives can nurture protective or resilience factors** such as[18]:

- Community engagement and supportive social networks
- Positive alternatives to alcohol and drug use – alcohol and drug free events
- Adequate finances and employment opportunities
- Low levels of family conflict.

Trauma Informed Practice

Traumatic events are defined as:

"An event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening"[19].

Experience of trauma is highly prevalent amongst those seeking support for substance use, with 75% of women and men attending substance use services reporting abuse and trauma in their lives[20].

Trauma Informed Practice recognises "the **prevalence and potential impact of trauma** and seeks to avoid the potential for people to exclude themselves from services as a result of trauma related distress triggered by any aspect of contact with staff and services"[21].

There is increasing recognition in Scotland that trauma related skills are essential across the **whole workforce**, not just for those providing services directly to those affected by trauma[22].

For staff and services to be trauma informed, there is a need for **all workers** to be able to[23]:

- Identify the kinds of experiences that are traumatic
- Identify the types of situations which can be retraumatising
- Keep in mind that a person's behaviour or reactions might be trauma-related
- Respond with empathy, and without criticism or blame
- Adapt practice and procedures to maximise a person's feelings of **choice, collaboration, trust, empowerment and safety.**

The NHS Education Scotland knowledge and skills framework for trauma outlines four practice levels reflecting various types of workers' roles in responding to the impact of trauma. While all workers should aspire to be trauma informed, those who have a greater level of contact with individuals who are likely to be, or are known to be, affected by trauma can work towards trauma skilled, trauma enhanced and trauma specialist practice levels[24].

Health inequalities and deprivation

The existence of health inequalities in Scotland **means that "the right of everyone to the highest attainable standard of physical and mental health is not being enjoyed equally** across the population"[25]. There is a need to ensure a clear and consistent awareness of equalities issues and to identify the needs of minority and special interest groups, as well as the wider population as a whole.

For example, in Scotland drug use harm disproportionately affects those who experience socio-economic disadvantage; and those who have an issue with drug use are "often amongst the most marginalised in society"[26]. The burden of drug use disorders are 17 times higher for those living in the most deprived areas of Scotland, compared with the least deprived areas, while the burden of alcohol dependence is 8.4 times higher in the most deprived areas[27] (see Evidence Briefing 4).

Tackling health inequalities can involve[28]:

- Programmes to ensure adequate incomes, the reduction of debt and the reduction of unemployment
- Programmes that target vulnerable groups by investing in "more intensive services and other forms of support for such groups, in the context of universal provision"
- Policies that use regulation and price (eg minimum unit pricing) to reduce risky behaviours (see Evidence Briefing 3).

Community empowerment

Patterns of alcohol and drug use are situated within specific local contexts; and communities are often impacted by the outcomes of alcohol and drug use. If communities are encouraged to actively participate in alcohol and drug prevention, programmes can be **tailored** to local needs and **embedded** within existing social networks and institutions.

Often it is difficult to achieve true community representation in planning structures and to engage with particularly hard to reach groups even through local alcohol and drug community forums and groups. However, on a local level, if given the right support, different stakeholders in the community can come together in "partnerships, task forces, coalitions [or] action groups"[29]. To achieve success, community models can benefit from being situated in a range of community settings such as families, schools, workplaces and entertainment venues[30].

For example, in 2014, Glasgow City Alcohol and Drug Partnership (ADP) commissioned research on community perceptions around the impact of alcohol. The resulting Ripple Effect report (2016) recommends[31]:

- Community members should have opportunities to shape the future of their community
- Community members, particularly young people, should be routinely consulted about improvement and details of services
- There should be increased awareness-raising and promotion of existing community facilities.
- The Scottish Government recognised the importance of community empowerment through the introduction of the Community Empowerment (Scotland) Act 2015[32]. This Act gave new rights to community bodies and placed new duties on public sector authorities. It covered 11 different topics, including changing community planning to make it work better and encouraging participation in public decision-making[33].

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