

Addiction Response Crumlin

Alcohol Reduction Programme Evaluation



Choose to Change...



Choose to Change

“ There were days I didn’t want to go in and I’d stay in bed. We’d get a call asking if we’re ok and if we were coming in, and then you’d go in. ”
(Participant)

“ On a Saturday morning you’d come up and there’s a breakfast in the morning time and you could blow a breathalyser on a Saturday morning. That was one thing for me that was really helpful. Friday nights were such a danger for me. ”
(Participant)

“ If we didn’t want to stop, they’d help us set goals like ‘If you’re getting your Vodka, don’t drink it all, just drink half’. ”
(Participant)

Acknowledgements & Citation

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Summary of Findings and Recommendations

Introduction

This is a summary chapter of the findings and recommendations from an evaluation of the Addiction Response Crumlin Alcohol Reduction Programme. This ten-week programme supports people who wish to reduce their alcohol use or abstain from alcohol use. The programme is based on the Reduce the Use model¹; a group cognitive behavioural therapy programme used commonly in addiction services across Ireland.

The evaluation was conducted between February and April, 2014, using interviews, focus groups, surveys and case studies. Over 30 people participated in the research:

- ▶ 17 programme participants participated in focus groups
- ▶ 16 programme participants completed surveys
- ▶ Two programme participants also participated in interviews
- ▶ Four participants provided detailed case studies
- ▶ Four staff of ARC participated in a focus group
- ▶ Ten professionals from other services completed online surveys
- ▶ Five stakeholders with a strategic role in relation to addiction service provision were interviewed

Finding One: A Successful Alcohol Reduction Programme

High attendance and completion rates: The programme ran three times in each year in 2012 and 2013. Completion of the programme requires 80% attendance, and in 2012, 23 of 29 people successfully completed the programme, which was an 80% completion rate for that year. In 2013, 34 people began the programme and 25 successfully completed it; a 74% completion rate.

Reduction in alcohol use: The ARC Alcohol Reduction Programme was successful in supporting significant change in alcohol consumption levels for people with problematic alcohol use. Participants who completed the programme showed an average reported improvement of four points in relation to alcohol use on the Outcome Star scale². This was supported by the results of surveys that participants completed themselves for this evaluation, which showed:

1 See The SAOL Project - Reduce the Use: <http://saolproject.ie/resources-rtu2.php>

2 The Outcome Star is a tool that was used by the ARC team and participants to measure different issues before and after the Alcohol Reduction Programme. The Outcomes Star was developed by Triangle Consulting for St. Mungoes Housing Services and has been adapted for use across a range of social service in the U.K and Ireland. It uses a scatter-gram to display change using a ten point likert scale under a number of thematic headings. Benchmarking data was not available to the researchers at the time of writing this report.

- ▶ Prior to the programme all participants drank regularly; after the programme 38% of participants never drank.
- ▶ Prior to the programme, 63% of participants drank every day; after the programme, no participant drank every day.
- ▶ Before the programme, everyone drank at least two to three times per week. After the programme, 69% of people drank less than this.

Improvements in other areas of life: There were high levels of change (3 points on the Outcome Star scale) in relation to emotional health, social networks, use of time and physical health. Where drug use, accommodation or criminality was a problem, there were also high levels of change reported in these areas. While the average changes in relation to family relationships were not as dramatic as other areas, it was clear from the surveys and focus groups that family was an area that had improved significantly for many people after participating on the programme, particularly parents, as described by the following quote:

Being able to sit down with my family, I can go to the pictures with my girlfriend, or play with the baby. Just being able to do normal things without my troubles bothering me is amazing.
(Participant)

The value of choices in recovery supports: Participants discussed previous experiences of treatment. A majority of people – 69% - had previously tried treatment for their alcohol use including Alcoholics Anonymous (AA), residential programmes, counselling and community detoxification. Almost 40% of participants had tried at least two different options. Only one third of participants had never tried anything prior to this programme.

While staff and participants saw the value in AA for some people, for the 31% of people who had tried it, they reported that AA was not a suitable environment or support for their recovery at that time. Participants who said they had been to residential treatment had not enjoyed success there. Two people reported having particularly unpleasant experiences relating to religious ethos in the centres they were in.

There was a general agreement in the staff group that the different types of treatment/recovery programmes were complimentary, and that there was a value in having a number of options available, and that community based reduction programmes are an important option within this range.

Finding Two: Flexible Access and Community Focus

Strengths: Two key strengths were identified in the research in relation to the accessibility of the programme; the community-based ethos of the programme and the fact that participants were encouraged to set their own alcohol reduction goals, which could include, but was not limited to, abstinence.

We all speak the same language. We are not talked down to.
(Participant)

Challenges: The challenges identified relating to programme access included a lack of referrals from some services, the perception that anonymity could be compromised because the service was so embedded in the

community, the times at which the programme was run, and the perception of the organisation as a service that primarily worked with people with drug problems.

I thought it was just for people on the gear. I didn't know they helped people like me. I think a lot of people think that.

(Participant)

Professionals from other services who responded to the survey were interested in hearing more about the programme. When asked if they had sufficient information about the programme, 60% of people said that they did not, and that they would like more information. 60% of people said that they would like to hear more through email, 50% would like posters or leaflets for their service, and 30% would like a meeting or information session with staff from the programme.

There is an opportunity to build on these strengths and manage the challenges outlined by focussing on branding, promotion and running the programme at additional times in the day or week.

Finding Three: Beneficial Programme Content and Delivery

The alcohol reduction programme provides group-based activities using a cognitive behavioural therapy (CBT) approach. It supports participants to either reduce or stop alcohol use. This evaluation found that the model, content and method of delivery are all supported by research in relation to good practice as detailed in the literature review. Key strengths of the model include:

Therapeutic alliance: there was a very significant positive regard for the facilitators of the programme by participants; arguably, one of the most valued aspects of the programme by participants. All participants (100%) said that they felt welcomed, accepted, cared for, appropriately challenged and did not feel judged.

Flexible goal setting: There was general agreement in the group (71%) that setting their own goals and making a commitment to the group about their drinking without being pressured into specific decisions or changes by anyone was a significant factor in their continued engagement.

Intimate, closed group setting: The trust, intimacy and family nature of the group was a significant strength; three quarters of focus group participants (76%) agreed with this.

1-2-1 Supports: The majority of participants (71%) said that the 1-2-1 support they received while on the programme was crucial to their recovery.

Additional Supports: Apart from group and 1-2-1 supports, the team provided a number of additional supports to participants on the programme. These supports were perceived by participants or staff to be instrumental to programme success:

- ▶ 65% of participants called facilitators outside of normal programme hours
- ▶ 100% of participants felt that breakfast was a very important part of the programme. Eight people who participated in focus groups said that that prior to the programme, they would habitually drink first thing in the morning and that having breakfast in ARC helped them to change this habit (note that this was only discussed in one focus group, where 11 people attended. This means that 72% of those who discussed it noted this change).

Finding Four: Insufficient Access to Alcohol Aftercare and Follow-on Supports

A key support required by participants moving towards abstinence or moderated drinking, is developing ways to use their time. The focus on developing skills for moving towards moderated alcohol use or abstinence are a key focus of the programme.

71% of focus group participants engaged with aftercare supports provided either by ARC or other services, and ARC provided information to participants on aftercare. Some participants stated that they would appreciate further information on other services available for recovery. There is also an opportunity to support sustained motivation by increasing follow-on contacts, and ensuring there are robust procedures for supporting repeat participants. There are barriers to socialisation for participants, and there are opportunities for ARC and their partners in the area to provide increased opportunities for people in recovery.

Finding Five: Strategic Approaches to Problem Alcohol Use

There are a number of strategic opportunities for supporting the programme and addressing problematic alcohol use in the Dublin 12 area. The following gaps in service provision were noted and highlighted by participants, staff or key professional stakeholders:

- ▶ There is a lack of alcohol reduction programme provision on evenings and weekends
- ▶ There is a need for a coordinated, strategic response to the alcohol issue in the area
- ▶ There is a need for more opportunities for employment for people in recovery and the potential for innovative responses such as social enterprise
- ▶ There is a need for a better understanding of the extent and nature of family and child need and how it is being met in the area, where there is problematic alcohol use in the family

Overview of Recommendations

Recommendations presented below were gleaned from the opinions of programme participants, facilitators and key professional stakeholders working in the D12 area or in alcohol service provision or policy. Recommendations were cross referenced with good practice in the literature, and are applicable at three levels; 1) programme improvements for ARC, 2) good practice considerations for other organisations implementing a similar programme, and 3) strategic recommendations for the Local Drugs Task Force in responding to problematic alcohol use at a local and national level. There is also one recommendation with a specific national application.

Recommendations: ARC

ARC Recommendation One: Develop the Outcome Measurement Process to Increase Learning, in order to Continually Improve the Programme

Currently, ARC use the Outcome Star to measure changes at the beginning and end of the programme. This is useful to the team and its function could be improved in a number of ways including measurement

at a mid-point in the programme to review progress and support care planning, and using a validated tool to assess change in alcohol consumption by standard drinks or units.

ARC Recommendation Two: Practical Measures to Protect Confidentiality

To promote confidentiality between different groups who use the premises, entrance and exit times should be staggered to reduce unnecessary contact between groups, or groups overhearing one another. There may also be potential for exploring alternative venues for groups.

ARC Recommendation Three: Content / Structure

As check-ins conducted at the beginning of each group progress (over the lifetime of the group), there is a possibility that they may seem to become, from the perception of the client, lengthy and unstructured. Ensure that the need for check ins, and that they are structured rather than random, is clearly explained to participants to ensure value of that part of the session is shared.

ARC Recommendation Four: Develop a Resource to Help Participants Access Groups, Clubs and Social Activities outside the Programme

Building on existing information provided to participants, develop a resource that participants can add to, with information on activities and supports for a range of needs and interests within the local area and in Dublin. Ensure that a variety of methods are explored with participants for the most effective way of communicating activities, which may include a notice-board, leaflets, text messages, social media and email.

Recommendations: Good Practice for Similar Programme Delivery

Good Practice Recommendation One: Use an Evidence Based Model for Provision of Community Based Alcohol Reduction Programme

Both Irish and UK guidelines emphasise the need for treatment programmes to have an evidence-base guiding the delivery of community supports for problem alcohol use. For Reduce the Use, the model is cognitive behavioural therapy.

Good Practice Recommendation Two: Adapt the Model to the Needs of the Client Group

While ensuring fidelity to the model, trial and review of different additions to a programme can ensure it is meeting the needs of the specific client group. ARC undertook a process of review and adaptation after each programme. This process resulted in development of aspects of the programme considered most beneficial by participants such as 'Filling the Void' and the inclusion of psycho-educational modules.

Good Practice Recommendation Three: Ensure Facilitators are Appropriately Trained and Experienced

Ensure facilitators of programme are formally trained in group facilitation, have a working knowledge or experience of addiction service provision. Training in CBT would be helpful but was not generally considered by professional participants as essential.

Good Practice Recommendation Four: Promote Flexible Goal Setting

Community based reduction programmes should consider an approach which supports service users to identify their own goals in relation to levels of substance use. Programmes should support participants with both reduction / moderation and abstinence goals.

Good Practice Recommendation Five: Ensure Service Users are Supported to Access Suitable Progression Pathways

Options may include AA, Lifering or other sobriety based social groups. Organisations should also seek to establish links with programmes promoting innovative opportunities which may increase access to employment and training, such as social enterprise.

Good Practice Recommendation Six: Importance of Tailored Reminders and Follow-up Support Calls

The importance of using phone calls, reminders and follow-ups to support engagement of participants on the programme, and to build trust and promote retention, is supported in the literature.

Good Practice Recommendation Seven: Supporting Development of the Therapeutic Relationship

The Reduce the Use model and the ARC programme promote the importance of providing opportunities for non-therapeutic engagements such as meals and outings. This was particularly valued by participants and can support programme retention and participant success.

Good Practice Recommendation Eight: Ensure a Mechanism for Evaluating Outcomes for Each Programme

Outcomes measurement tools, alongside a structured system for client feedback can help to measure changes in alcohol use and improvements in coping skills and life skills over the course of a programme or series of interventions. Measuring a range of changes was important to clients on the programme, and helped to identify individual successes and key areas on which to focus.

Recommendations: Strategic

Strategic Recommendation One: Establish a Promotion Strategy for the Programme in 2014 / 2015

A promotion strategy to be developed with support of the Local Drugs Task Force and the D12 Interagency Collaboration Subgroup, building on the good promotional work undertaken by the ARC team and stakeholders thus far. A promotional strategy should consider how to reach members of the community who may not be aware of ARC, or would not traditionally be users of community addiction services. The promotion strategy should consider the findings in this report in relation to key messages to promote.

Strategic Recommendation Two: Provide an Alcohol Reduction Programme in Evenings or Weekends

The Local Drugs Task Force should explore ways of supporting an evening programme to provide for people who are attending work in normal office hours. ARC should adapt the Reduce the Use training programme to include additional modules provided by ARC, and explore opportunities for training co-facilitation with Reduce the Use trainers. In partnership with the Local Drugs Task Force Interagency Collaboration subgroup, identify local partners to potentially support an evening or weekend programme and train suitably qualified people to facilitate the programme.

Strategic Recommendation Four: Develop a Local D12 Alcohol Strategy

There is a need for a coordinated, focussed response to alcohol problems in the Dublin 12 area. The strategy should consider learnings from other areas and look at key external opportunities and developments. It should address supports required for different levels of severity including the need for out-patient detoxification, reduction and aftercare. It should involve all key partners and include a review mechanism. Learning can be taken from Ballymun LDTF in this area.

Strategic Recommendation Five: Support the Development of a Recovery Movement

The potential for the development of recovery networks³ at a local, cross Task Force or citywide level should be explored. This should involve the review successful models and innovative developments in other Task Force areas and other jurisdictions such as the US and the UK, and in the fields of mental health and addiction.

Strategic Recommendation Six: Undertake Research into Family Need and Support in Relation to Alcohol Use

Conduct research into parenting and family problems and need as a result of problematic alcohol use, and

Although there is no agreed or standard definition of a 'recovery movement' or 'recovery network', it is largely understood to refer to a client-led psycho-social recovery model, defined by the creation of social and environmental opportunities to support recovery from mental health and addiction problems.

map service provision in the D12 area against this. Problems and need can be inferred from existing national data. The Local Drugs Task Force should assess whether the current strategy is meeting needs in this area and develop a plan to fill gaps, alongside key partners working with children, parents and with families in addiction.

Strategic Recommendation Seven: Provide Feedback to Organisations with a Religious or Spiritual Approach

A number of participants felt alienated by their experiences with the religious or spiritual approach taken in some recovery centres. It may be useful to ensure that this feedback is being provided by Task Force services to support these organisations to best meet the needs of their client groups.

Recommendation: National

All local and regional Drugs Task Forces should consider the implementation of an alcohol reduction programme that supports individual goal setting and uses a model developed from an evidence based approach, such as Reduce the Use. Literature supports that group format can be used without decreasing treatment effectiveness, and may be more cost-effective than reliance on 1-2-1 supports.

Overview, Methodology and Literature

1 Overview of Programme

1.1 ARC and the Alcohol Team

ARC (Addiction Response Crumlin) is a community-based and community-led service established in 1996 to provide support for addiction issues to the local people of Dublin 12 who have substance use issues and their families.

ARC's mission is to 'provide holistic, client-centred, non-judgemental, professional, and caring services; to support our clients to develop their self-esteem and confidence, and to provide them with alternative life-options. We recognise the interdependence of the individual, the family and the community in all our services. Community-led and based on community development, we seek to raise community awareness of the problem of addiction, its impact, and how best to respond to it'. (www.addictionresponsecrumlin.ie)

ARC's work is grounded in a core belief of the organisation; that despite social injustice and inequality, people 'can and do recover from addiction and go on to reach their full potential'.

Since its inception, ARC has adapted to the changing needs of the community, broadening their range of services as considered necessary. The range of services provided currently includes methadone maintenance, stabilisation and detoxification programmes, a cocaine and poly drug-use programme, an alcohol reduction programme, alcohol free programmes, an under-18s substance misuse support service, recovery and aftercare services, counselling, complementary therapies and holistic therapies.

ARC also provide opportunities to those in recovery to progress to mainstream education and training through the provision of a community employment programme. ARC highlight the importance of community-based services on their website:

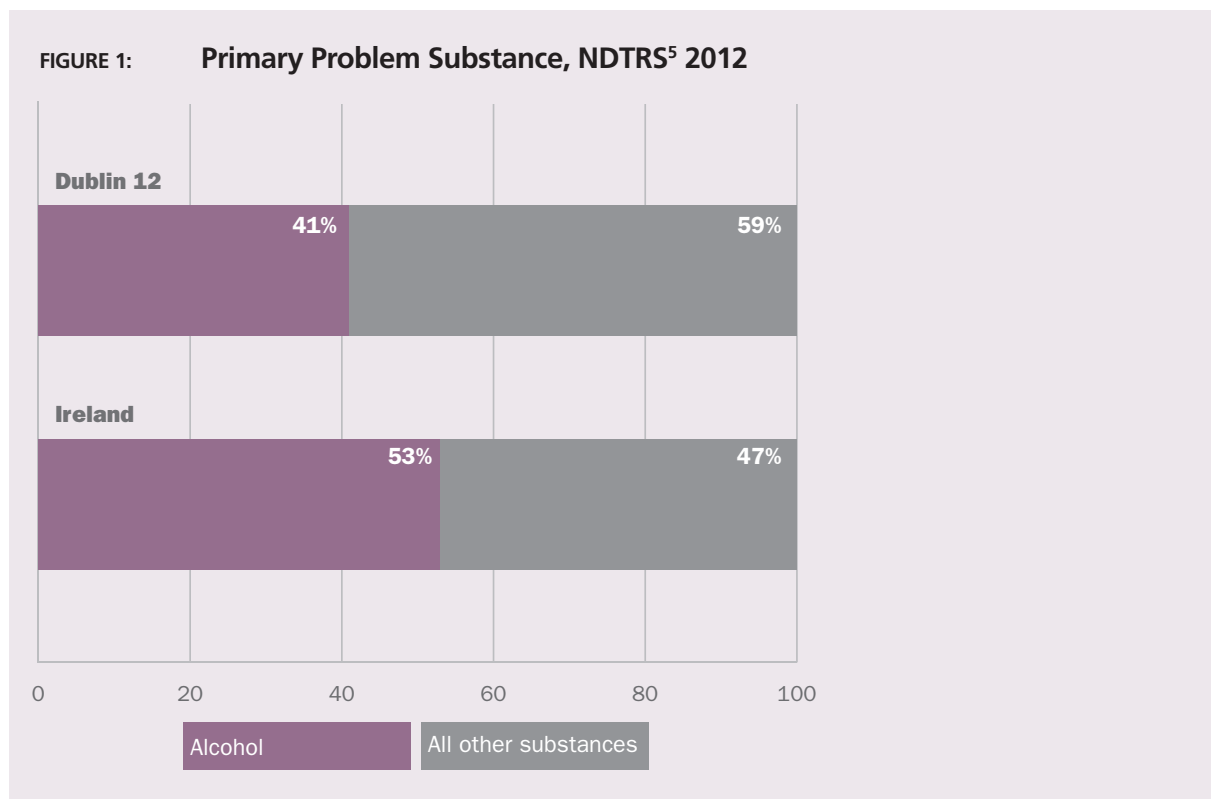
Government policy has increasingly acknowledged the important role of organisations such as ARC, and recognises its central role in a multi-agency approach to treatment of substance misuse. ARC is widely acknowledged as one of the strongest most effective community addiction projects to have been set up in Ireland since the mid-1990s.

(www.addictionresponsecrumlin.ie)

1.2 The Local Context – Dublin 12

In 2011, the Dublin 12 area had a population of almost 55,000 people, with slightly more women than men⁴. Many smaller areas in Dublin 12 are considered in the relative deprivation index to be disadvantaged, particularly parts of Crumlin, Kimmage, Walkinstown and Drimnagh.

In 2012 in Dublin 12, there were 316 cases of people seeking treatment for alcohol or drugs. One hundred and twenty nine of these cases stated that alcohol was their primary problematic substance, which made up for 41% of all cases of people seeking treatment. This is lower than the national average, where 53% of cases (8336 / 15699 cases) of people seeking treatment state that their primary problematic substance is alcohol. This is depicted in the graph below:



While the figures may be slightly lower than the national average, the Dublin 12 area has seen significant growth in the numbers seeking alcohol treatment over the last number of years, with the figure growing from 88 cases in 2009 to 129 cases in 2012.

1.3 Alcohol Reduction Programme

ARC established the Alcohol Reduction Programme in 2012, in response to a growing need in the community for specialised alcohol supports, and an absence of such supports in the area. Participants ranged from those using alcohol alone to those with poly-substance use issues. Participants were recruited through word-of-

⁴ CSO 2011 Census Data

⁵ National Drug Treatment Reporting System: www.drugsandalcohol.ie

mouth, posters and information circulated to other services. The programme ran three times during 2012 and 2013, and was expected to run three times in 2014. It is based on the Reduce the Use model developed by the SAOL Project in 2001. While this model has not been formally evaluated, according to SAOL, over 250 professionals have been trained across the country, and the manual has been downloaded almost 1,500 times.

1.3.1 Objectives and Target Group

The ARC Alcohol Reduction Programme is a ten-week programme for people who wish to reduce or abstain from alcohol in a group setting. It aims to:

- a) Provide quality services in response to the unique needs of individuals affected by alcohol misuse
- b) Empower, support and encourage change within a group setting
- c) Assist each person to recognise their individuality and potential

1.3.2 Content of Programme

The programme provides group-based activities using a cognitive behavioural therapy (CBT approach). The programme supports participants to either reduce or stop substance misuse. Some content was changed or added in response to feedback from participants,

Some of the most significant changes from the original Reduce the Use model included:

- ▶ A focus on experiencing alcohol-free social activities including cinema, bowling and walking (just under a half of sessions in the initial two courses and around a third of sessions in the last course were dedicated to facilitating alcohol free social activities)
- ▶ A session on 'wet brain' and the harmful effects of alcohol
- ▶ A session on addiction and loss, which explored the grieving process in giving up alcohol
- ▶ A session on co-dependency
- ▶ Preparation for events and social occasions
- ▶ Learning about the Wheel of Change / process of addiction

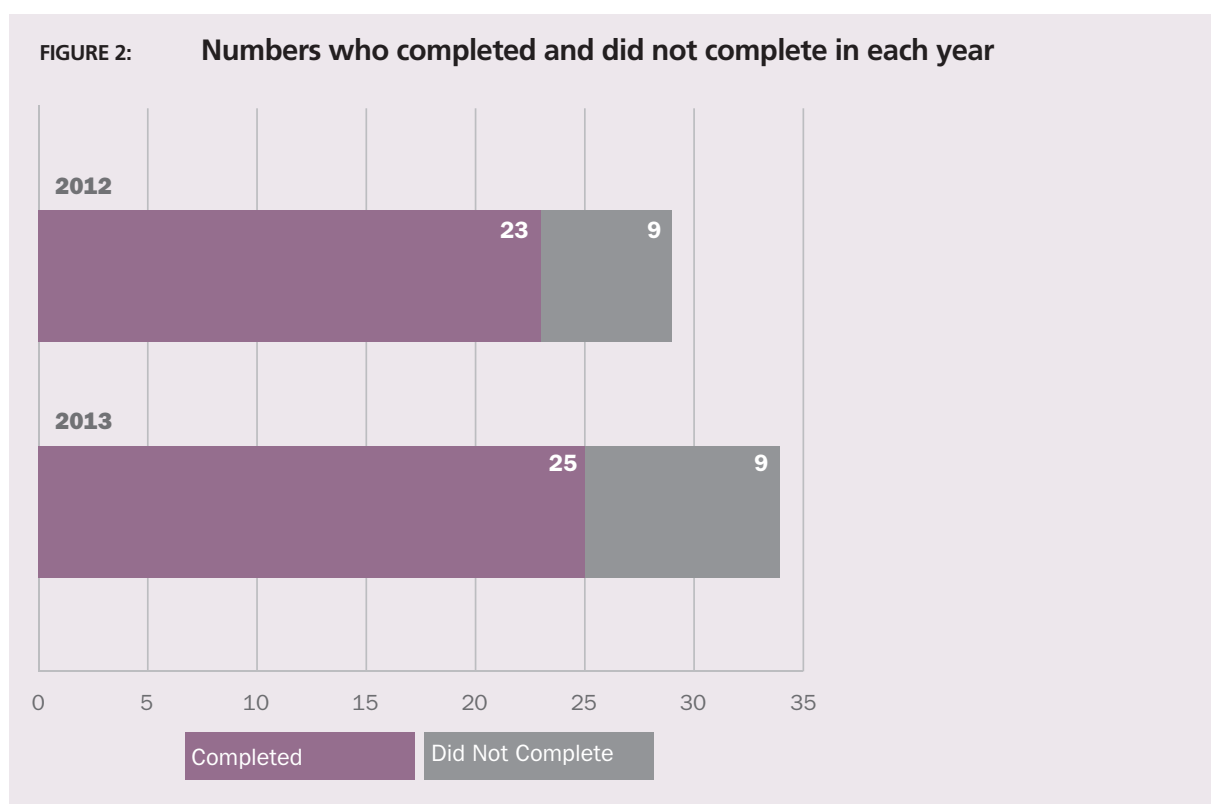
Original modules covered in line with Reduce the Use were:

- ▶ The role of thoughts and beliefs
- ▶ Changing our thoughts
- ▶ Identifying goals
- ▶ Personal action plan
- ▶ Refusal skills
- ▶ Cravings and social support systems
- ▶ Relapse prevention
- ▶ Social situation preparation and planning

In addition, safe plans and drink & cravings diaries were distributed and discussed at each session. There were also 1-2-1 key working sessions available to participants before, during and after the programme.

1.3.3 Attendance

The programme ran three times in each year in 2012 and 2013. Completion of the programme requires 80% attendance, and in 2012, 23 of 29 people successfully completed the programme, which was an 80% completion rate for that year. In 2013, 34 people began the programme and 25 successfully completed it; a 74% completion rate, as illustrated in the graph below:



1.3.4 Staff Time

The Addiction Response Crumlin team estimate that the organisation invested 1,040 staff hours to run three programmes in a year, which works out at approximately 347 staff hours per programme. This includes time for managing referrals, brief assessments, comprehensive assessments, programme planning, programme delivery and administration.

1.4 Alcohol Free Programme

1.4.1 Objectives and Target Group

The Alcohol-free programme is a 20-session programme that provides service users with the skills to avoid relapse and deal with trigger situations. The target group are people who are alcohol free for 28 days or

more, living in the D12 community. The programme is also a follow-on for those that have achieved their goal of abstinence in the alcohol reduction programme.

1.4.2 Content of Programme

The contents of the programme include:

- ▶ Individual safety plan
- ▶ Alcohol refusal skills and assertiveness training
- ▶ Coping with cravings
- ▶ Stress reduction and lifestyle balance
- ▶ Problem solving skills and decision making
- ▶ Thought stopping and worry control
- ▶ Managing a relapse
- ▶ Dealing with high risk and social situations
- ▶ Co dependency
- ▶ Dual Diagnosis, alcohol and mental health
- ▶ Liver wellness
- ▶ Wet brain syndrome

1.5 Aftercare Group

1.5.1 Objectives and target group

The aim of the Alcohol Aftercare Group is to provide a therapeutic group, which supports people who wish to remain alcohol free. It is run for one hour weekly. The target group for this programme is people who are accessing aftercare and those that have completed either or both of the alcohol groups in ARC. It is also available to anyone in the D12 area looking for support that has completed a residential detox or are in employment.

1.5.2 Content of programme

There are a number of key areas that are covered on the programme including alcohol related brain injury, personal development, weekly planning, relapse prevention and coping with cravings, preparing for social events and there are also options for doing skills based or creative programmes. Additional programme content is decided by the group themselves, as it is a therapeutic support group.

1.5.3 Attendance

ARC staff noted that attendance varied on average between four and nine people per week.

2 Literature Review

2.1 Overview

The aim of the literature review was to explore good practice and learning from other programmes in order to support the assessment of the ARC Alcohol Reduction Programme.

This chapter begins with a review of the alcohol use prevalence and treatment provision in Ireland, as well as looking at the policy framework for this. Literature on treatment approaches and good practice recommendations for provision of similar programmes is explored. Finally, as the issue of family need in relation to alcohol use was a prominent theme in the research, a summary of findings in relation to children of alcohol users is provided.

The literature highlights the need to look at treatment programmes from a number of angles. This includes the programme model, the staff, the fit between client and the programme or organisation, and how the programme is evaluated.

2.2 Problem Drinking and Treatment in Ireland

There are a number of ways that we can estimate the extent of alcohol problems in Ireland, and the range of ways that people are receiving support for their problems. The two main sources consulted here are information from services that treat problem use, and data from surveys with the general population in Ireland to explore prevalence (meaning the levels of alcohol consumption and alcohol problems nationally).

2.2.1 Prevalence

In 2012, there were 8,366 cases of people treated for problem alcohol use in Ireland⁶. This was a majority of all cases treated for substance use, but is likely a gross under-estimation of the number of people with alcohol problems in the country. In the UK, it is estimated that only 6% per year of people aged 16–65 years who are alcohol dependent receive treatment (20).

The National Prevalence Survey of 2011 revealed that 87% of Irish adults were ‘current drinkers’, meaning they had drunk within the last year. The patterns of drinking that people reported were measured against a tool to assess levels of harmful drinking. This revealed that half of the population aged 18–64 years and 58% of current drinkers could be classified as harmful drinkers. When young adults were assessed on their own (aged 18 – 24), 82% of males and 68% of females were harmful drinking (3). Other studies have shown that Irish drinkers have the highest rate of binge drinking in the EU (28).

An analysis of data on harm to others as a result of drinking among Irish adults was published in 2014. This report showed that 28% of people had experienced harm by another’s drinking. The most common types of harm were; family problems (14%), followed by being passenger with a drunk driver (10%), being physically assaulted (9%), and property being vandalised (9%) (39).

⁶ National Treatment Data from the National Drug Treatment Reporting System: www.drugsandalcohol.ie

2.2.2 Treatment

Of the 8,366 cases presenting for alcohol treatment in Ireland in 2012, over half (5,027) were provided in day settings. Of these, 52% of cases received individual counselling, 42% received brief interventions, 27% received group counselling and 24% received alcohol detoxification. Other treatments included complementary therapy, social and occupational reintegration, family therapy, aftercare and psychiatric treatment (29).

2.2.3 Recovery Movements and Supports in Ireland

While the recovery movement (see footnote 2, above) in Ireland has not developed to the extent that it has in the US, the UK or other jurisdictions, the recovery approach and ethos appear to be gaining traction in Ireland. In January 2012, the British-Irish Council heard a discussion paper on recovery from problem drug use and agreed that member administrations would promote a focus on recovery and would work together to evaluate and share successful approaches (35).

There are a number of recovery services and groups active in Ireland including; AA, NA (Narcotics Anonymous), Lifering, as well as day programmes provided by community voluntary organisations that support recovery through group supports, recovery coaching and education provision. Some structured supports are also provided by the HSE for people in recovery from alcohol.

2.2.4 National and Local Strategy

A review of the Drugs Task Forces and structures above them was published by the Department of Health in late 2012, and outlined a number of recommendations in relation to the role and composition of Task Forces. These recommendations included a renaming of the Task Forces to Drug and Alcohol Task Forces, the reconstitution of the Drugs Advisory Group (DAG) as a National Coordinating Committee for Drug and Alcohol Task Forces to drive implementation of the National Drugs Strategy (40). In January 2013, a steering group from the Department of Health examining this issue made 45 recommendations in relation to alcohol, a number of which promoted the role of community services as outlined below (33). At the time of writing this research, Drug and Alcohol Task Forces were still waiting for clarity in mandate, resourcing and other issues to progress their role in responding to alcohol use. However, a number of alcohol strategies have been developed at a local level, including Galway City (41) and Ballymun (42). A case study on the Ballymun Strategy is appended to the report.

2.3 Treatment Approach

2.3.1 The Need for Evidence-Based Programmes

The national clinical guidelines for the treatment of alcohol in the UK note that all psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention (20). This is echoed in the Irish government's guidance on alcohol treatment which promotes the use of evidence based interventions including cognitive behavioural interventions, community reinforcement approach, coping and social skills training, neuropsychological assessment and self-help groups (33).

2.3.2 Group Therapy vs. I-2-1 Counselling

A randomized clinical trial with 155 people compared the influence of CBT provided in a group and an individual setting and found that similar outcomes were produced in both settings. They 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 efficacious cost-effective alternative to individual therapy under many different conditions (5). This research shows that at least in terms of successful outcomes, these methods are interchangeable and may indeed be complementary when used in tandem.

2.3.3 Good Practice: Additional Supports and Retention in Treatment

There is ample evidence for what interventions are successful in supporting someone towards successful treatment. Apart from the programme model and the facilitators themselves, there is research that has shown that a number of additional factors can promote retention in treatment or adherence to a treatment programme.

Reminders for appointments have been shown to work in mental health services (11). Research with social workers in New York in the 1970s showed that following up consistently with those who do not show for appointments, and providing crisis support outside of normal working hours was shown to halve early drop out (12).

The personal touch – either through a phone call or letter, has been shown to be effective in supporting retention in treatment (11, 18). Research in Belfast with people who had recently completed alcohol treatment showed that regular contact from a concerned professional after the programme had ended, significantly increased the chances of sustaining abstinence (22). A review of 43 control studies in relation to mental health treatment revealed that scheduling appointments promptly, reminder letters and telephone calls, soliciting patient commitment, and helping to resolve obstacles to attending the session may improve retention in treatment (24).

2.3.4 Alcohol Treatment Setting and Cost

The previous section of this review showed that the majority of people in Ireland receive alcohol treatment in a community setting, rather than in a residential setting (e.g. hospital or residential treatment). A review of treatment practices in the UK has noted similarly that the majority of people with alcohol dependence issues that are uncomplicated by serious mental illness or social chaos receive treatment in the community (16). Clinical guidelines in the UK note that people should be offered community based support for alcohol problems where there is adequate social support available, and where other problems do not prevent them from being able to address their problem in a community setting (19).

There is no conclusive evidence of optimal treatment setting; however, there is ample evidence to suggest that residential treatment services are needed for certain groups of service users with other issues or conditions (13). However, there is no significant difference in outcomes between residential and outpatient treatment of alcohol dependency (9, 10, 16).

In 2007, the total cost of tangible alcohol related harm in Ireland was estimated at €3.7 billion, representative of 1.9% of GDP in Ireland (32). Analysis from the United Kingdom Alcohol Treatment Trial suggests that for every £1 spent on alcohol treatment, the public sector saves £5 (2). Other analysis calculates in-patient detoxification to be six times more expensive than outpatient detoxification (23).

2.4 Flexible Goal Setting

There are a number of approaches to the treatment of problematic alcohol use. Approaches range from programmes that prioritise abstinence, to programmes that support people towards goals of reducing harm while continuing to drink, or moderation in relation to drinking. A summary of the literature on harm reduction approaches to alcohol reduction by Marlatt et al (34) noted that providing a choice of goals may increase an individual's motivation to change behaviour and may allow problem drinkers to ease into a controlled drinking or abstinent lifestyle. Marlatt et al cite Hodgins, Leigh, Milne, and Gerrish (1997) who found that when individuals are given a choice of goals, many people choose abstinence (46%) and over the course of treatment, there is more movement in the direction of moderation to abstinence goals. Marlatt et al draw a conclusion regarding social cognitive theory - that individuals view themselves as more capable of achieving, and will work harder to achieve, self-selected goals (34). Marlatt goes on to highlight a number of studies evidencing efficacy of CBT-oriented approaches for moderation goals in reducing alcohol consumption and alcohol-related problems following treatment. Moderation management groups have been shown to be effective for individuals with low to moderate alcohol dependence (34).

2.5 Developing a Good Fit between Client and Programme

2.5.1 Range of Services

A review of the literature on treatment outcomes by Thomas McLellan has definitively concluded that programmes that provide the most services (e.g. those that focus not only on the substance use but provide appropriate services for different problem areas) and programmes where there is suitable 'fit' between problems presented and services provided show the best outcomes (25).

The idea that a one size fits all approach is not effective at reducing problem substance use in the general population is now reflected in national policy both in Ireland and in other jurisdictions. The National Treatment Agency in the UK notes that a range of alcohol treatment options need to be available that reflect different levels of risk and complexity of need. The range of supports that should be available includes information and advice, through screening and brief interventions, to structured community based treatment and specialist inpatient residential treatment (2). The Irish government, in the National Substance Misuse Strategy Report (33) endorses this finding and promotes a four-tier model of service provision, similar to the UK where services should work in partnership to provide an appropriate range of treatment options. This is also reflected in the national guidelines for substance misuse rehabilitation, the National Drug Rehabilitation Implementation Committee (NDRIC) framework (1).

The Irish government are increasingly acknowledging the diverse needs of people with alcohol problems; in strategy documents, there is increasing emphasis on the need for various service providers from the community voluntary and the statutory sectors to work together to provide a range of services (1, 33).

2.6 Important Considerations for Programme Facilitators

2.6.1 Therapeutic Relationship

The therapeutic relationship, also known as the therapeutic alliance, has many definitions, but generally, it refers to a constructive relationship between therapist and client, where both are working together positively towards change for the client (8).

One of the most influential thinkers about the therapeutic alliance, Carl Rogers noted that for a successful therapeutic relationship and successful outcomes for the client, there must be three core conditions in the therapeutic relationship; empathy, congruence and unconditional positive regard from the therapist to the client (6). In a review of the literature on the role of the therapist in creating these conditions, Horvath and Luborsky (7) note the following; the majority of findings reveal that it is the client's perception of the therapist as an empathic individual, rather than the behaviours of the therapist, that yielded the most robust correlation with successful outcomes.

2.6.2 Capacity of Staff

The National Substance Misuse Strategy Report places significant emphasis on the need for psychosocial interventions to be provided in general community settings by appropriately trained 'non-specialist'⁷ personnel delivering evidence-based, outcome oriented interventions to meet varying need (33). The national clinical guidelines for the treatment of alcohol dependence in the UK state that appropriately trained and competent staff (20) should deliver all interventions for people who misuse alcohol.

2.7 Children of Parents or Family Members in Addiction

There is an increasing focus on the needs of children of parents or family members in addiction in Ireland. Parents who are trying to manage addiction often experience a range of problems that affect their capacity to parent including mental illness, unemployment, stress and impaired family functioning (37). A review of the literature on parental substance misuse on children conducted by the National Advisory Committee on Drugs found that children of substance misusers are more likely to experience problems with mental health, social skills, academic achievement and substance use (38). This review of the literature made a number of recommendations, which included reviewing the extent to which treatment services are currently supporting parenting and working with other children's services and other relevant services.

In research on harm caused by drinking in Ireland published in 2014, one in ten adults reported that children for whom they have parental responsibility experienced at least one or more of the harms as a result of someone else's drinking. These circumstances included being left in unsafe situations, being verbally or physically abused, or witnessing serious violence in the home. This was more pronounced among adults from lower socio-economic groups. A child is more likely to experience one or more harms as a result of someone else's drinking when parents themselves are regular risky drinkers (39).

⁷ This likely refers to non-medical /clinical professions

3 Methodology

3.1 Overview of Methods Used

The aims of this research were to conduct an evaluation of the ARC Alcohol Reduction Programme to identify its effectiveness, areas for improvement and recommendations for future development. In total, 36 individuals were consulted for this evaluation through five methods, outlined in the following table.

Table 1: Stages of Research

Step	Method	Details
1	Data Analysis	Anonymised programme outcomes measures analysed
2	Literature Review	Analysis of relevant literature
3	Focus Groups	17 programme participants 4 ARC Staff
4	Participant Surveys (facilitator supported)	16 programme participants
	Professional stakeholders survey	10 professional stakeholders
5	Semi Structured interviews conducted by phone	2 programme participants 5 key stakeholders
6	Case Studies	4 programme participants
6	Collation of Report	Final evaluation report

3.2 Analysis of Existing Data

Data on participants' perceptions of various domains of their lives was collected by Addiction Response Crumlin team using the Outcome Star before and after participation on the programme. The Outcome Star is a tool that was developed by Triangle consulting for St. Mungoes Housing Services and has seen been adapted for use across a range of social services in the U.K and Ireland. The Outcome Star uses a scatter gram to display change using a ten point likert scale under a number of thematic headings.

3.3 Staff Focus Group

The purpose of the focus group with staff was to identify what they felt worked for the participants and for themselves as facilitators, to look at areas for future development and to discuss any lessons that have been learnt throughout the programme that may be of use to other services running Reduce the Use or similar courses. The staff focus group was conducted as a SWOT analysis of the programme under a number of categories:

- ▶ Promotion / getting people onto the programme
- ▶ Flexibility of programme or adhering to the pre-developed course
- ▶ Timing of delivery (time of year / week)
- ▶ On-going supports for clients
- ▶ Showing outcomes and impact

- ▶ What helped or hindered clients
- ▶ Assessment of resources into the programme
- ▶ Transferability of the programme to other areas or projects
- ▶ Staff knowledge, experience, training and qualifications
- ▶ Supports for staff and internal communication structures

3.4 Participant Focus Groups, Interviews and Surveys

There were two participant focus groups with 17 participants in attendance in total; seven women and ten men. One was held in the morning and one in the evening, to facilitate those who were working during the day or those who had childcare considerations. Two interviews were also held with participants who had not completed the programme to elicit feedback on their experiences. The focus groups, interviews and case studies explored the following themes with programme participants:

- ▶ Things that drew them to the programme
- ▶ Their perceptions of the programme and the organisation before they joined
- ▶ Challenges in accessing the programme and how they managed them
- ▶ What worked well on the programme
- ▶ What could be improved on the programme
- ▶ What other types of treatment they had previously availed of
- ▶ What additional supports they availed of since
- ▶ How they were at the time of the consultation, and how they were spending their time

Facilitators of participant focus groups administered surveys to all participants who attended, and 16 were completed. Facilitators helped participants who identified themselves as requiring support with reading and writing to fill in the surveys. The surveys asked questions about alcohol consumption and other change areas from the Outcome Star. The purpose of this was to check and validate findings from the Outcome Star evaluations that had been conducted with programme participants by ARC staff at the beginning and end of their engagement with the programme.

3.5 Professional Stakeholder Surveys

The research team developed surveys in conjunction with staff from ARC and the Local Drugs Task Force. These surveys were hosted online using the SogoSurvey platform and a link to the survey was sent to representatives from a number of agencies who had a connection to Addiction Response Crumlin either through their work with a similar client group or because they are a social service located in and around the Dublin 12 area. Ten responses were received, which represented an approximate 25% return rate on surveys.

All participants worked with people with alcohol problems who need professional support; four people said 'yes' and six people said 'sometimes'. 40% (four people) said that between 25% and 49% of their client group had alcohol problems, and likewise 40% of respondents (four people) said that less than 10% of their client base had alcohol problems. Only one person said they worked with none, and one person did not answer the question.

3.6 Professional Stakeholder Interviews

Semi-structured phone interviews were conducted with five professional stakeholders for the following purposes:

Table 2: Strategic Stakeholder Consultations

Role	Reason
The Managing Director of ARC	Strategic overview of the ARC organisation Feedback on the capacity of the organisation Feedback on gaps and blocks to service provision in the local area
The Coordinator of the Local Drugs Task Force	▶ Strategic overview of service provision in the local area ▶ Feedback on capacity in the area generally ▶ Feedback on gaps, blocks and strategic opportunities for interagency groups and service providers in the area
The Chairperson of the Local Drugs Task Force	As above
The Coordinator of the Ballymun Drugs Task Force	▶ To provide learning from another Task Force area who had taken a strategic and targeted approach to the issue of alcohol in the region
The Director of the SAOL Project	▶ To provide expert input as the Director of the SAOL Project who developed the Reduce the Use model used by ARC. SAOL have trained over 250 professionals nationally in facilitating the programme.

3.7 Case Studies

The research contains four case studies with participants. These were captured through semi-structured interviews. Interviews were held with volunteers in a quiet room, and researchers typed or wrote notes. Participants told their story, and were supported to do so by a number of open questions that guided the discussion. The purpose of these case studies was to provide a nuanced, detailed exploration of the experience and impact of a number of participants. In all cases, the names were changed, and identifying information was omitted to protect anonymity.

3.8 Limitations to the Research

Limitations identified for the research are as follows:

- ▶ Sample size: 36 people were involved in the research in total. This included 17 programme participants, four ARC staff, five key strategic stakeholders and ten professionals from other services.
- ▶ Comparative studies: as the Reduce the Use programme has not been evaluated, there is no comparable data. Likewise, no publically available benchmarking system has been agreed for the Outcome Star so there is no way of measuring whether the change for the participants in this research was more or less significant than in other programmes.

- ▶ Participant Responder Bias: People who participate are more likely to be able to have been successful in the programme; those who are drinking problematically may be less likely to return to a therapeutic environment or to participate in a focus group.
- ▶ Professional Responder Bias: It is possible that those who have worked with ARC previously, those who know their work, and those who think favourably of the work of ARC were more likely to respond to the professional stakeholder survey.
- ▶ There is a possibility that changes in drinking and other areas measured through the survey may not be accurate as they are self-reported and reported from memory rather than using any objective data. However, this has been mitigated to some extent with reporting on data referring primarily to the pre-post outcomes star measures.



3.8.1 CASE STUDY ONE -

Sylvia's Story

Sylvia is 52 and had her first drink when she was fifteen. Her daughter was in foster care due to alcohol use in the family since she was ten years old. Her daughter is now in a supported home getting additional supports for behavioural issues.

Sylvia heard about the course through her brother:

'The facilitator gave me a call to see if I would like to come down. I was a little scared and nervous about coming down. I wouldn't say anything for a while, and then they encouraged me to talk. I thought I was talking rubbish but they let me know I wasn't. Now I have friends here you can trust and say anything to, they don't judge.'

Since gaining control of her drinking, Sylvia has more access to her daughter, and they are getting on well.

'We have had problems in our family. I have also been into Strengthening Families in ARC, this really helped our family, we acted our feelings and they gave rewards.'

Through the course, Sylvia has greatly reduced her drinking and has seen the negative effects of this on her health and her family. Sylvia stated that she feels an immense sense of pride in her achievements.

'The facilitator rang me the other day, and asked if I wanted to come back to aftercare. My next step is to keep off the drink. I go to college on Tuesdays, I organised this myself and have a one-to-one teacher.'

3.8.2 CASE STUDY TWO -



Paul's Story

Paul is in his late thirties, and he has had alcohol problems since he was sixteen years old. From a very early age, he was in trouble with the police, having spent time in St.Pat's detention centre. Paul has two teenage children but feels like his drinking has damaged his family. Before coming to ARC, in the previous two years, Paul had thirteen months of sobriety:

I was doing well until march of last year; I got bad news about a family member and went back on it. I just went back drinking vodka in the morning afternoon and evening at my lowest point. Paul went over to ARC one evening because he was fed up trying to give up drink by himself. He needed help. In 2012, he did the course.

I thought it was brilliant. The fact that you're able to sit down, make friends with people who've been through it. The fact that you can share things and other people who have an alcohol problem can understand you. You're shown friendship.

Nowadays, Paul has started repairing relationships with his son and daughter, and often brings his son fishing. He's on a supported employment programme and seeing a key worker. A big challenge for Paul is that all of his old friends are drinkers so he finds it hard to socialise. He also has some charges that he must face in court that are from when he was drinking and he's anxious about going back to prison.

Paul's looking forward to chilling out, meeting someone and enjoying evenings in.

Findings

1 Client Outcomes

1.1 Overview

This section presents what changed for clients as a result of the programme, what worked in the programme and any areas that would benefit from further development. This chapter also highlights some key lessons from participant's previous experiences of treatment.

1.2 Key Data on Changes in Alcohol Use

In both 2012 and 2013, alcohol was the area in which the most change was observed. The average reported improvement in both 2012 and 2013 was by four points on the Outcomes Stars 10 point likert scale. A four-point movement can be described with reference to the following definitions of metrics on the outcome star:

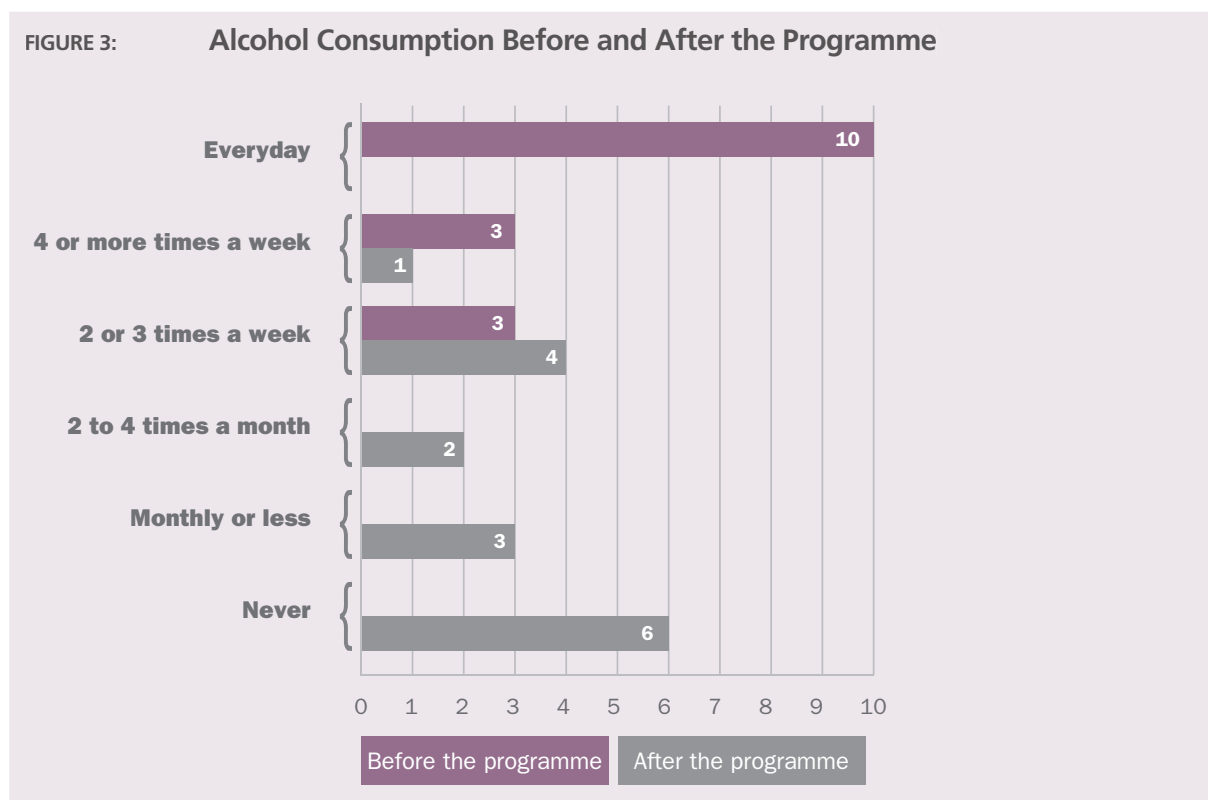
Table 3: Meaning of Scores in Relation to Alcohol on the Outcome Star

Score	Interpretation
1	I don't think I have a problem with alcohol, although others think I do
2	Maybe my drinking does cause problems, but that's just the way it is
3	Maybe I need some help around my drinking
4	I am willing to try things my worker or doctor say will help
5	I see that I need to make changes myself to tackle my drinking
6	I am doing some things myself to address my drinking
7	I understand why I have / had a problem and what I need to do to stop
8	I am not drinking problematically, but need support to maintain that
9	My drinking is not a problem but I need occasional help to keep this up
10	I don't have an alcohol problem, I can manage without support from the service

Because the Alcohol Reduction Programme is a lower threshold support, the scoring was adapted to reflect participant goals within the scope of the programme. The findings reported in the Outcome Star were replicated in the survey undertaken as part of this review, adding weight to their accuracy. The following data was obtained through independent surveys undertaken with 17 service users.

The changes in alcohol consumption as captured by the survey (completed by 16 of 17 participants) are depicted in the chart on the following page. Some of the key findings include:

- ▶ Prior to the programme all participants drank regularly; after the programme, 38% of participants (six people) said they never drank.
- ▶ Prior to the programme, 63% of participants (ten people) drank every day; after the programme, no participant said they drank every day.
- ▶ Before the programme, everyone drank at least two to three times per week. After the programme, 69% of people (11 people) drank less than this.
- ▶ It also of note that in the focus groups, two people stated that they had already ceased alcohol use prior to beginning the programme.



1.3 Key Data on Other Changes Made by Participants

In order to measure outcomes, the team in ARC used the Outcomes Star tool to measure progress towards goals in a variety of domains from the participant's perspective. The star data is written collaboratively between the participant and keyworker on the Alcohol programme at the beginning of the process and at the end of the process. Only those who completed the programme filled out the final data, meaning information is not included for those who did not complete the programme. For the purposes of this review, progress was measured as follows:

Table 4: Interpretation of Levels of Change

Heading	Heading
No improvement:	▶ 0 point increase
Smaller improvement:	▶ 1 point increase
Moderate improvement:	▶ 2 point increase
High Improvement:	▶ 3 – 4 point increase

The following are highlights from the 2012 and 2013 programmes as measured by the outcomes star:

1.3.1 Areas of High Collective Improvement (3-4 points)

In 2012, participants reported a high level of change in emotional health (+three points). Participants also reported a high level of change in social networks and use of time (+three points), as described below by one participant in the focus group:

I have a daughter who is 16 who doesn't live with me, because of alcohol. She's now going to counselling and we are going to a family group. My control over alcohol is really helping me with my daughter. We have a good relationship.
(Participant)

In 2013, on average, physical health also scored highly (+3 points), as illustrated:

I can walk around cause of the change in alcohol. I am fitter and healthier.
(Participant)

1.3.2 Areas of Moderate Collective Improvement (2 points)

In 2013, participants, on average, reported a moderate improvement in a number of areas including physical health, use of time, social networks and emotional health.

1.3.3 Areas of Smaller Collective Improvement (1 points)

The areas in which participants showed small improvements in both 2012 and 2013, were accommodation and drug use. In 2013, money also showed small improvements. There was no change marked for offending in either year. However, when comparing the findings from the outcomes star with those from the surveys conducted for this research, there are some interesting points to note:

Drug Use: For ten of the 16 people who participated, drugs were not identified as an issue. For all those who identified it as an issue, they said that there had been significant change since participation on the programme.

I've cut my weed use by half.

(Participant)

On this issue, a key stakeholder with expertise in Reduce the Use noted:

Lots of times people will come with poly drug use and they will reduce the use to zero for the most problematic drug...We often see a major change in one of the substances and minor changes, but awareness raising with the others.

(Key Stakeholder)

Offending: For seven of the 16 people, offending was not identified as an issue, and for all those who did identify it as an issue, significant change was recorded since participation on the programme – all marked a rate change of between seven – ten (marked as 'big change' on a visual scale) in this area.

Accommodation: For ten of the 16 people, accommodation was not identified as an issue, but for four of the remaining five, significant change in accommodation was recorded since participating in the programme (all four marked a ten, while the fifth person marked a one):

I moved out of my family home, out of my mothers. My brother was an alcoholic so I'm much better off now.

(Participant)

Financial: Results in the outcome stars showed that financial situations had, on average, not improved significantly. However, it is of note that some participants in the surveys reported significant improvements in their financial situation three to six months following the programme. While this does not provide pre and post data, it indicates a general sense of improved financial situations for those who participated.

I am able to go on a holiday!

(Participant)

Improvement in Family Situations: While the average changes in this area noted in the Outcome Star results were not as dramatic as others, it was very clear both from the surveys and focus groups that family relations was an area that had improved significantly for many people, particularly parents.

I bringing my son to his football matches – that's my big change, he's nine, he's delighted to see me watching him playing football.

(Participant)

I was always into training horses, since I got sober, I have bought two horses, and after school I pick the kids up we go and muck out, the kids love it.

(Participant)

FIGURE 4: Changes for Participants in 2012

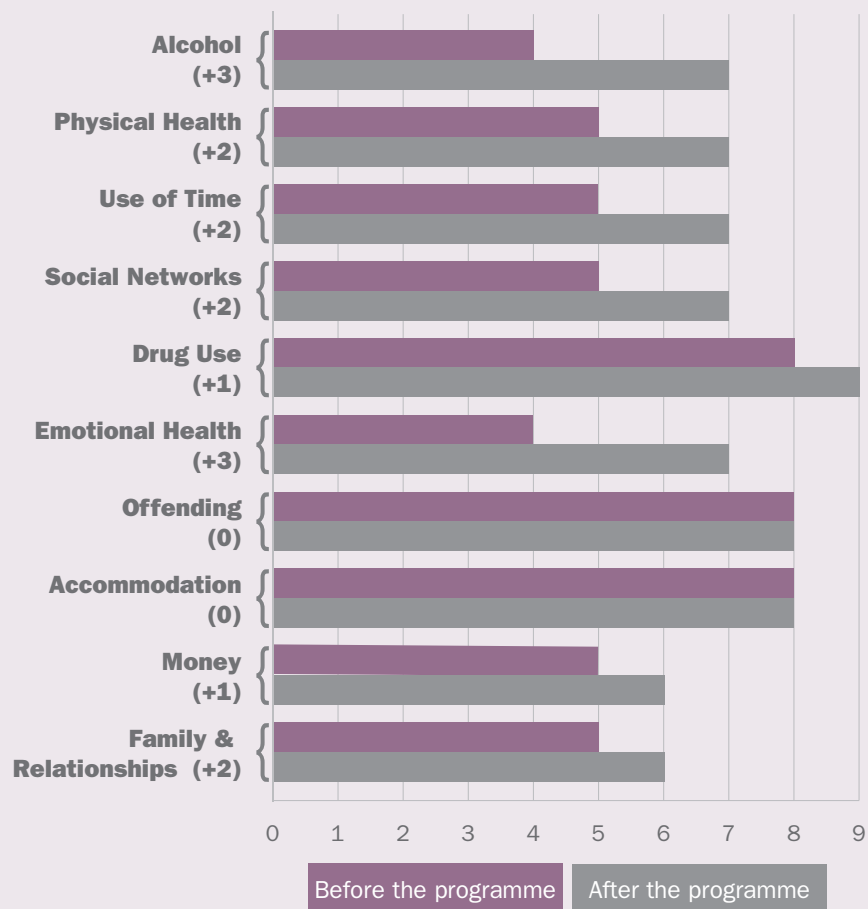
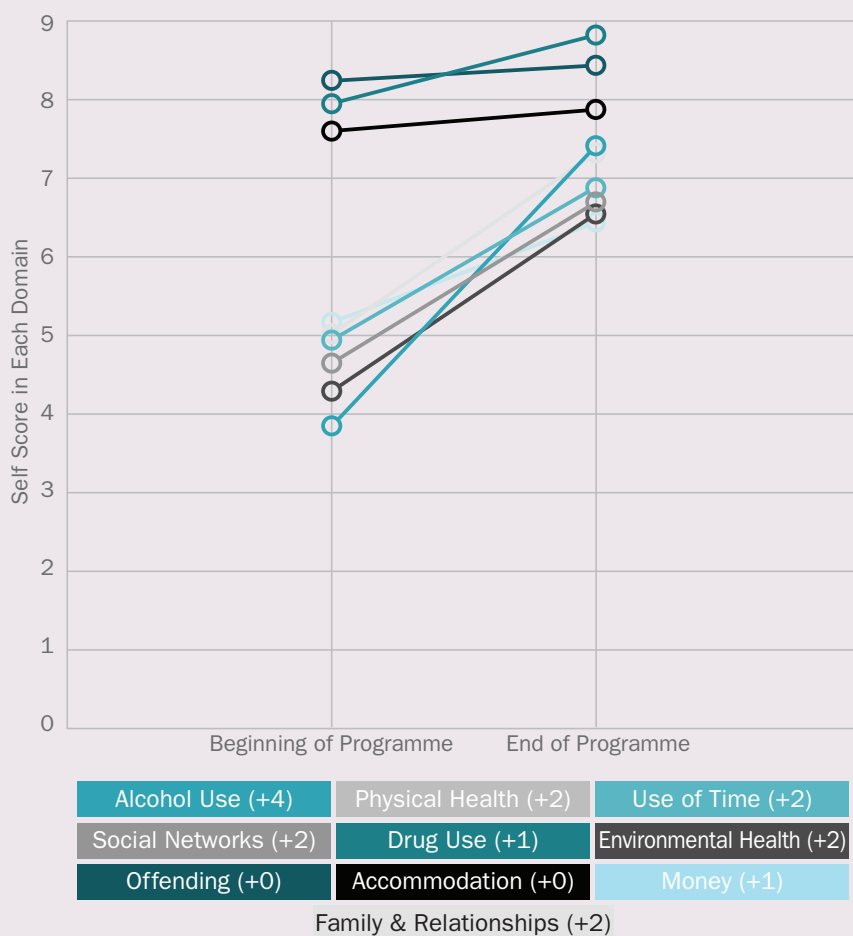


FIGURE 5: Changes for Participants in 2013



1.4 Previous Experiences of Treatment

A majority of people: 69% (eleven people), had previously tried treatment for their alcohol use. The following statistics show that a number of people had tried a number of different treatment or support options:

- ▶ 31% (5 people) had tried AA
- ▶ 19% (3 people) had tried residential
- ▶ 38% (6 people) had tried a counsellor
- ▶ 19% (3 people) had tried a detox with their doctor
- ▶ 31% (5 people) had never tried anything
- ▶ 38% (6 people) had tried at least two different things

In focus groups, particular conversations arose around the difference between AA and the Alcohol Reduction Programme, and participants' experiences of residential treatment. These are described below.

1.4.1 Alcoholics Anonymous (AA)

Almost one third of the group had previously tried AA meetings, and while staff and participants saw the value in this programme, it became clear that for this cohort, AA was not a suitable environment or support for their recovery at that time. Concerns noted by participants included the transitory nature of membership of AA compared to the closed style group in the Alcohol Reduction Programme and the focus in AA on sharing stories about drinking:

In AA they all talk about the past, this programme [the Alcohol Reduction Programme] was all about what to do now and how do it.

(Participant)

AA did agree with me for the beginning, after going to a group like this, I can see how there is a lot of one up-manship like 'you used to drink eight, I used to drink 16'.

(Participant)

After discussing the roles of the different groups, there was a general agreement in the staff group that the two programmes were complimentary, and that there is a value in having a number of treatment options for community based alcohol supports.

1.4.2 Residential

The need for diverse treatment options was clear from the experiences of those participants in the focus groups who had tried residential treatment programmes. All three residents who had tried residential had said the experience had not been successful for them, and two people found it particularly unhelpful. Some general disadvantages to residential versus community-based treatment were noted:

They're more controlling in residential. You're in a cocoon. It's protected and there's no temptation. Out here, it's up to you.

(Participant)

As well as some advantages:

You're told what to do and when do to it; when to sleep and eat. It does give you structure.

(Participant)

The only thing I got out of it was giving my body the three-month break.

(Participant)

There were some stories told about some religious run treatment centres that people found inappropriate and concerning:

I saw a couple of people who didn't agree with their philosophy who were thrown out the gate. You were forced to do [religious] things.

(Participant)

These experiences with AA and residential treatment centres should be considered in light of the fact that both of these types of treatment are the preferred method for some people. It can be presumed that a programme such as the Alcohol Reduction Programme would likewise not be suitable for some people. It is outside the bounds of this evaluation to compare different types of provision; it was clear from conversations in the group that the Alcohol Reduction Programme was a viable and successful local alternative for many people. This reinforces the need for a variety of treatment options and strong inter-agency referral pathways to ensure that people are directed towards services that best suit their needs and can support positive outcomes for service users.

1.5 Service User Deaths

ARC reported that over the course of the two years that three service users passed away. One person was actively engaged with the alcohol free programme, and two had previously completed the alcohol reduction programme.

2 Accessibility of the Alcohol Reduction Programme

2.1 Overview

The findings in this section highlight a number of features of the programme that make it accessible and effective according to participants and stakeholders, the chapter also highlights some areas for potential development in terms of increasing awareness of and referral to the programme.

2.2 Strengths

2.2.1 Community Based Ethos

Three quarters of the focus group participants (76%, 13 of 17) were attracted to the programme because they felt that ARC offered a service that 'spoke' to people in the same language as they used. They felt this was different to services they had received previously which were felt to be less accessible due to attitudes, language or culture of the professionals involved and a perceived distance between their culture and that of the professionals:

[In ARC] We all speak the same language. We are not talked down to.
(Participant)

The doctors are middle class and sometimes don't understand. [The Doctor] said one more pint is going to kill you – that's not true. A hundred maybe, but one won't. Everyone is the same level here.
(Participant)

Key stakeholders with a strategic oversight in the area also agreed that this was a key strength of the programme. They felt that there were a number of opportunities for the Task Force and other partners to promote the programme to those who may need it. Any promotion strategy will benefit from highlighting the community based and accessible nature of the programme and the fact that the programme involves people with experience in addiction who talk in a way that is easily understood and meaningful to those on the group.

2.2.2 The Opportunity to Reduce without an Obligation to Abstinence

The ARC Alcohol Reduction Programme offers participants the opportunity to set their own goals in relation to their alcohol use. The fact that the programme offered the option to reduce, without an expectation of abstinence, appealed to almost three quarters of the focus group participants (71%, 12 people). This openness created a sense of not feeling judged for many participants. Supporting both reduction /

moderation and abstinence goals accommodates those who have concerns about immediately working towards abstinence, which is often a requirement of most residential programmes. On discussing this issue with a key stakeholder with expertise in Reduce the Use, he noted:

It was absolutely central to Reduce the Use. As far as I'm concerned, that is the thing that made Reduce the Use work.

(Key Stakeholder)

2.3 Challenges

2.3.1 Lack of Referrals from Some Services

The alcohol team in ARC described their efforts to promote the programme with a diverse range of key stakeholders in the community. Efforts have included handing leaflets and information packs into other community services including doctors, health services, Gardaí, libraries and community facilities. Despite these efforts, they felt that referrals to the programme did not reflect unmet need in the community.

Of the professionals in other services who responded to the survey, three had worked with participants on the alcohol programme, but only one person had referred to the ARC Alcohol programme. Normally they refer people with alcohol problems who need additional professional support to:

- ▶ HSE Alcohol Services (5 people mentioned this)
- ▶ A community service other than ARC (5 people mentioned this)
- ▶ Residential services (4 people mentioned this)
- ▶ AA (3 people mentioned this)

A number of programme participants said that prior to attending or being referred to the ARC Alcohol Reduction Programme they had not heard of ARC or the alcohol programme. This indicates a need to explore alternative efforts to promote information about the service to ensure that suitable people in the community are informed about this treatment option:

I was two years around the corner before I knew about this

(Participant)

The impending adoption of the NDRIC protocols in the area presents opportunities for increased, formalised interagency working. One of the key stakeholders identified this:

D12 is bringing in the NRDIC framework; it would be good to champion that

(Key Stakeholder)

Local Nature of the Programme

While the local, community-based nature of the service was perceived as a strength of the programme, there was also a disadvantage to this. Two participants discussed the fact that because the project was local that it was initially a deterrent to them joining the programme. One participant knew that many of her neighbours used ARC services and found this off-putting. This concern regarding confidentiality in the community was also echoed by one professional survey participant:

Most clients who have had contact with ARC are very positive about the programme, some clients however, wish to avoid the programme as other ARC service users are known to them and they wish to avoid these individuals
(Key Stakeholder)

Other professional survey participants who had previously chosen not to refer to the programme, despite knowing about it, were asked why. For two people, they were not working with people with alcohol issues. For one person the treatment modality was not suitable, for one person the client had previously worked with ARC and did not wish to go back, and one person did not know about the programme.

When asked if they had sufficient information about the programme, 60% of professional survey participants (six people) said that they did not, and that they would like more information. 60% said that they would like to hear more through email, 50% (five people) would like posters or leaflets for their service, and 30% would like a meeting or information session with staff from the programme.

2.3.2 Timing of the Programme

Some participants felt that the programme was inaccessible because it was on during the day and many people who might need the support work typical business hours. The participants suggested that an option to participate at evenings and weekends would be helpful. This consideration is noted as a recommendation for the programme in the recommendations in the first section of this report.

2.3.3 Branding and Misconception about the Service

A number of participants mentioned that they had not previously sought help from ARC because it has a reputation as a drug service or they considered it an AA meeting type service:

I thought it was just for people on the gear. I didn't know they helped people like me. I think a lot of people think that.
(Participant)

I was intimidated at first as I thought it was like AA.
(Participant)

One professional who completed the survey also noted this:

Some clients have commented that the ARC website focuses heavily on drug use and this may be worth reviewing in terms of putting a clearer focus on alcohol.

(Professional Stakeholder)

Given the success of the organisation in responding to drug problems in the area, and the fact that the organisation was established to respond to the heroin crisis, as well as the fact that the alcohol programme is a relatively new development within the organisation, this misconception is unsurprising. Indeed, as one key stakeholder pointed out in an interview, this challenge is not exclusive to ARC:

The branding issues does not just lie with ARC, it lies with the whole sector. It's to do with general perceptions of drugs and alcohol.

(Key Stakeholder)

2.4 Summary

There is an opportunity to build on these strengths and manage the challenges outlined by focussing on branding, promotion and the expansion of the service to more accessible hours. These considerations are addressed in the recommendations section.

CASE STUDY:

Ellen's Story

Ellen is married, in her sixties and has lived in Dublin all of her life. Ellen wanted to stop her drinking as she was overdoing it. She was starting to drink in the morning and continuing throughout the day. Ellen felt people were talking about her, and was feeling physically and mentally unwell. Ellen fell and hit her head and was admitted to hospital. The doctors let Ellen know that it was time to reduce her drinking. It was time to change.

Ellen talked about her drinking problem with a friend who had also had a drink problem. Her friend recommended that she come to the alcohol programme in ARC.

"Everyone was very kind, caring and helpful and they put you straight – it's a mugs game really that drinking. The programme gave me confidence and hope – it truly did. I was able to save a few bob in the credit union for a holiday as well. I'm now a year off alcohol, although I did have two drinks at Christmas. My life has improved. It's great, I can walk around feeling proud, I'm happier – I'm not a bit bitter about not having a drink. I can now do it without the programme. I can go to the pub and drink the alcohol free Erdinger".





CASE STUDY:

Dave's Story

Dave is a 35 year-old Dubliner. Drink has been a problem nearly as long as he can remember. He was shy, had no confidence and the drink helped him cope, but then he couldn't stop. He was thrown out of school at 16 for it. Only in the last two years has he started to realise and admit that he has issues with it.

"I found out about the course through my doctor. It was a life-saver, in a way. I was in a mess. I'd gone to AA but it wasn't for me. I thought that there were no other alternatives."

Looking back, for Dave the first few sessions on the Alcohol Reduction Programme were difficult. The facilitators asked the tough questions. Dave realised that he had co-dependency in many of his relationships and had to make some hard decisions about cutting people out of his life.

"For me writing it down was important - the negatives and positives, things like the isolation. I couldn't do groups and talk in front of people. I could see the slow changes and I stuck it out. Now I am so much more comfortable with groups and people. I am seeing a life-coach; he's a great support."

Dave is now off drink. He still feels challenged socially, for many years it was the only way he could meet people and he's finding that hard to replace. He's working on this issue with his life coach.

"I'm not recognisable now from two years ago. You couldn't pay me enough to take this away from me."

3 Programme Content and Delivery

3.1 Overview

This section outlines some of the key strengths and challenges identified in the delivery of the programme. Key strengths included the role of staff attitudes in fostering a therapeutic alliance, the flexible nature of goal setting, the mixed method of delivering support, the skills of the facilitators and the responsive approach to using an evidence-based approach⁸. A number of challenges and opportunities for development were also identified with regard to programme structure and external barriers to development including a lack of alcohol-free social opportunities for participants.

3.2 Strengths

3.2.1 Staff Attitudes

There was an overwhelmingly positive regard for the facilitators of the programme by the participants. This was arguably one of the most valued aspects of the programme for participants. All participants said that they felt welcomed, accepted, cared for, challenged and did not feel judged:

There was care from the facilitators. They made me feel like I deserved help.
(Participant)

A key stakeholder with expertise in Reduce the Use confirmed the importance of this element in the programme:

Showing empathy, care, kindness and acceptance facilitates permission to ask that question [about change]. When you eventually ask someone 'what would you like to do', when you're asked by someone who is kind and accepting, it's a completely different experience.
(Key Stakeholder)

3.2.2 Flexible Approach to Goal Setting

The Alcohol Reduction Programme took a flexible approach to working with participants using techniques from a broad range of approaches from harm reduction, to abstinence supports and relapse prevention:

If we didn't want to stop, they'd help us set goals like 'If you're getting your Vodka, don't drink it all, just drink half'.
(Participant)

8 See literature review for summary of evidence to approach

There was general agreement in the group (71%, 12 people) that setting their own goals and making a commitment to the group about their drinking without being pressured into specific decisions or changes by anyone was a huge help:

Everyone made their own deal, but it was out of respect for the group and the facilitators you kept them. If you did stay and extra hour [in the pub] or buy cans then it wasn't the end of the world".

(Participant)

Even if people were struggling to meet their goals, there was a perceived unconditional acceptance of participants, which was clearly an important factor:

When you're an alcoholic, you need encouragement. You can see that the staff here care. You trust them. You tell them when you feel you've messed up. It's great when someone is telling you it's your decision not to drink.

(Participant)

There was general agreement that the programme was a safe place to make mistakes, and that you were judged on the goals you set for yourself, and not by the standards of others.

3.2.3 Group Work – Trust and Belonging

For many participants, it was their first time addressing their issues in a group setting and the experience of sharing, and learning from others stood out:

You're learning off others in the group. Others say, "That's why I failed", and you learn from this.

(Participant)

The trust, intimacy and family nature of the group was a significant strength: three quarters of focus group participants agreed with this (76%, 13 people):

Outside of here, there are not many people you can talk to about your problems. Not many people will understand you. I was scared, but as soon as I walked in here, on the first day, I felt like I wasn't alone.

(Participant)

The staff agreed that the intimacy of the programme – the closed structure – facilitated better therapeutic alliances between staff and participants and between participants:

In AA, it's different and there's always new people. It can put you off sharing. Here you have the chance to build trust.

(Participant)

A key stakeholder with expertise in Reduce the Use noted that the most important aspect of the group from his perspective was the learning that participants gleaned from one another:

The group are the ones bringing the insights and expertise. When people are at different places in their addiction and/or with different drugs, that can be a huge benefit. Someone can say 'when I went through this, this is what I did'.

(Key Stakeholder)

The value of the group setting and the closed structure of the group was a significant strength of the programme.

3.2.4 1-2-1 Supports

As well as attending group meetings, participants felt that the 1-2-1 support provided to them was hugely helpful in helping them to stick with the programme and to achieve their goals. 71% (12 people) of participants highlighted this as something particularly valuable to them about the programme. Participants were given the opportunity to select a key worker. Both staff and participants identified the advantage of having male and female staff members available in this regard. Staff also highlighted the importance of freedom of choice for participants in terms of building relationships:

The 1-2-1 support helped me to keep on track and to deal with my problems and feelings.

(Participant)

3.2.5 Additional Supports

Apart from providing group and 1-2-1 supports, the team provided a number of additional supports to participants while they were on the programme. These included calling residents outside of programme hours to check in on them, providing staff phone numbers for participants to contact on days where the programme was not on, and providing informal breakfast prior to the beginning of the session.

Discussing the additional supports provided through Reduce the Use, a key stakeholder with significant expertise in the programme noted the importance of environmental factors in developing the therapeutic alliance, citing Miller and noting the importance of 'engagement' in developing the therapeutic alliance:

It's all part of engagement. How can we communicate respect and understanding? It's kindness in action... the phone calls and reminder phone calls, checking in, getting good biscuits. We're developing the therapeutic alliance. We're getting permission to ask these very intimate questions.

(Key Stakeholder)

Phone calls: Participants were provided with the facilitators' phone numbers to call outside of programme hours (but within working hours). They perceived this to be very helpful, and eleven of the seventeen (65%) focus group participants availed of this at some point while they were on the programme.

Participants also discussed the fact that if they were not doing very well, if they were late coming in or missed a day, they would generally receive a phone call from one of the facilitators to see how they were:

There were days I didn't want to go in and I'd stay in bed. We'd get a call asking if we're ok and if we were coming in, and then you'd go in.

(Participant)

Participants were asked if these phone calls ever felt intrusive, all of the participants who answered said that it did not. They said that such communications always felt supportive and non-judgemental. All participants in the focus groups said that this additional support made them feel like the team cared:

You would get phone calls unexpectedly to check on how you were. They're listening to your voice to tell if you are alright. Everyone felt that they were being cared for by the call.

(Participant)

Although staff reported that friendships between participants outside of the programme were discouraged, the participants were encouraged to exchange phone numbers with other members to call for support when needed. Almost half of participants (47%, eight people) availed of this support at some point.

Breakfast: Every morning before the session began, the staff provided an informal breakfast to participants. Many participants felt that the breakfast was an important part of the programme and the reasons given included that it made the day informal and took some of the pressure off at the earlier part of the day. For some, eating breakfast was also an important symbolic difference between their lives as programme participants and their lives prior to addressing their alcohol use:

'I would wake up in the middle of the night and drink half a bottle of vodka to try and avoid the hangover, breakfast wasn't in the picture'.

(Participant)

Of those who were asked, 100% of participants felt that breakfast was a very important part of the programme. Almost three-quarters of those who responded (73%, eight people) said that prior to the programme, they would habitually drink first thing in the morning. They discussed how alcohol reduced appetite, and an idea none as 'eating is cheating'; that eating was perceived to reduce the effect of any alcohol that would be taken over the course of the morning.

As soon as you came in to the group and had breakfast, it changed you from thinking about drinking. It got us used to eating.

(Participant)

The group saw a very strong value of the breakfast and highlighted that this helped them change their morning routine, bring food back into their schedules 'get used to eating again', as well as reduce anxiety about programme participation.

Opening Hours of the Service: The fact that ARC was open on a Saturday and at difficult times such as Christmas Eve and Christmas Day was helpful, as these were said to be difficult days for people struggling with alcohol:

On a Saturday morning you'd come up and there's a breakfast in the morning time and you could blow a breathalyser on a Saturday morning. That was one thing for me that was really helpful. Friday nights were such a danger for me.

(Participant)

3.2.6 Filling the Void

A core facet of the programme was giving participants practical experience of being active and social without alcohol. Filling the void involved supporting participants to experience a range of social activities and to develop communication skills in a social setting. This was generally appreciated by participants who noted a number of benefits including relaxation, fun, doing something different, and doing something they may not normally be able to afford:

The trips were good for wind down and bonding, we also get to have a laugh and forget about our problems for a while.

(Participant)

We learnt how to enjoy ourselves and be out in the world without drink. I was looking forward to it, felt like we had achieved it, when you come out we felt better.

(Participant)

3.2.7 Reduce the Use and Additional Modules

Reduce the Use is a ten session cognitive behavioural therapy based programme developed by SAOL project. The programme is aimed at people active in addiction to drugs, who wished to reduce their use but did not wish to commit, at least in the first instance, to full cessation of use. This programme was used and adapted by the team at ARC. Staff brought their own skills base to the course (outlined in the following section). The team used the complete Reduce the Use model, but changed the drug focus to alcohol and added a number of modules as outlined in the introduction to this report.

The team noted that every time they ran the programme, they reviewed and made an effort to improve on it. For example, the 'Filling the Void' component was felt to be a core facet of the programme. Unfortunately, because it required significant resources it was reduced; it involved bringing participants on field trips which were often costly and time consuming. It had been 40% of the programme in programme one and two, but had been reduced to 30% of the programme for programme three and is likely to remain at this level for future programmes, due to on-going resource constraints.

3.2.8 Staff Training and Experience

The staff team have a wealth of experience and qualifications in their field. Staff involved in programme delivery had between five and fourteen years of work experience in drugs or addiction. All staff involved in delivery of the programmes had a primary degree in addiction or social care. All staff members had also completed certified training in a number of areas including the Community Reinforcement Approach (CRA), Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI). The staff also mentioned using their skills in Harm Reduction, Humanistic Therapy, Reality Therapy, Client Centred Approach and Choice Theory in their interactions with clients. Staff felt that while training in CBT can be helpful for facilitators, they did not feel that it is an essential qualification to use the Reduce the Use or other reduction programmes.

There was consensus on the staff team that having different approaches, skills and personalities was important to building positive relationships with the diverse group of participants on the programmes:

Staff all have different personalities and clients have a choice in who they open up to. Clients on the aftercare could still be seeing staff from the Reduce the Use.

(Staff Member)

A key stakeholder with expertise in Reduce the Use noted that staff competence is an essential component for running these programmes successfully noting in particular the need for group facilitation skills and connection with addiction services:

You need someone who's got very good group skills, because they have to manage time, assess who needs extra time and the ability to cope with whatever happens to emerge. If you have someone who's not used to being able to manage disclosures, domestic violence, slips, tears... it's not safe. You need someone to be able to hold the group.

(Key Stakeholder)

Staff also felt that team dynamics and professional support was a key element to the success of this programme, and in particular, an encouraging environment for discussing challenges arising and seeking advice from colleagues:

A huge strength is that as an alcohol team, we're very friendly with each other and get on really well with each other. We sit and talk about the programme and about individual service users. None of us are afraid to share problems we are having and get advice from each other.

(Staff Member)

Formal and informal meeting and information sharing structures supported effective communication on the team about participants.

3.2.9 Coping Skills and Personal Development

In focus groups, it was clear that participants put considerable value on a number of coping skills they had developed including anger management, ability to manage stress and substance misuse in the home, as well as improvement in self-confidence, and feelings of self-worth. Some of these changes experienced by participants are illustrated in the following quotes:

It helped me to deal with my anger. To stop and think before I lost it. It was about helping me to not feel like a scumbag, helping me see that I deserved to be happy

(Participant)

I was left with a lot of problems once the drink was gone. I learned about the fact that everything keeps changing, so when you're low, it will change too.

(Participant)

3.3 Challenges

3.3.1 Filling the Void

A major challenge facing those in recovery is filling time that used to be occupied with drinking. The programme prepared participants to successfully 'fill the void' by facilitating social activities. The aim of this programme was to support clients to develop new interests, coping skills for dealing with difficult times and to make plans to help them to occupy their time in an enjoyable manner. Examples provided by the staff included outings, art therapy, preparing for Christmas and other occasions.

On the alcohol free programme, resources were limited so the focus was mainly on planning and skills development, rather than the experiential element. If the programme had the budget, the staff said that trips would have been a part of the alcohol free programme.

A particular strength of the alcohol reduction programme was the availability of a bus borrowed from another community service, and the facilitator having a license to drive a bus, which meant that outings could be provided for participants at a lower cost.

3.3.2 Client Mix

There were mixed feelings among the group regarding the age mix. The broad spectrum of ages was felt by staff to be advantageous, and they observed that young people learned a lot from older participants. However not all participants who discussed this agreed:

It's hard for a sheltered, unconfident older person. Young people just constantly talk over you, laughing and joking and making fun and they don't realise, and they talk about their drinking loads. Young people mix together and isolate away from the rest of the group.

(Participant)

There were two people on the group who had previously stopped drinking before they began the group and mentioned feeling like they were on a different level and that it was a bit hard being around people who were drinking.

3.3.3 Group Work is Not for Everyone

A participant mentioned that they never got over their discomfort with group-work, but found the 1-2-1 extremely helpful, and two participants mentioned that they had been very frightened at the beginning and did not speak, but eventually opened up:

For me, the group was difficult. I never got the hang of it. The 1-2-1 was way more important to me.

(Participant)

One participant mentioned that some people could be very domineering and take over the group. One key professional stakeholder indicated that clients were more inclined towards 1-2-1 support and this is why they may go to another service:

Information on ARC is routinely provided, as part of a menu of options, as per our own alcohol policy. Clients often have prior experience of multiple alcohol agencies and in my experience, often favour a service which immediately can offer them individual counselling appointments. Many clients discuss and plan to attend ARC... as it is a local service with a good reputation.

(Key Stakeholder)

These issues may be a natural facet of group dynamics, however they highlight a need to pay continued attention to management of the group. For many people, groups are a particularly challenging environment and there is an opportunity in the closed, intimate structure of the Alcohol Reduction Programme to ensure that quieter people or those who are less comfortable in a group are given sufficient support to stay in the group, and opportunity to participate.

3.3.4 Check-ins

Three participants in one group mentioned that the check-ins at the beginning of the group were very long and boring and went on for too long. They felt that structured work was too short sometimes. On discussing this particular issue with a key stakeholder with expertise in Reduce the Use, it was noted that:

The time you allocate to a check in at the start of the group gets longer and longer as people open up and that's taking up more and more time. It's not about how are you doing, it's about how was your safe plan and your goals – it's a structured review of the participants previous week.

(Key Stakeholder)

3.3.5 Confidentiality

Some concerns were raised in one of the focus groups about the confidentiality of the space. Participants said that they could hear others voices outside their room towards the end of the group, and when they were leaving they had to pass through a waiting group. They said they would like a 'buffer zone' either in terms of time or space so that this would not happen.

3.4 Summary

Strengths of the programme highlighted by staff and participants support the aims of the original Reduce the Use model in relation to providing a non-judgemental therapeutic environment, using creative ways to support retention on the programme and the therapeutic alliance between facilitator and participant, and promoting recovery and independence through the development of coping skills including pro-social alcohol-free activities. The findings also point to a number of factors that need to be considered in running such a group including the client mix, managing group dynamics, the availability of resources and suitability of timing of classes / venue. All of these learnings have been incorporated into the recommendations section of the report.

4 Alcohol Aftercare and Follow-on Supports

4.1 Overview

A key support required by participants moving towards abstinence or moderated drinking is finding ways to use their time. This was both a strength of the programme and a challenge for participants. Participants did learn to use their time in a meaningful way and many engaged with aftercare supports. However, there are barriers to socialisation for participants, and opportunities for ARC and their partners in the area to provide increased care of, and opportunities for, people in recovery.

4.2 Strengths

4.2.1 Participants Learned to Use their Time

Being in active addiction can be a very time consuming way of life. Many of the participants described their drinking and pursuit of alcohol as a full-time activity. A significant challenge that participants encountered as they reduced or ceased drinking was how to fill the time. All participants bar one had found rewarding ways to fill their time since completing the programme:

- ▶ One person was about to return to full time education
- ▶ Three people had taken places on Community Employment programmes
- ▶ Four people said they go walking in the evenings
- ▶ Five people said they are spending more time with their family
- ▶ Others mentioned activities including the cinema, swimming, horses, art and shopping

Four participants (24%) reported no longer feeling shame, and feeling able to be out in public:

[I enjoy] walking around, which I was afraid to do before. Before I would take to my room, as I was ashamed, and I would just watch telly, now I bring the dog for a walk, and I intend to go to a counsellor as a back-up.

(Participant)

4.2.2 Follow- On Supports

The majority of focus group participants (52%, n=9) had accessed follow on supports, both within ARC and elsewhere, to help them to keep to their goals in relation to alcohol use and other issues in their lives:

I ended up going to the alcohol free programme. I wouldn't have gone there if it wasn't for the reduction programme, I was slipping and sliding.

(Participant)

Aftercare is a social place to be, it's generally in the evening. It keeps me focused.
(Participant)

Staff in ARC identified the increasing need for structured aftercare supports in the area.

4.3 Challenges

4.3.1 Socialising

There was almost unanimous agreement in participant focus groups that socialising without alcohol is one of the most significant challenges. It was noted that the recovery community and/or the geographical area can both have relatively small populations, so meeting new people – friends or romantic relationships – can be challenging.

Staff identified similar concerns regarding social opportunities, but also highlighted that supporting friendships between participants on the alcohol reduction programme can be counter-productive and compromise recovery. They noted that when people are alcohol free they can access aftercare and do social activities outside group hours, but with the alcohol reduction programme there is less support in terms of socialising together:

We don't encourage friendships in the group setting. In the past when we have, it's gone belly-up, there's been trouble. What happens is one person slips and brings the other with them. Because we don't encourage it, quite often people who come to the service remain isolated
(Staff Member)

Participants in the focus group were enthusiastic about the value of associating with other people in recovery and the idea of establishing more solid social networks for people who are alcohol-free. Respondents were asked about the most appropriate means of communicating in relation to social events. For many participants, the internet was not the most accessible format. They agreed that text messages would be the best way to communicate information about meet ups and activities with them.

4.3.2 Onward Referral / Information about Other Services

There was general agreement in one of the groups that they did not feel they had enough information about other services available to them and that they would appreciate this as part of the course, or a noticeboard in the programme with lots of leaflets and posters. Few, if any participants could recall being referred on to other services outside of ARC and two people in one of the focus groups mentioned that they did not know that there was cheap or free 1-2-1 counselling available in the area. This may relate to the fact that ARC contains a full continuum of care within the services, and so many referrals are internal. However, it points to potential to improve the service by making participants aware of the full range of activities available to them within the local and extended community and supporting participants to access them.

4.3.3 Participants who are Unsuccessful

The question of what happens when someone has repeated the programme and it doesn't work for them was one of particular concern for staff. As it currently stood, people were invited back to participate a second time, but staff were concerned about the value of offering a place for a third time.

People have asked if they can do it a third time and we're not sure there's any benefit to it for them. You have to judge it case by case... but if they've done the two full programmes and shown up every week, it may be that they need something else and then to come on to the alcohol free group.

(Staff Member)

On presenting this finding to a key professional stakeholder with significant expertise in Reduce the Use, he agreed that taking such situations on a case-by-case basis is important, and having a strong initial assessment can help to identify whether a third or fourth round of the programme would be helpful:

If someone is genuinely stuck, being in an environment where other people are trying to make change can help the penny to drop. We also know that people are doing the 'right thing' to keep social workers etc. happy and really aren't interested in change at this time...If a third or fourth time isn't going to help then don't offer it.

(Key Stakeholder)

For those who are not successful, or may not genuinely want to engage with the programme, there is a need for ensuring strong interagency links and clear referral pathways to other services for participants who may not be suitable for the programme.

4.3.4 Follow-On

While considerable resources are channelled into supporting retention on the programme, there may be opportunities for supporting continued motivation with follow on phone-calls after an agreed length of time after completion of the programme. This is illustrated by a quote from one of the participants in the focus groups:

If calls were made to people more after the course, that could help them with their motivation. Call them again is the advice.

(Participant)

4.3.5 Reviewing the Programme

Staff currently use the Outcome Star to measure progress at the beginning and end of the programme, and this provides very useful data for staff both in terms of monitoring change at an individual and an aggregate level. However, the staff do not currently assess mid-term progress on the programme, medium term outcomes (e.g. at three / six months after the programme) or outcomes for those who do not complete the programme.

4.4 Summary

The focus on developing skills for moving towards moderated alcohol use or abstinence are a key focus of the programme. There is an opportunity to support sustained motivation by increasing follow on contacts, providing additional information on other supports available outside the organisation, and ensuring there are robust procedures for supporting repeat participants. Additionally, the organisation can focus on improving the range of information gathered to assess outcomes and identify successes and gaps in the programme. A number of challenges were present in relation to the resourcing of pro-social activities, which primarily relates to strategic barriers, which are discussed in the following section of the report.

5 Strategic Considerations for Dublin 12

5.1 Overview

This section explores some of the key strategic or interagency challenges and opportunities arising in relation to problem alcohol users in the community. Key opportunities identified include the development of a cross-task force regional or national recovery movement and the development of an alcohol specific strategy for the area. Some challenges that may be managed by interagency coordination include allocation of resources, employment opportunities for people in recovery and the needs of parents and children living with problematic alcohol use.

5.2 Strengths and Opportunities

5.2.1 Strategic Support for the Development of a Recovery Network

The absence of adequate opportunities for socialisation and filling time for people in recovery has been highlighted previously in the report. Both the staff on the programme and all key stakeholders consulted in interviews agreed that there is a need for different Task Force areas and service providers to work together to support the development of a recovery model similar to the UK and other jurisdictions:

There's a need for a network of services who delivery recovery programmes to work together.
(Key Stakeholder)

5.2.2 Development of a Local Alcohol Strategy

There is potential for engaging enthusiastic partners in the development of a local strategy using existing networks and resources for development and implementation. All key professional stakeholders agreed that the development of an alcohol specific strategy will support a response to the issue in the area. There was concern expressed about the capacity of Task Forces and service providers to respond to this issue:

The Task Forces are being given the role of being drug and alcohol task forces. We can't do that without taking a strategic approach. There's an appetite to address it but there's also an apprehension because services have been constrained by budgetary cutbacks and we're conscious of the challenges.
(Key Stakeholder)

While resources are tight, it isn't just about money. There are things that can be done without money.
(Key Stakeholder)

5.3 Challenges

5.3.1 Funding Alcohol Work

Currently, funding is not ring fenced for alcohol work in ARC and the project are struggling to meet the needs of clients presenting with alcohol use. This challenge was noted by key professional stakeholders as one that is endemic in the sector:

[The state] needs to implement the findings of the substance misuse alcohol group now, not in five years. We would like a dedicated funding stream to run an alcohol project but our drugs services are already overstretched.

(Key Stakeholder)

All key stakeholders agreed that the pressure on Task Forces to respond to the alcohol problem threatens the capacity of services to continue to respond to drug problems, particularly considering the potential extent of the alcohol problem compared to the illicit drug problem:

Sometimes Task Forces lack clarity and mandate at national level. To what extent are we expected to, or do we have the capacity to, ask our projects to respond to alcohol without diluting the services they are already offering on dwindling budgets?

(Key Stakeholder)

5.3.2 Employment

All participants who discussed the issue, including all professional stakeholders, agreed that there are very limited opportunities for income generation and employment for those in recovery:

They want the nights here - relaxation, massage and all that - but they also want employment, they need up-skilling.

(Key Stakeholder)

As part of the alcohol strategy and other local strategies, there is a need to explore opportunities in relation to employment. All key stakeholders agreed that exploring innovative opportunities such as a social enterprise supported by community business clauses would be a useful approach to addressing this issue.

5.3.3 Childcare

All key stakeholders agreed that a challenge that needs a strategic response is the combined issue of parenting for people in addiction, and the needs of their children:

Current childcare for people seeking support around their addiction is not good enough. I'd love to see childcare – parenting support and supporting parents in addiction not to lose their children to social services. They need support with school work, mental welfare, confidence. The kids of people in addiction need to get the extra supports they need. We have some service provision but the new Child and Family Agency and addiction services in the area need to come together to develop childcare support specifically for children of parents in addiction, including a family therapist and structured programmes.

(Key Stakeholder)

5.4 Summary

Needs of people with problematic alcohol use and the barriers experienced by services working with them require a strategic response and creative use of existing resources and expertise in the community. These considerations inform a number of recommendations outlined in the first section of the report.



References and Appendices

References

1. Doyle, J. & Ivanovic, J. National Drugs Rehabilitation Framework Document. Dublin: HSE; 2010.
2. National Treatment Agency for Substance Misuse. Models of Care for Alcohol Misusers (MoCAM). London: Department of Health; 2006.
3. National Advisory Committee on Drugs and Public Health Information and Research Branch. Drug use in Ireland and Northern Ireland. Alcohol consumption and alcohol-related harm in Ireland: 2010/2011 Drug Prevalence Survey. Bulletin 7. Dublin: NACD and PHIRB.
4. Tillitski, Christopher J. A meta-analysis of estimated effect sizes for group versus individual versus control treatments. *International Journal of Group Psychotherapy*; 1990.
5. McRoberts, C., Burlingame, G. M., & Hoag, M. J. Comparative efficacy of individual and group psychotherapy: A meta-analytic perspective. *Group Dynamics: Theory, Research, and Practice*, 1998: 2(2); 101.
6. Rogers, C. *Client Centred Therapy*. Cambridge Massachusetts: The Riverside Press; 1951.
7. Horvath, A. O., & Luborsky, L. The role of the therapeutic alliance in psychotherapy. *Journal of consulting and clinical psychology*, 1993: 61(4); 561.
8. Bordin ES. The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 1979: 16; 252–260.
9. Guydish, J., Sorensen, J. L., Werdegar, D., Chan, M., Bostron, A. & Acampora, A. A randomized trial comparing day and residential drug abuse treatment: 18 month outcomes. *Journal of Consulting and Clinical Psychology*, 1999: 67; 428–434.
10. Miller, William R. Hester, Reid K. Inpatient alcoholism treatment: Who benefits? *American Psychologist*, 1986: 41(7); 794-805.
11. Donohue, B., Azrin, N. H., Lawson, H., Friedlander, J., Teichner, G., & Rindsberg, J. Improving initial session attendance of substance abusing and conduct disordered adolescents: A controlled study. *Journal of Child & Adolescent Substance Abuse*, 1999: 8(1); 1-13.
12. Panepinto, W. C., & Higgins, M. J. Keeping alcoholics in treatment: Effective follow-through procedures. *Quarterly Journal of Studies on Alcohol*, 1969.
13. De Leon G, Sacks S, Staines G, McKendrick K. Modified therapeutic community for homeless mentally ill chemical abusers: treatment outcomes. *American Journal of Drug Alcohol Abuse*, 1999: 26(3); 461-80.
14. Greenwood, G., Woods, W., Guydish, J. & Bien, E. Relapse outcomes in a randomised trial of residential and day drug abuse treatment. *Journal of Substance Abuse Treatment*, 2001: 20; 15–23.
15. Raistrick D, Heather N & Godfrey C. *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency; 2006.
16. Raistrick, D. Management of alcohol detoxification. *Advances in Psychiatric Treatment*, 200: 6(5); 348-355.
17. Edgar P. Nace, Madeline Naegle *Managing alcohol abuse in primary care*, *Patient Care*, 1993: 27(5); 102.
18. Budd, T. D., Budd, L. D., & Budd, M. D. Effective and inexpensive procedures for decreasing client attrition in an outpatient alcohol treatment program. *The American Journal of Drug and Alcohol Abuse*, 1980: 7(1); 73-82.

19. Department of Health (England) and the devolved administrations. Drug Misuse and Dependence: UK Guidelines on Clinical Management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive; 2007.
20. NICE Clinical Guideline 115. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.
21. NIL
22. Patterson, D. G., McCourt, M. W., & Shiels, J. R. Community psychiatric nurse aftercare for alcoholics. *Irish Journal of Psychological Medicine*, 1991.
23. Klijnsma MP, Cameron ML, Burns TP, McGuigan SM. Out-patient alcohol detoxification – outcome after 2 months. *Alcohol and Alcoholism*, 1995: 30 (5); 669-673.
24. Lefforge, N. L., Donohue, B., & Strada, M. J. Improving session attendance in mental health and substance abuse settings: a review of controlled studies. *Behavior Therapy*, 2007: 38(1); 1-22.
25. McLellan, T. Questioning the Effectiveness of Addiction Treatments in Miller, W & Weisener C. (eds) *Changing Substance Abuse Through Health and Social Systems*. New York: Kluwer Academic; 2002.
26. Raistrick, D. Management of Alcohol Detoxification in Day E (ed). *Clinical Topic in Addiction*. Royal College of Psychiatrists: London; 2007.
27. Joint Committee on Health and Children. Report on the Misuse of Alcohol and Other Drugs. Dublin: Department of Health and Children; 2012
28. World Health Organisation. European Status Report on Alcohol and Health. WHO: Copenhagen; 2010.
29. Health Research Board. Treated problem alcohol use in Ireland: figures for 2012 from the National Drug Treatment Reporting System. National Health Information Systems, Health Research Board. Available at www.hrb.ie/publications/21518
30. Moyers, T. B., Martin, T., Manuel, J. K., Hendrickson, S. M., & Miller, W. R. Assessing competence in the use of motivational interviewing. *Journal of Substance Abuse Treatment*, 2005: 28(1); 19-26.
31. Long, J., Jackson, T. Kidd, M., Kelleher, T. & Sinclair, H. Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas, 2000 to 2002 Occasional Paper No. 10, Dublin: Drug Misuse Research Division (Health Research Board); 2004.
32. Byrne, S. Costs to Society of Problem Alcohol Use in Ireland. Dublin: HSE; 2010.
33. Department of Health and Children. Steering Group Report on a National Substance Misuse Strategy. Dublin: DOHC; 2013.
34. Marlatt, G. A., & Witkiewitz, K. Harm reduction approaches to alcohol use: Health promotion, prevention, and treatment. *Addictive Behaviors*, 2002: 27(6); 867-886.
35. Pike B. British-Irish Council discusses recovery from problem drug use. *Drugnet Ireland*, Issue 41, Spring 2012 . p. 9.
36. Burke, S. & Keane, M.. A new model of progression for recovering drug users. *Drugnet Ireland*, Issue 30, Summer 2009 . p. 17.
37. Breshears, E.M., Yeh, S. & Young, N.K. *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers*. U.S. Department of Health and Human Services. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2004.
38. Horgan, J. *Parental Substance Misuse: Addressing its Impact on Children - A Review of the Literature*. Dublin: National Advisory Committee on Drugs; 2011.
39. Hope, A. Alcohol's harm to others in Ireland. Dublin: Health Service Executive; 2014.
40. Department of Health. Report on the review of drugs task forces and the national structures under which they operate. Dublin: Department of Health; 2012. Available at <http://www.drugsandalcohol.ie/19054/> Accessed on 23/04/2014
41. Galway Healthy Cities. Galway City Strategy to Prevent and Reduce Alcohol-Related Harm 2013-2017. Available at: <http://www.galwayalcoholstrategy.ie/uploadedfiles/Galway%20Alcohol%20Strategy%202013%20-%202017.pdf> Accessed on 24/04/2014
42. Ballymun Local Drugs Task Force. *A Road to Change: Ballymun Community Alcohol Strategy 2010 – 2016*. Dublin: Ballymun Local Drugs Task Force; 2010.

Appendix: Case Study: The Development of the Ballymun Local Alcohol Strategy

This case study was developed through a phone interview with the Ballymun LDTF coordinator.

The Ballymun Local Drugs Task Force in conjunction with a number of key partners developed an alcohol strategy for the local area.

Agreement Regarding Need and Scope

The need for a strategy was originally identified by residents in the community. As far back as the early 2000's, issues were being voiced at regular community consultations. At the time alcohol was considered to be outside the remit of the Drugs Task Forces. In 2008, the Task Force began to look at a structured approach to the issue and initiated a number of round table discussions on alcohol related harm in the community. After the first roundtable, there was a unanimous agreement that a collective response was needed.

“We invited Gardaí, politicians, service providers just to tell us how they encountered alcohol harms in the area. Once people expressed that, and they saw the impact at a community level, we had to move with it. It was clearly such a huge issue affecting so many people”.

The group considered the target population for the strategy and decided from an early point focussing on problem street drinkers would not be enough as it was an issue that affected the whole population in a more significant way than illegal drug use or poly substance use.

Building an Evidence Base

First steps taken were to look at evidence from other areas, with the help of experts and consultants in the relevant areas. A population study to mimic the national household study was conducted in the area and used the same company to conduct the research as had conducted the national household study on alcohol. They interviewed 355 households in the area to establish attitudes and behaviour around drinking.

“This gave us a fairly sharp focus around some of the behaviour, especially around younger adults, how they drink and their behaviour around drinking”.

Building a Coalition

Looking at it from a multi-faceted approach and engaging as many stakeholders in the process was considered a key strength. A consultant with expertise in the area was formally engaged in the process, and support was elicited from a number of other experts in relevant areas.

We took on Dr. Ann Hope as a mentor for our community alcohol strategy. Dr Shane Butler in TCD was very helpful to us too.

Apart from community members and service providers, a number of key players were identified:

Dublin City Council: Having Dublin City Council bought into the strategy was very helpful; there were successes in having access to the city development plan and being able to intervene in planning applications for alcohol retail businesses.

The Gardaí: The Gardaí were very involved and they worked with retailers to develop responsible codes of practice regarding the sale of alcohol. The Task Force also ran responsible service and trader trainings in conjunction with the Gardaí.

Local Councillors: Having the city councillors were considered helpful in lobbying around certain issues. For example, with regard to alcohol delivery services, the Gardaí were awaiting direction from the Director of Public Prosecutions as to whether they could clamp down on these services. The councillors had been able to raise this matter in appropriate fora to put pressure on the DPP to provide a response.

The HSE: The HSE were at the table and very involved from the outset, and this was considered helpful in a recent acquisition of funding for an alcohol treatment programme.

However, one barrier noted in this area, namely the national remit of some of the organisations involved meant that decision-making could be slower, and commitments were not made as early as they were needed.

Identifying Barriers in the External Environment

There were barriers to implementing many solutions that have been shown in evidence to work to influence alcohol consumption, including minimum pricing and marketing restrictions. In areas such as this, the Task Force had to await developments at a national or legislative level, while they focussed on areas where they could take action.

Providing Support to Services to Implement the Strategy

As well as the training provided to alcohol businesses in responsible serving, the Task Force ran training in a brief intervention model with 46 professionals in the area including GPs, teachers and youth workers.

Resourcing Development of the Strategy

Funding was not ring-fenced from the Task Force budget, resources were made available from the existing Task Force complement, namely the coordinator and two staff who lead the process. The organisations involved in the strategy brought their expertise and resources to the table. The Community Policing Forum also provided some resources from the Ballymun Regeneration budget.

Reviewing Progress

The strategy was developed and regularly reviewed in line with the pillars of the National Drugs Strategy.

“Initially the strategy was fairly cursory; we didn’t go down into an implementation plan. Five round table discussions were held over the following four to five years to refine the strategy”.

One particularly useful development was the identification of a gap in relation to treatment. Recently, the Task Force, in partnership with two other local Drugs Task Forces in Finglas and North County Dublin, successfully applied for funding from the HSE to develop a structured out-patient community detoxification programme.

Areas for Development: Recovery Opportunities

At the time of the research, the Task Force were engaged in a mapping exercise regarding employment and educational opportunities, as well as recovery supports for those who successfully address problematic substance use, and anticipated developing a plan for this.



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