

# **The delivery of psychological interventions in substance misuse services in Scotland**

**A guide for commissioners, managers, trainers and practitioners**

## Contents

<b>Foreword</b> .....	<b>3</b>
<b>Acronyms</b> .....	<b>5</b>
<b>Executive summary</b> .....	<b>6</b>
<b>1. Introduction</b> .....	<b>8</b>
<b>2. Who is the guide for?</b> .....	<b>12</b>
<b>3. Which interventions should be delivered, and by whom?</b> .....	<b>14</b>
Principles of psychological intervention delivery .....	14
<b>4. Considerations around particular groups presenting to substance misuse treatment services</b> .....	<b>23</b>
Psychological interventions in trauma-informed substance misuse services .....	23
Psychological interventions for cognitive impairment in substance misuse services.....	25
<b>5. Training and governance of psychological interventions in substance misuse services</b> .....	<b>29</b>
<b>6. When should different interventions be provided?</b> .....	<b>34</b>
How stable does someone need to be to engage in psychological therapy? .....	34
Do we need to consider medication dosage? .....	34
Integrated interventions.....	35
<b>Appendix 1. Example audit tool to identify recommended level of training and supervision</b> .....	<b>36</b>
<b>Appendix 2. Outcome measurement</b> .....	<b>38</b>
<b>Glossary of terms</b> .....	<b>39</b>

## Foreword

We are delighted to support this report and commend it to those with responsibility for commissioning services for some of our most vulnerable people. The report marks a significant contribution to improving our collective understanding of the value of psychological interventions to prevent and to treat mental health problems among people with problematic drug and alcohol use.

What the report demonstrates is that building capacity across health, social care and wider services to be psychologically informed can bring huge benefits, and can support early and effective interventions. There are excellent examples of dual diagnosis in Scotland, and some practice which is making a real difference. Our ambition is that there should be consistency in both access and the quality of such services.

The report will help inform the implementation of a number of the ambitions in our Mental Health Strategy. We want to see improved access to high quality, evidenced-based, specialist mental health care for those who have higher levels of need, as well as general health care for people with mental health problems. NHS Boards are working hard to reduce waiting times for access to psychological therapies for all ages and waiting time standards for drug and alcohol services continue to be met. The Scottish Government will continue to offer national support to NHS Boards working in this area, with a programme of improvement and learning from good practice.

This emphasis is also a key part of our drugs strategy “Road to Recovery” published in 2008, and is currently being refreshed. This report has been published under the auspices of the Partnership for Action on Drugs in Scotland, and has its roots in our work to improve quality and consistency, as well as promote innovative and imaginative models of service delivery to better support those with complex needs.

The report also contributes to the delivery of two specific Actions (27 and 28) in our Mental Health Strategy about improving referral and treatment arrangements for people with both problem substance use *and* mental health diagnosis (“dual diagnosis”). This report creates a platform through which we can develop the practice that we want to see, and supports commissioners, and front line services to be more aware of the range of interventions that might be possible.

In the last decade, mental health services have changed dramatically with excellent work from NHS, local authorities, and third sector organisations. Staff in all of these organisations, at all levels, make life-changing, and life-saving, interventions every day. The emphasis in the report on the psycho-social aspects of treatment will support continued change for the good, and provide hope of recovery for those struggling with problematic substance misuse. We want to take this opportunity to thank all those involved in producing the report.



*Maureen Watt*

Minister for Mental Health



*Shireen Campbell*

Minister for Public Health and Sport

## Acronyms

ACE-III	Addenbrooke's Cognitive Examination, 3 <sup>rd</sup> edition
ADP	Alcohol and Drug Partnership
BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
DCP	Division of Clinical Psychology
EMDR	eye movement desensitisation and reprocessing
LDP	local delivery plan
LPASS	Lead Psychologists in Addiction Services Scotland
MI	Motivational Interviewing
NES	NHS Education for Scotland
NICE	National Institute for Health and Care Excellence
NTA	National Treatment Agency for Substance Misuse
ORT	opiate replacement therapy
PTSD	post-traumatic stress disorder
SDF	Scottish Drugs Forum
SIGN	Scottish Intercollegiate Guidelines Network

## Executive summary

### Introduction

This guide sets out a strategy for the delivery of psychological interventions for substance misuse services in Scotland. Fundamentally, its purpose is to increase access to evidence-based psychological interventions for people working to recover from problematic alcohol and drug use.

### Who is the guide for?

The guide was written primarily for managers and commissioners to support the development of psychological intervention provision in substance misuse services. It is also intended as a guide for training providers to assist them in prioritising, designing and implementing training programmes, and for practitioners to benchmark their own practice and guide their professional development.

### Which interventions should be delivered, and by whom?

A matched-care model of delivery is presented. This model offers 'tiers' of care, so that each step up leads to more intensive interventions for service users with more complex needs, requiring additional competencies, training and supervision structures for providers.

The model proposes that the foundation for all service delivery within a substance misuse service should be psychologically informed care (Tier 1). Psychologically informed care uses principles of Motivational Interviewing, therapeutic engagement and node-link mapping to support service users on their recovery journey. Clinical staff working across all services (including integrated non-statutory or social care partners) will have a role in delivering Tier 1 interventions

Low intensity interventions (Tier 2) are aimed at mild-to-moderate addiction difficulties, and mild-to-moderate co-morbid mental health problems. They are delivered by a range of multidisciplinary practitioners trained in specific structured interventions.

High intensity interventions (Tier 3) are aimed at moderate/severe addiction difficulties and co-morbid mental health problems. These are standardised psychological therapies delivered to protocol by applied psychologists and Cognitive Behavioural Therapy therapists trained to certificate and diploma level. Tier 3 interventions require specific competencies, accreditation in the particular intervention, and supervision by an appropriately trained supervisor.

Highly specialist interventions (Tier 4) for complex and enduring problems are individually tailored interventions based on case formulations drawn from a range of psychological models. They are most frequently delivered by clinical and counselling psychologists where there is a need to modify standardised approaches or devise a novel approach for a specific presentation.

## **Considerations around particular groups**

### **Trauma**

Most people attending substance misuse services are thought to have a history of trauma (as well as being particularly vulnerable to experiencing further trauma). The concept of complex trauma has been proposed to capture the often-overwhelming range of symptoms with which people with such histories present.

Integrated interventions that address both difficulties in a parallel intervention are recommended when working with co-morbid trauma and substance use. In cases of complex trauma and substance use, phased or staged approaches are recommended by expert consensus.

A matched-care model for the delivery of trauma-informed care within a substance misuse service is presented. The model mirrors the one outlined earlier in the guide, but relates specifically to different levels of interventions for co-morbid substance misuse and post-traumatic stress disorder (PTSD)/complex PTSD.

### **Cognitive impairment**

Due to the impact of chronic alcohol and drug use on the brain, many service users presenting to substance misuse services will experience impairment of cognitive abilities. When this goes unrecognized, it can impact on an individual's ability to engage with, and make progress in, treatment. It is therefore important to screen for cognitive impairment early in treatment, when clinically indicated.

Recommended screening tools include the Addenbrooke's Cognitive Examination, 3<sup>rd</sup> edition, and the Montreal Cognitive Assessment. Where cognitive screening suggests that further investigation is indicated, a referral for comprehensive neuropsychological assessment should be made to a clinical psychologist or clinical neuropsychologist.

Once again, a matched-care model of interventions for people with cognitive impairment is presented.

## **Training and governance of psychological interventions**

This section outlines the minimum training requirements for the competent delivery of psychological interventions at each tier of the matched-care models.

### **When should different interventions be provided?**

To engage in a psychological therapy, some stability in substance use is recommended, but an individual does not need to be completely drug- or alcohol-free. In general, dependent or chaotic substance use needs to be addressed prior to engaging in more formal psychological interventions (tiers 2–4). However, psychologically informed care will support engagement and motivation in all service users.

# 1. Introduction

This guide on delivery of psychological interventions<sup>1</sup> for substance misuse services in Scotland is designed primarily to support commissioners and providers in developing effective recovery-oriented systems of care, with psychological and psychosocial interventions at their heart.

Psychosocial interventions are key components of effective substance misuse treatment. In some cases, where no pharmacological interventions are available, they offer the only evidence-based treatment.<sup>2</sup>

Although the guide focuses primarily on delivering psychological interventions in specialist substance misuse services, many of its recommendations are equally relevant to delivery for people with substance misuse problems in other settings, such as primary care, mental health and prisons/forensic settings.

The guide relates to a number of national strategies and policy drivers in the fields of substance misuse and mental health. Box 1 highlights Scottish Government health policy and guidelines that the guide aims to complement.

The guide has evolved from strategic work carried out by the Lead Psychologists in Addiction Services Scotland (LPASS) and has drawn on work from the British Psychological Society's (BPS) Faculty of Addiction.<sup>3</sup> It was written to correspond with recently published UK guidelines on clinical management of drug misuse and dependence<sup>4</sup> and links directly to several actions outlined in the Mental Health Strategy 2017–2027,<sup>5</sup> particularly:

- **Action 24** – fund work to improve provision of psychological therapy services and help meet set treatment targets
- **Action 27** – test and learn from better assessment and referral arrangements in a range of settings for dual diagnosis for people with problem substance use and mental health

---

<sup>1</sup> Psychological interventions in this guide refer to both psychological and psychosocial interventions. These terms are often used interchangeably in the literature when describing processes and interventions aimed at enabling psychological and social change.

<sup>2</sup> Wanigaratne S, Davis P, Pryce K, Brotchie J. (2005). The effectiveness of psychological therapies with drug misusing clients. Research briefing 11. London: National Treatment Agency for Substance Misuse. ([http://www.dldocs.stir.ac.uk/documents/rb11\\_final.pdf](http://www.dldocs.stir.ac.uk/documents/rb11_final.pdf))

<sup>3</sup> British Psychological Society. (2012). The contribution of clinical psychologists to recovery-oriented drug and alcohol treatment systems. Leicester: British Psychological Society. (<http://www.nta.nhs.uk/uploads/contributionofcpsychologiststorecoveryorientateddrugandalcoholtreatment2012-022013.pdf>)

<sup>4</sup> Department of Health. (2017). Drug misuse and dependence. UK guidelines on clinical management. London: Department of Health. ([https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/628634/clinical\\_guidelines\\_2017.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628634/clinical_guidelines_2017.pdf))

<sup>5</sup> Scottish Government. (2017). Mental health strategy: 2017–2027. Edinburgh: Scottish Government. (<http://www.gov.scot/Resource/0051/00516047.pdf>)

- **Action 28** – offer opportunities to pilot improved arrangements for dual diagnosis for people with problem substance use and mental health diagnosis.

It also relates to two local delivery plan (LDP) standards:

- 90% of patients to commence psychological therapy-based treatment within 18 weeks of referral (previously HEAT A12)
- 90% of clients will wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (previously HEAT A11).

### **Box 1. Scottish Government health policy and guidelines**

#### **Drug treatment**

- Essential care: a report on the approach required to maximise opportunity for recovery from problem substance use in Scotland (2008) (<http://www.gov.scot/Publications/2008/03/20144059/0>)
- The road to recovery: a new approach to tackling Scotland's drug problem (2008) (<http://www.gov.scot/Publications/2008/05/22161610/0>)
- Delivering recovery. Independent expert review of opioid replacement therapies in Scotland (2013) (<http://www.gov.scot/Publications/2013/08/9760>)
- The Quality Principles: standard expectations of care and support in drug and alcohol services (2014) (<http://www.gov.scot/Publications/2014/08/1726>)

#### **Alcohol treatment**

- Changing Scotland's relationship with alcohol: a framework for action (2009) (<http://www.gov.scot/Publications/2009/03/04144703/14>)
- Quality alcohol treatment and support (QATS) (2011) (<http://www.gov.scot/Publications/2011/03/21111515/0>)

#### **Mental health and co-morbidity**

- Mind the gaps: meeting the needs of people with co-occurring substance misuse and mental health problems (2003) (<http://www.gov.scot/Publications/2003/10/18358/28079>)
- Mental health in Scotland: closing the gaps – making a difference: Commitment 13 (2007) (<http://www.gov.scot/Publications/2007/12/10141643/0>)
- Mental health strategy: 2017–2027 (2017) (<http://www.gov.scot/Publications/2017/03/1750>)

#### **Workforce development**

- Supporting the development of Scotland's drug and alcohol workforce (2010) (<http://www.gov.scot/Publications/2010/12/AandD>)

#### **Psychosocial interventions and psychological therapies**

- The Matrix: a guide to delivering evidence based psychological therapies in Scotland (2015) ([http://www.nes.scot.nhs.uk/media/3325612/matrix\\_part\\_1.pdf](http://www.nes.scot.nhs.uk/media/3325612/matrix_part_1.pdf)).

The guide is designed to support services to deliver timely access to effective psychological therapies. It is anticipated that it will therefore assist services to meet and maintain the 18-week psychological therapies LDP standard. The effective delivery of evidence-based psychological interventions (through improving outcomes for patients, reducing failure demand on services and

improving patient throughput) can also support services in meeting and maintaining the three-week drug and alcohol treatment LDP standard.

It is important to acknowledge that the guide has been influenced by, and sits alongside, the recently launched knowledge and skills framework for the Scottish workforce on transforming psychological trauma.<sup>6</sup> Section 4 of the guide, on the delivery of psychological interventions for people with co-morbid complex trauma and substance misuse, is very much in line with the framework's recommendations.

A robust evidence base outlines effective psychosocial and psychological interventions that support people to change their behaviour and maintain recovery, based on a psychological understanding of addictive behaviours. Section 3 provides an overview of the evidence-based psychological interventions recommended in substance misuse services. Section 5 outlines supervision and training requirements, highlighting the importance of workforce development and partnership-working across substance misuse services. In short, the guide seeks to illustrate which interventions will work for which people, when, and how they should be delivered.

The aim is to provide an aspirational model for delivery of psychological interventions in substance misuse services in Scotland. Delivery of the proposed model will require commitment from commissioners, managers and frontline staff, alongside creative thinking about prioritisation of service delivery within the context of available funding. The model is designed to be adapted for NHS boards of different size and scale, and recommendations support this where possible. Section 5 presents recommendations on access to training and support for areas in which the capacity and competency level of the workforce currently is not able to deliver the model as presented.

Fundamentally, the guide seeks to ensure that all people looking to recover from problematic substance misuse have access to the evidence-based psychological interventions they need. At all levels of the proposed delivery model is the acceptance that people will often still be using substances while accessing psychological interventions: indeed, many of the recommended psychological interventions aim specifically at a person's substance misuse problems.

Historically, people struggling with mental health problems alongside their problematic drug and alcohol use (often termed co-morbidity or dual diagnosis) have experienced difficulties accessing psychological interventions. The model presented here accepts that for many people, stopping substance misuse before dealing with co-morbid psychological difficulties is simply not possible. Indeed, the function of substance misuse is often to help the person cope with underlying and unaddressed psychological difficulties. It is therefore vital that people have access to treatment for these

---

<sup>6</sup> NHS Education for Scotland. (2017). Transforming psychological trauma. A knowledge and skills framework for the Scottish workforce. Edinburgh: NHS Education for Scotland. (<http://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf>)

difficulties alongside treatment for their substance misuse problems if they are to achieve lasting recovery.

## 2. Who is the guide for?

The guide has been prepared largely to support managers and commissioners in developing psychological intervention provision in specialist substance misuse services. It is hoped that it will also be useful to managers and commissioners of other services that work with people for whom substance misuse is a significant issue (such as mental health and prison services).

The guide:

- outlines the competencies required to deliver effective psychological interventions for service users and families
- considers the evidence base for the delivery of interventions, as well as integrating new interventions for which evidence may still be developing
- considers how best to implement training on psychological interventions into practice, and how to set up robust systems of clinical governance and practice development.

Commissioners can use the guide to:

- inform governance of services delivering psychological interventions across substance misuse services
- assess services delivering psychological interventions for substance misuse (an example audit proforma is given in Appendix 1).

Managers can use it to:

- support professional development
- inform development opportunities, and develop job descriptions incorporating psychological interventions competencies
- influence workforce development requirements
- support service redesign, ensuring those with competencies to deliver psychological interventions are integrated within teams
- ensure compliance with quality assurance and clinical governance expectations.

Training providers and coaches can use it to:

- prioritise workforce development for the substance misuse service workforce
- analyse their activities to enhance the impact of training activities and implementation in practice
- design and develop programmes of training and coaching that provide a range of learning opportunities aimed at supporting application to practice
- design and deliver training and coaching that is guided by the competencies required for each tier of the matched-care model described
- align programmes of training to systems of quality assurance and governance.

Practitioners can use the guide to:

- benchmark their own practice
- guide professional development
- provide evidence of development and reflection on practice in annual appraisals and reviews.

### 3. Which interventions should be delivered, and by whom?

#### Principles of psychological intervention delivery

All psychological interventions should be delivered as part of a recovery care plan, integrating the most appropriate psychological, social, medical and other non-medical interventions for an individual in recovery. Interventions should be based on a comprehensive assessment of need.

The choice of psychological intervention should be based on a formulation of an individual's difficulties. Psychological formulation is a way of understanding a person's, couple's or family's difficulties; it is developed in collaboration with them, links theory with practice, and provides a roadmap for intervention.

All delivery should be carried out within a clear structure of managerial and clinical supervision to ensure effective delivery and governance. Psychological interventions are delivered via a complex interpersonal interaction. Supervision specifically designed to support delivery is essential at each tier to ensure the safety and integrity of interventions for both service users and practitioners.

Peer support and access to the recovery community should be available at every tier, along with the potential for family and network interventions.

Most interventions will be delivered face to face, but some may be accessed by telephone or via the Internet, particularly in remote areas or as part of ongoing work. Care should be delivered in accordance with the Scottish Government's Quality Principles.<sup>7</sup>

A matched-care model of delivery is presented in Figure 1. This is based on the Psychological Therapies Matrix,<sup>8</sup> which outlines evidence-based psychological interventions for alcohol problems and substance misuse in Scotland. This model offers 'tiers' of care: each step up leads to more intensive interventions for service users with more complex needs, requiring additional competencies, training and supervision structures for providers. Staff with additional training and competencies can provide consultation and liaison to support early recognition and treatment of needs requiring higher-tier interventions.

Treatment may also be understood to move in 'phases' of care, recognising that different interventions may be more appropriate at different times in a service user's treatment journey. Interventions at all times should be based on

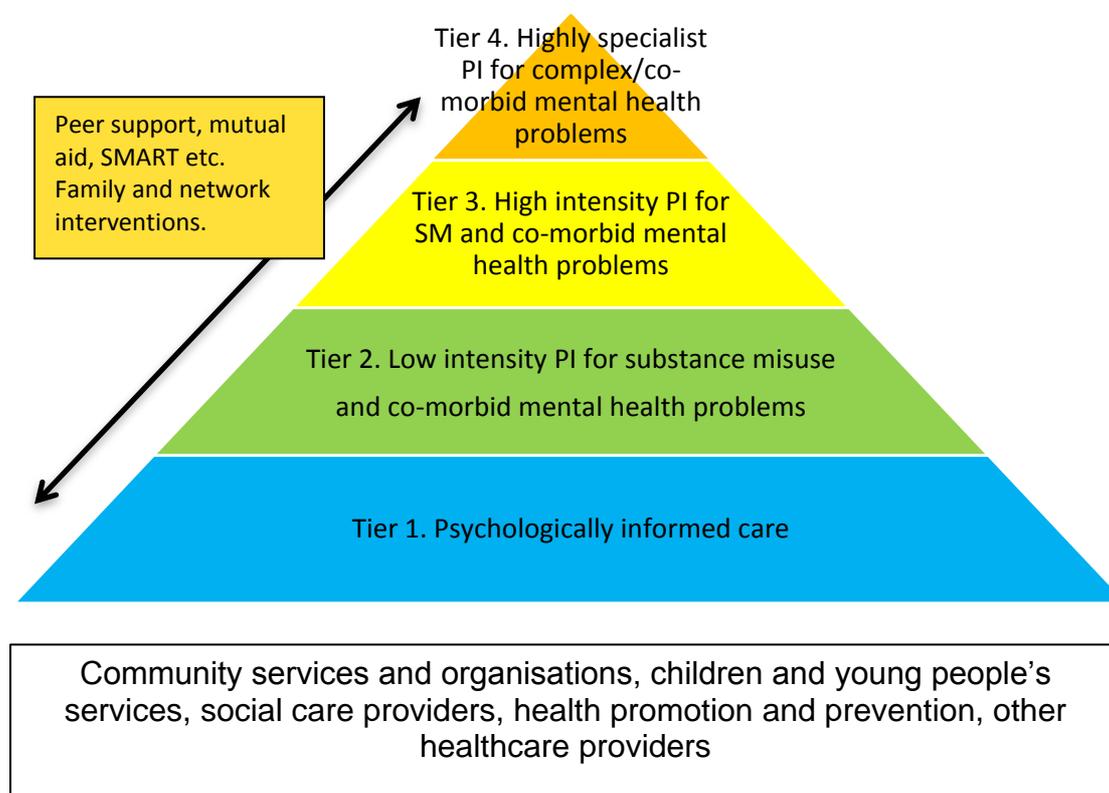
---

<sup>7</sup> Scottish Government. (2014). The Quality Principles: standard expectations of care and support in drug and alcohol services. Edinburgh: Scottish Government. (<http://www.gov.scot/Publications/2014/08/1726>)

<sup>8</sup> NHS Education for Scotland. (2015). The Matrix: a guide to delivering evidence-based psychological therapies in Scotland. Edinburgh: NHS Education for Scotland. ([http://www.nes.scot.nhs.uk/media/3325612/matrix\\_part\\_1.pdf](http://www.nes.scot.nhs.uk/media/3325612/matrix_part_1.pdf))

assessment and review of service users' changing needs and motivations throughout the recovery journey.

**Figure 1. A matched-care model of delivery of psychological interventions (PI) in substance misuse (SM) services**



The model in Figure 1 proposes that the foundation for all service delivery in a substance misuse service should be psychologically informed care provided by all clinical and care staff. This guide takes a broad definition of 'psychologically informed care' to support adaptation to the range of service settings across Scotland, but is based on the understanding that substance treatment services will be embedded within a recovery-oriented system of care. This should be seen as being complementary to the recommendations that treatments in substance misuse services should also be psychologically informed<sup>9</sup> and trauma-informed.<sup>10</sup>

The competencies required to deliver psychological interventions are outlined further in this section. They build on those described in *Supporting the*

<sup>9</sup> National Treatment Agency for Substance Misuse/British Psychological Society. (2010). Routes to recovery: psychosocial interventions for drug misuse. London: NTA. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_231394\\_EN\\_UK38\\_Residential%20drug%20treatment%20service\\_a%20summary%20of%20good%20practice.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_231394_EN_UK38_Residential%20drug%20treatment%20service_a%20summary%20of%20good%20practice.pdf))

<sup>10</sup> Scottish Government. (2014). The Quality Principles: standard expectations of care and support in drug and alcohol services. Edinburgh: Scottish Government. (<http://www.gov.scot/Publications/2014/08/1726>)

*development of Scotland's drug and alcohol workforce*,<sup>11</sup> specifically the learning priorities at levels 2–4, and outline the knowledge and skills required to deliver effective and evidence-based psychological interventions in substance misuse services.

As outlined in the UK guidelines on clinical management of drug misuse and dependence<sup>12</sup> and the Psychological Therapies Matrix,<sup>13</sup> the choice of psychological and psychosocial interventions should depend on their suitability, effectiveness (from the evidence base), appropriateness and acceptability to the individual or group, availability of trained staff and cultural appropriateness. Some approaches and interventions, such as counselling, psychotherapy and therapeutic community approaches, have not been included in the guide as they would not be classified as specific psychological interventions, according to the definition outlined below.

Psychological interventions are delivered by trained practitioners from a wide range of professions, such as nursing, social care, psychology, counselling and psychotherapy, and in various settings, including outpatient, hospital-based and therapeutic communities. It is important to differentiate between the intervention (what work is being delivered), the practitioner (who is delivering it and his or her training background), and the situation (the setting and context).

Evidence-based psychological interventions reflect research that specifically defines the work done in partnership with a service user based on the principles of research methodology. They are operationally defined, often through the use of manuals, worksheets, exercises, protocols, formulation and/or guidelines, which allows the delivery of the specific intervention to be observed and its integrity monitored and progress tracked. Research clearly demonstrates that the therapeutic relationship is essential to the effectiveness of these interventions, with counselling skills establishing the foundation from which evidence-based interventions are delivered. Research also emphasises, however, the importance of defining clearly the intervention being delivered within this therapeutic relationship for effective change to occur.

All staff delivering psychological interventions at every tier should receive regular skills-based supervision and have access to psychological advice when required. While all references have not been included in this section, the interventions presented are drawn from the evidence base for psychological

---

<sup>11</sup> Scottish Government. (2014). Supporting the development of Scotland's drug and alcohol workforce. Edinburgh: Scottish Government.

(<http://www.gov.scot/Publications/2010/12/AandD>)

<sup>12</sup> Department of Health. (2017). Drug misuse and dependence. UK guidelines on clinical management. London: Department of Health.

([https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/628634/clinical\\_guidelines\\_2017.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628634/clinical_guidelines_2017.pdf))

<sup>13</sup> NHS Education for Scotland. (2015). The Matrix: a guide to delivering evidence-based psychological therapies in Scotland. Edinburgh: NHS Education for Scotland.

([http://www.nes.scot.nhs.uk/media/3325612/matrix\\_part\\_1.pdf](http://www.nes.scot.nhs.uk/media/3325612/matrix_part_1.pdf))

interventions in substance use disorders and co-morbid mental health difficulties. Evidence tables for the delivery of psychological interventions for mental health disorders are available from the Psychological Therapies Matrix, the Scottish Intercollegiate Guidelines Network (SIGN), and the National Institute for Health and Care Excellence (NICE).

The model sits on a foundation of community services and organisations that support the pathways into and out of specialist care – social care and voluntary organisations, for example. It should also be seen within the context of wider social and healthcare provision due to shared agendas around, for example, children's and young people's care, physical health care and perinatal care.

The model should be understood as being embedded within a recovery-oriented system of care that is trauma-informed, with a commitment to peer recovery support services, access to holistic care, and clear routes for communication between treatment services and the recovery community. Where areas have an established recovery community, this may act as a bridge into services and support those exiting services to reintegrate into the community. This may include organisations and groups such as 12-step fellowships, recovery groups, peer supporters, SMART groups and recovery cafes.

The different tiers of the model are defined below, along with interventions recommended at each tier.

### **Tier 1. Psychologically informed care**

Psychologically informed care uses principles of therapeutic engagement alongside a range of psychological approaches to support service users on their recovery journey. It is key for supporting a service user's engagement and responsive care planning and is the foundation on which the matched-care model rests. A number of clinical tools, such as self-help materials, node-link maps, websites and apps, may be used to enhance interventions at this tier, which should be available across all teams in a substance misuse service, including integrated, non-statutory and social care partners.

Psychologically informed care should be woven into the fabric of addictions services. All clinical staff in the service should therefore have competencies in these areas to maximise the effectiveness of interventions (both psychological and pharmacological) the service provides. Most staff delivering at this tier are likely to be substance misuse keyworkers and may be supported by treatment protocols and node-link mapping tools. In many services, keyworking is understood as the role that drives and supports service users' treatment journeys at every tier of the model and at every phase of the journey.

Cross-cutting skills, including crisis and risk management, multi-agency working and liaison with other agencies, and support to access the recovery community and peer support and/or mutual aid, are required at every phase of treatment.

Table 1 is adapted from the Skills Hub developed by the Skills Consortium and supported by the National Treatment Agency for England and Wales.<sup>14</sup>

**Table 1. Knowledge and skills required by all staff in substance misuse services**

	Phase of treatment	Knowledge and skills required	Cross-cutting knowledge and skills
Attending to the therapeutic relationship: empathic, collaborative, reflective conversations to guide change	Engagement	Comprehensive assessment, including: <ul style="list-style-type: none"> <li>• risk assessment (including assessment of risk around child protection, gender based violence, adult support and protection, mental health)</li> <li>• health monitoring</li> <li>• harm reduction</li> <li>• recognition of cognitive impairment</li> <li>• assessment of motivation and readiness</li> </ul>	<p><b>Psychosocial techniques, supported by clinical tools and resources:</b> Motivational Interviewing techniques, self-monitoring, activity scheduling, relaxation training, mapping techniques</p> <p><b>Trauma-informed care:</b> trauma awareness, handling disclosure, emotional containment and self-awareness</p>
	Preparation	Building a therapeutic relationship: <ul style="list-style-type: none"> <li>• establishing the relationship</li> <li>• communication, active listening, observation</li> <li>• reflective practice</li> <li>• self-awareness</li> </ul>	
	Change	Recovery planning: <ul style="list-style-type: none"> <li>• engaging with recovery planning</li> <li>• creating a recovery plan</li> <li>• setting and refining treatment goals</li> <li>• identifying personal resources</li> <li>• identifying recovery capital</li> <li>• recovery/coping skills development</li> </ul>	
	Completion	Reintegration: <ul style="list-style-type: none"> <li>• planning for reintegration</li> <li>• strengthening community integration</li> <li>• building social networks</li> </ul>	
	Reintegration		

**Case example: Joanne (1)**

Joanne has a 15-year history of polysubstance misuse, including intravenous heroin use for two years. She has a daughter who is currently in the care of her mother.

Joanne attends a third sector needle-exchange drop-in and gets talking to the addiction worker on duty. She wants things to be different, and the worker suggests that she attends an assessment clinic later that week (Tier 1: use of Motivational Interviewing to spot motivational hooks, create non-judgemental therapeutic relationship and offer information, alongside harm reduction).

<sup>14</sup> Substance Misuse Skills Consortium. (2017). Skills hub [website]. London: Substance Misuse Skills Consortium. (<http://www.skillsconsortium.org.uk/skillshub.aspx>).

She attends the assessment clinic and says she feels like she is in chaos. She is using daily, and reports that she sometimes harms herself. She is ambivalent, defensive and a little argumentative in the assessment, but the worker responds empathically and agrees with her that her current situation is hard to tolerate (Tier 1: building discrepancy, handling disclosure, managing resistance).

This de-escalates the situation, and Joanne discloses parts of a traumatic history (Tier 1: trauma awareness, managing disclosure). The worker helps Joanne begin to think about next steps and she chooses to be referred to the local drug and alcohol treatment service to titrate onto methadone.

## **Tier 2. Low intensity psychological interventions for substance misuse and co-morbid mental health problems**

Low intensity psychological interventions are aimed at mild-to-moderate addiction difficulties, and mild-to-moderate co-morbid mental health problems. They are delivered by a range of multidisciplinary practitioners trained in specific structured interventions.

Low intensity psychological interventions require additional competencies.<sup>15</sup> They are designed to be delivered alongside medical and pharmacological approaches by selected clinical staff to selected service users to enhance progress.

Staff delivering interventions at this tier will be from a number of professional backgrounds, but will have developed appropriate competencies to deliver low intensity interventions safely and effectively. They are delivered within protected time and to protocols, often based on a cognitive behavioural approach, and can be accessed through 1:1 or group interventions.

Frontline practitioners are likely to use psychological and social techniques and tools (such as motivational techniques, relaxation training, alcohol/drug diaries and self-help materials) as part of their practice within a psychologically minded approach. These techniques do not constitute a psychological intervention, but are invaluable components of routine care.

Practitioners delivering low intensity psychological interventions should have protected time in which to deliver care and attend supervision. This will help to ensure the intervention is delivered as it should be and reduce the likelihood of therapy drift in the face of ongoing emerging difficulties with this complex client group.

A number of low intensity interventions are recommended to address alcohol and drug use:<sup>16</sup>

- Motivational Interviewing (MI) for drug and alcohol misuse
- Contingency Management for drug misuse

---

<sup>15</sup> Competency frameworks for psychological therapies can be accessed at: [www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks](http://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks)

<sup>16</sup> Details of the interventions listed here are available in the Psychological Therapies Matrix and the National Treatment Agency for Substance Misuse/BPS document *Routes to recovery: psychosocial interventions for drug misuse*, both previously referenced.

- cognitive behavioural skills-based interventions to enhance coping skills and prevent relapse.
- Community Reinforcement Approach
- Social Behaviour and Network Therapy.

**Case example: Joanne (2)**

Joanne enters the titration clinic of the treatment service and attends two appointments a week while her dose titrates up. During these appointments, she has access to a peer support service (cross cutting: peer support and recovery community access, building hope and motivation) and agrees to attend Narcotics Anonymous with a peer (cross cutting: access to mutual aid). She also accesses a number of health checks, including for blood-borne viruses and sexual health, and begins to stabilise her use.

She is interested to hear that there are incentives for attending all appointments and begins to work towards clinical privileges, such as take-home doses (Tier 1: harm reduction, health monitoring; Tier 2: contingency management).

Low intensity psychological interventions for common mental health problems such as anxiety and depression are outlined in the Psychological Therapies Matrix and may include interventions such as Cognitive Behavioural Therapy (CBT)-based guided self-help. They may include:

- behavioural activation
- computerised CBT
- guided self-help
- trauma-informed psychoeducation around developing safety and stability for difficulties relating to complex trauma.

**Case example: Joanne (3)**

Joanne is allocated to a mental health nurse for ongoing keyworking due to her poor mental health. As her use stabilises, she begins to feel emotionally overwhelmed and her self-harm increases. She discloses this to her keyworker, who normalises her distress and supports her to develop a safety plan, following a protocol to do so over six sessions (Tier 1: trauma awareness, emotional containment, psychoeducation; Tier 2: CBT techniques to support safety and stabilisation, emotion regulation).

With Joanne's consent, the keyworker seeks consultation with the team psychologist, and they develop a joint formulation of Joanne's difficulties (Tier 4: formulation of complexity, support with treatment planning). The keyworker shares this with Joanne, and she chooses to attend the next Survive and Thrive course – an educational course for survivors of trauma that is run by the psychologist and a nurse therapist.

Joanne is unsure, but speaks to the peer supporter involved with the group and decides to go (Tier 1: building supportive social network; Tier 2: safety and stabilisation educational course; cross cutting: peer support). She attends 8/10 sessions, and learns some strategies for coping with emotions and caring for herself more compassionately. She begins to use healthier strategies for coping, and her self-harm reduces.

### **Tier 3. High intensity psychological interventions for substance misuse and co-morbid mental health problems**

High intensity interventions are aimed at moderate/severe addiction difficulties and co-morbid mental health problems. These are standardised psychological therapies delivered to protocol but may be adapted for specific groups. They are aimed at moderate-to-severe difficulties with significant complexity.

High intensity interventions require specific competencies, accreditation in the particular intervention, and supervision by an appropriately trained supervisor. They are delivered by applied psychologists and CBT therapists trained to certificate and diploma level. High intensity therapies may target mental health difficulties and addictive behaviour change as part of an integrated treatment approach and require protected therapy time.

A number of interventions are recommended for addressing substance misuse at this tier:

- Behavioural Couples Therapy for drug and alcohol misuse
- CBT for alcohol misuse and relapse prevention.

#### **Case example: Joanne (4)**

Throughout Joanne's engagement with the group, her keyworker has supported her to build her recovery capital (Tier 1: building resources, maintaining change), access the recovery community and attend SMART meetings (cross cutting: engagement with mutual aid and recovery community), but she has continued to use heroin weekly. Her keyworker takes her case to the team MI coach for some support, which helps the keyworker use MI skills more consistently (cross cutting: MI; access to practice development).

Joanne realises that she doesn't believe in her ability to stay drug-free long term and struggles with cravings (cross cutting: MI skills in building discrepancy, functional analysis, confidence in changing). She discusses this with her keyworker, and is offered a place at a local third sector mindfulness group, Life after Addiction, run in conjunction with peers (cross cutting: MI, peer support; Tier 1: building social networks; Tier 3: mindfulness-based relapse prevention).

The third sector organisation has links to college and employability courses, and Joanne begins to make future plans (Tier 1: community reintegration, building recovery capital). She connects with peers she meets through the course and uses the skills she has learned and the confidence she has gained to stop her illicit use completely. Contact with the course offers opportunities around training and mentoring, and Joanne begins volunteering.

High intensity interventions for mental health problems are outlined in the Psychological Therapies Matrix and may include a range of interventions for specific mental health problems.

Much current evidence focuses on single diagnosis studies, rather than including people with complex co-morbidities, which can present a challenge for planning interventions for people with co-occurring mental health and substance misuse problems. An evidence base for interventions designed for co-morbid difficulties is nevertheless emerging: computerised CBT with MI, for example, is recommended for co-morbid depression and alcohol or cannabis

misuse. Integrated models of treatment addressing co-occurring needs are recommended, rather than sequential treatments.

#### **Tier 4. Highly specialist psychological interventions for complex/co-morbid mental health problems**

Highly specialist interventions for complex and enduring problems are individually tailored interventions based on case formulations drawn from a range of psychological models and identifying the combination of interventions most appropriate for an individual's needs.

They are most frequently delivered by clinical and counselling psychologists where there is a need to modify standardised approaches or devise a novel approach for a specific presentation. All applied psychologists are trained in at least two models of psychological intervention and should be aware of, and able to draw from, additional therapeutic models.

Tier 4 interventions are designed for service users experiencing severe, complex and co-morbid mental health problems. In substance misuse services, these problems commonly relate to personality disorders (particularly emotionally unstable personality disorders) and the consequences of complex trauma. Interventions are frequently delivered in collaboration with other members of the multidisciplinary team.

## **4. Considerations around particular groups presenting to substance misuse treatment services**

There is growing recognition that some groups attending alcohol and drug treatment services may have specific vulnerabilities that can impact on their ability to engage with treatment. This section will consider two groups in particular: people presenting with difficulties relating to complex trauma; and those with cognitive impairment that may or may not be recognised.

### **Psychological interventions in trauma-informed substance misuse services**

In early life, the quality of the attachment an infant develops with the primary caregiver influences the infant's social and emotional development and ability effectively to recognise and regulate emotional experience. If the primary attachment relationship is inconsistent, neglectful or unpredictable, infants are unable to escape this, and so learn to manage themselves as best they can within the confines of the relationship. They may then grow into adults who are likely to have more difficulties in regulating their emotions and relationships.

Developing an insecure attachment style in early life increases the risk of developing poor mental health or addictive behaviours in later life, because it makes it harder to cope with adverse experiences. The ability to cope with adverse experiences may be mediated by an individual's confidence in coping and being able to access support – in other words, his or her attachment security.

The Scottish Government Quality Principles state that all substance misuse services must be trauma-informed. Most people attending substance misuse services are thought to have a history of trauma, and some will meet criteria for post-traumatic stress disorder (PTSD). People who have suffered prolonged, repeated trauma often experience additional symptoms, however, and the concept of complex trauma has been proposed to capture these symptoms.

Additional symptoms associated with complex trauma may include difficulties in regulating emotions and relationships, self-perception, memory and consciousness. Substance use may become a way of managing overwhelming difficulties in the short term, but it becomes a problem in its own right, leading to further difficulties with emotional regulation, the risk of further victimisation, and the substance use becoming increasingly entrenched.

Individuals may present with multiple mental health and physical co-morbidities alongside substance dependence, and a number of clinical decisions are required to ensure they receive comprehensive treatment:

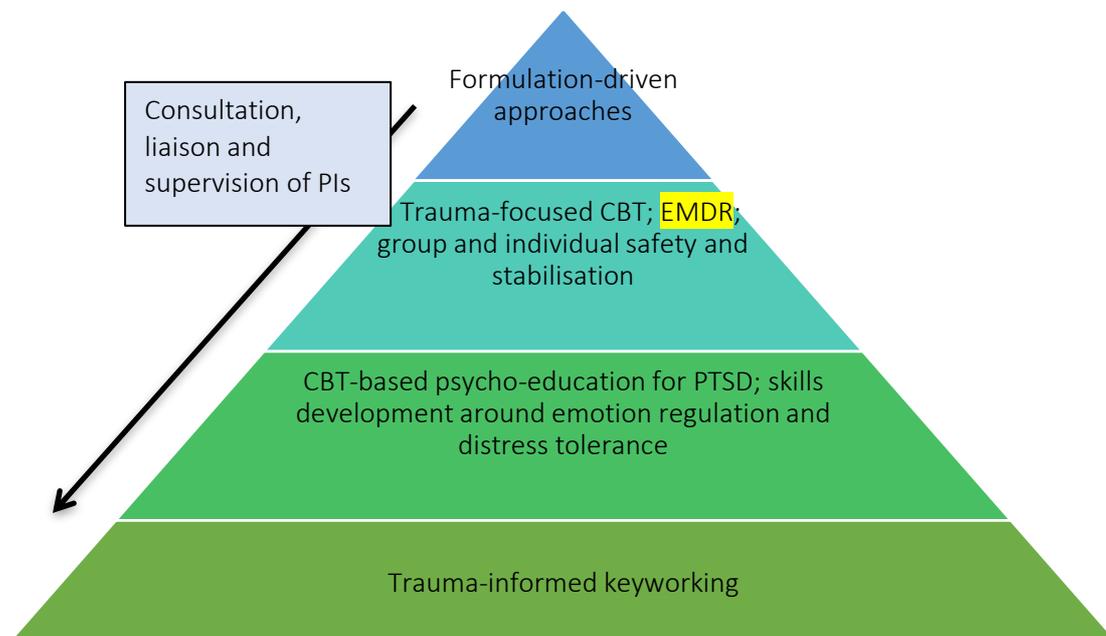
- integrated interventions that address both difficulties in a parallel intervention are recommended when working with co-morbid trauma and substance use

- phased or staged approaches are recommended by expert consensus in cases of complex trauma and substance use; phase 1 of treatment should aim to establish safety and stability, including in substance use, and should enable the individual to develop skills in regulating emotions, reducing risk, and asserting and meeting their needs appropriately
- treatment of PTSD and complex trauma should also include an exposure component (phase 2); for this stage, it will be important for clients to have attained some measure of stability through, for example, feeling able to tolerate emotional distress without using substances, and with established supports and resources available within the community.

The development of trauma-informed substance misuse services means that services need to hold core values, including safety (physical and emotional safety), trust (clear expectations and boundaries), choice, collaborative treatment and empowerment. Staff in a trauma-informed service are required to understand the impact of trauma to recognise the multiple ways it may present, but are not all required to deliver trauma-specific interventions that seek to address the consequences of traumatic experiences.

Figure 2 suggests a matched-care model for the delivery of trauma-informed care within a substance misuse service. Trauma-informed keyworking competencies are described at Tier 1. Tiers 2 and above illustrate interventions recommended for PTSD and complex trauma. Practitioners at each tier should receive clinical supervision.

**Figure 2. Matched-care model of trauma-informed psychological interventions**



Trauma-informed keyworking competencies map onto those described as psychologically informed care in Figure 1. As a minimum, clinical staff should have some awareness of the emotional, physical and cognitive consequences of trauma and be aware of the range of behaviours that may manifest. Staff should have access to training in managing disclosure and recognise pathways of care outlined in the NHS Education for Scotland(NES)/Scottish Government *Transforming psychological trauma* knowledge and skills framework for the Scottish workforce.<sup>17</sup>

Low intensity interventions appropriate for PTSD and complex PTSD include CBT-based guided self-help materials to educate individuals about symptoms. Aspects of other interventions, such as Dialectical Behaviour Therapy, may be helpful for those with more complex presentations who are likely to require a period of developing stability and learning to regulate emotional difficulties in the here and now.

High intensity interventions appropriate for PTSD are designed to support individuals to process the impact of the traumatic event, and involve trauma-processing interventions such as trauma-focussed CBT, prolonged exposure, and eye movement desensitisation and reprocessing (EMDR). Where individuals present with complex PTSD, particularly in cases where resilience and personal coping strategies are low, or where there is a high risk of relapse to substance use, a period of high intensity work around developing safety and stability is indicated. Individual and group interventions, including Seeking Safety, Survive and Thrive, and Safety & Stabilisation, have been designed to meet this need.

Formulation-driven approaches may be indicated where individuals are presenting with complex difficulties and multiple morbidity. The psychological intervention here is likely to be one component in a multidisciplinary care package.

## **Psychological interventions for cognitive impairment in substance misuse services**

Cognitive functioning is often compromised in service users presenting with drug and alcohol problems. This may be due to the impact of chronic alcohol and drug use on the brain, or the impact of pre-existing difficulties such as learning disability, acquired brain injury or other neurological conditions. Those who have had a disrupted educational history may also experience literacy and numeracy difficulties.

As a result, service users presenting to substance misuse services may experience both transient and longer-term impairment of cognitive abilities. When this goes unrecognised, it can impact on an individual's ability to engage with, and make progress in, treatment: he or she may, for example, forget appointments or not remember the content of sessions. A lack of engagement may be misattributed to lack of motivation rather than an impairment that may be managed with adaptations to treatment.

---

<sup>17</sup> NHS Education for Scotland. (2017). Transforming psychological trauma. A knowledge and skills framework for the Scottish workforce. Edinburgh: NHS Education for Scotland. (<http://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf>)

All substances are associated with some alterations in memory, emotional processing and some 'higher-order' processes, including decision-making. This means that the neuropsychological impact of these substances can directly influence an individual's ability to control and change behaviour.

It is therefore important to screen for cognitive impairment at an appropriate stage of treatment, noting that current substance use will influence scores on screening measures. NICE recommended assessment of cognitive functioning as part of a comprehensive assessment for those presenting for treatment of alcohol use disorders,<sup>18</sup> but cognitive screening will also be useful for people presenting for treatment of other substance use disorders and for those on long-term maintenance prescriptions of opiates and benzodiazepines. Recommended screening tools include the Addenbrooke's Cognitive Examination, 3<sup>rd</sup> edition<sup>19</sup> (ACE-III), and the Montreal Cognitive Assessment.<sup>20</sup>

The Mini Mental State Examination is not recommended for screening those with cognitive impairment relating to drug or alcohol problems, as it does not assess impairments of executive functioning (complex cognitive functions including planning, problem-solving and cognitive flexibility), which are frequently impaired as a result of drug or alcohol use.

Where cognitive screening suggests that further investigation is indicated, a referral for comprehensive neuropsychological assessment should be made to a clinical psychologist or clinical neuropsychologist. This will allow a more in-depth assessment of cognitive strengths and weaknesses, offer recommendations for individualised rehabilitation, and can support differential diagnosis where there may be multiple causes of impairment.

Adaptations to interventions can be made to support engagement and progress in treatment. These are made from adaptations to psychological therapies for those with brain injuries and are recommended where memory or executive functioning impairment may be likely. They include:

- providing prompts for attending appointments (text prompts, for example)
- providing visual or written summaries of sessions
- using a range of modes to aid learning and processing of therapeutic information (such as visual, movement-based and music) rather than relying on verbal strategies alone
- providing handouts or worksheets
- structuring sessions so they have a consistent format

---

<sup>18</sup> National Institute for Health and Care Excellence. (2011). Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Clinical guideline CG115. London: National Institute for Health and Care Excellence. (<https://www.nice.org.uk/guidance/cg115>)

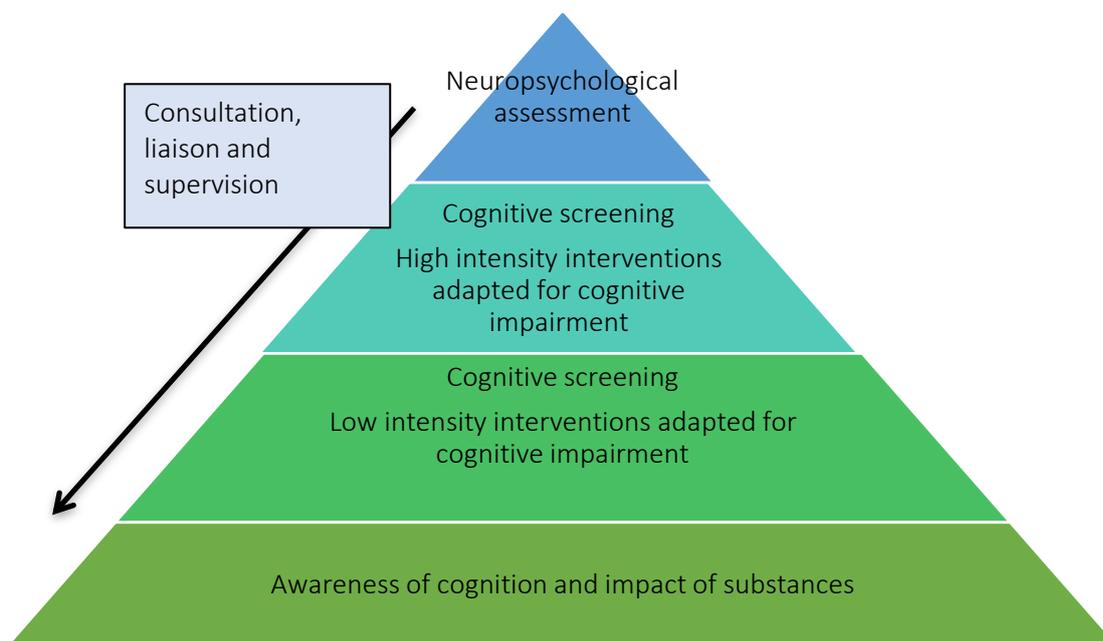
<sup>19</sup> Mioshi E, Dawson K, Mitchell J, Arnold R, Hodges J. (2006). The Addenbrooke's Cognitive Examination Revised (ACE-R): a brief cognitive test battery for dementia screening. *International Journal of Geriatric Psychiatry*. 21: 10.1002/gps.1610.

<sup>20</sup> Nasreddine ZS, Phillips NA, Bédirian V, Charbonneau S, Whitehead V, Collin I, Cummings JL, Chertkow H. (2005). The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. *Journal of the American Geriatric Society*. 53 (4), 695–699.

- offering shorter sessions for service users with attention/concentration problems
- delivering interventions jointly with keyworkers
- integrating interventions with peer-support activities
- involving supportive family or network members in interventions.

The node-link mapping approach designed by the National Treatment Agency for Substance Misuse (NTA) offers a structured and visual set of tools that is likely to support people with and without cognitive impairment to engage more fully with treatment. Figure 3 recommends competencies/interventions required for managing cognitive impairment at each tier.

**Figure 3. Matched-care model to manage the impact of cognitive impairment on interventions**



Tier 1 competencies for working with cognition include being aware of the impact of different substances on cognition, and the effect this may have on engagement and progress in treatment, particularly where individuals are prescribed high doses of opiates or benzodiazepines or have a chronic history of alcohol excess.

Tiers 2 and 3 include additional competencies in cognitive screening and awareness of how to adapt interventions to compensate for cognitive impairment.

Tier 4 includes neuropsychological assessment, where available. Clinical psychologists and neuropsychologists have specialist competence in delivering neuropsychological assessment and can provide liaison and consultation to support adaptations to existing interventions at tiers 1, 2 and 3.

**Case example: Jim**

Jim is attending keyworking appointments but does not seem to remember the details discussed, and his attendance is poor. His keyworker carries out an ACE-III assessment and discusses the results with the team clinical psychologist/neuropsychologist, who suggests that Jim may have executive functioning impairments impacting on his ability to retrieve information from his memory.

The keyworker begins to use phone prompts to support Jim's attendance and mapping tools to provide Jim with visual memory aids of keyworking appointments. Jim agrees to recruit his partner to support his treatment, and discusses progress with her. She is invited to attend some appointments. Jim's attendance improves, and he begins to make faster progress towards his recovery.

## 5. Training and governance of psychological interventions in substance misuse services

The matched-care model assumes a staff skill mix in substance misuse services, with staff working at different tiers having a set of competencies appropriate to the level of therapeutic intervention provided. As the model outlines, while all frontline staff should have some level of psychological knowledge, smaller numbers of staff will require more specialist training. Competency frameworks are outlined in the NTA/BPS document *Routes to recovery: psychosocial interventions for drug misuse*.<sup>21</sup>

All staff delivering psychological interventions should receive regular clinical supervision and be able to access more specialist psychological advice when required. Supervision is essential in ensuring that the delivery of the intervention adheres to protocols and maximises effectiveness for the service user. Supervision makes a fundamental contribution to quality assurance and evaluation of competence, as well as supporting the therapist's educational development and practice. Psychological therapies that are inappropriately or inadequately delivered can cause harm and supervision is key to ensuring safe practice.<sup>22</sup>

The Psychological Therapies Matrix provides guidance on the recommended psychological interventions to consider in the quality assurance and clinical governance plans of Scottish alcohol and substance misuse services. Guidelines for supervision and training are included to ensure that training, supervision and delivery of low and high intensity interventions meet the standards necessary for evidence-based implementation.

Training in psychological interventions can be co-ordinated by the local substance misuse psychology service, psychological interventions team (or equivalent), or psychological therapies training co-ordinator of each NHS board. Training may include a blend of courses from different providers, including NES, the Scottish Drugs Forum (SDF), in-house training delivered by organisations, and bespoke modules from individual trainers.

The way in which training is delivered may be blended to enhance accessibility and effectiveness, and may include e-learning modules, short workshops, multiple-day courses and workplace-based coaching to apply learning. Table 2 outlines the minimum training requirements for the competent delivery of psychological interventions at each tier, based on the Psychological Therapies Matrix.

---

<sup>21</sup> National Treatment Agency for Substance Misuse/British Psychological Society. (2010). *Routes to recovery: psychosocial interventions for drug misuse*. London: National Treatment Agency for Substance Misuse. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_231394\\_EN\\_UK38\\_Residential%20drug%20treatment%20service\\_a%20summary%20of%20good%20practice.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_231394_EN_UK38_Residential%20drug%20treatment%20service_a%20summary%20of%20good%20practice.pdf))

<sup>22</sup> Kouimtsidis C, Davis P, Reynolds M, Drummond C, Tarrier N. (2007). *Cognitive-behavioural therapy in the treatment of addiction: a treatment planner for clinicians*. London: Wiley.

**Table 2. Minimum training requirements for the competent delivery of psychological interventions at each tier, based on the Psychological Therapies Matrix**

Tier of psychological intervention		Training
Tier 2	Low intensity psychological intervention for alcohol/substance use disorders	<ul style="list-style-type: none"> <li>- Pre-employment professional training plus additional training in psychological interventions, usually comprising a series of short courses/workshops (e.g., core cognitive and behavioural skills in relapse prevention and recovery management (NES); MI (SDF))</li> <li>- The minimum training required is typically 5–10 days plus regular ongoing supervision</li> </ul>
Tier 2	Low intensity psychological intervention for mild–moderate common mental health conditions delivered within protected therapy time	<ul style="list-style-type: none"> <li>- SPIRIT training</li> <li>- Certificate-level CBT training</li> <li>- Individual clinicians who have been trained to a recognised high level in a specific therapeutic approach</li> <li>- The minimum training required is typically 5–10 days plus regular ongoing clinical supervision</li> </ul>
Tier 3	High intensity psychological therapies for moderate–severe presentations with significant complexity and impact on functioning; standardised psychological therapies delivered to protocol, within protected therapy time	<ul style="list-style-type: none"> <li>- Individual clinicians with a highly developed special interest, who have been trained to a recognised high level in a specific therapeutic approach</li> <li>- Diploma/master’s-level CBT training</li> <li>- Doctoral-level clinical psychology training (or equivalent)</li> <li>- The minimum training required is 24 days formal teaching of CBT plus 24 days of workplace CBT practice plus intensive supervision over at least one year</li> <li>- Ongoing clinical supervision is required</li> </ul>
Tier 3	High intensity specialist psychological therapies for moderate–severe presentations with significant complexity and effect on functioning; standardised psychotherapies developed and modified for specific patient groups	<ul style="list-style-type: none"> <li>- Individual clinicians with a highly developed special interest, normally including involvement in research and identified by colleagues as having the requisite knowledge and skills</li> <li>- Diploma/master’s-level CBT training plus further training in the application of CBT to specialist area, acquired through formal training or specialist supervision</li> <li>- Doctoral-level clinical psychology training (or equivalent)</li> <li>- Ongoing clinical supervision is required</li> </ul>
Tier 4	Highly specialist psychological therapies for highly complex clinical presentations, including enduring mental health problems with a high likelihood of co-morbidity that are beyond the scope of standardised treatment	<ul style="list-style-type: none"> <li>- Individual clinicians with a highly developed special interest, normally including involvement in research and identified by colleagues as having the requisite knowledge and skills</li> <li>- Doctoral-level clinical psychology training (or equivalent)</li> <li>- Ongoing clinical supervision is required</li> </ul>

Competent delivery of psychological interventions requires that interventions are delivered to protocol, practitioners have the necessary training and knowledge, practice is observed to ensure fidelity, and interventions are delivered under supervision. National initiatives on practice development and coaching groups for low intensity psychological therapies are intended to complement supervision provision, rather than replace it.

The intensity of supervision provided will vary in accordance with the intensity of therapy and, consequently, the severity and complexity of clinical presentation. A high intensity CBT therapist may receive individual supervision on a fortnightly basis, whereas a low intensity practitioner may receive supervision together with one or two colleagues every three to four weeks.

Training and supervision alone cannot ensure that training is implemented in practice. When staff attend training, it does not always translate into changes in practice without work-based implementation support. This wastes resources and potentially deprives service users of receiving interventions based on the best and most up-to-date evidence available. Without opportunities to consolidate training into practice and receive feedback, staff can feel de-skilled and unmotivated. Implementation science highlights this problem: Figure 4 illustrates factors that support implementing training into practice. There is a need for strategic planning and leadership so that training is provided in a targeted way and in line with service requirements.

**Figure 4. Factors that help support training into practice<sup>23</sup>**



<sup>23</sup> Adapted from: Fixsen DL, Blase K, Naoom S, Metz A, Louison L, Ward C. (2015). Implementation drivers: assessing best practices. Chapel Hill, NC: National Implementation Research Network, University of North Carolina at Chapel Hill; and Moore MH (1995). Organisational strategy in the public sector. In: Budd L, Charlesworth J, Paton R (eds.). (2006). Making policy happen. London: Routledge/Open University.

There is a need to develop a strategic approach regarding CBT training for addiction service staff. It is important that the substantial investment in training CBT therapists yields a return for the service. Therapeutic skills need to be utilised for the provision of CBT following completion of training, and trained staff need protected time in which to practice and attend supervision to maximise the significant investment. Trained CBT staff can also be a valuable resource in supporting practitioners at tiers 1 and 2.

There is also a need to consider the numbers of CBT therapists that need to be trained to provide sufficient capacity to meet future demand, and to identify locations in which there may be gaps in provision. In a similar vein, the level of provision of psychologists needs to be considered as part of a strategic plan, rather than on an arbitrary basis. In addressing these issues, it is necessary to consider the competency and skill mix required to deliver the stepped/matched-care model of psychological therapies delivery.

It is important to consider the role of applied psychologists in supporting delivery of psychological interventions in substance misuse services. All services should have access to consultant-level psychologists to lead on the development and delivery of interventions and support supervision structures.

An example of an audit proforma to support the development of robust training and supervision structures for psychological therapies in substance misuse services is provided in Appendix 1.

Outcome measurement of interventions is an essential component of delivery that allows services to measure effectiveness, continually improve delivery, ensure that the integrity of interventions is maintained and add to the evolving evidence base. Appendix 2 provides an overview of validated outcome measures recommended for different aspects of psychological therapies delivery. This should not be read as an exhaustive list, but provides examples of the types of measure that may be useful for clinicians and commissioners alike. Outcome measures chosen may reflect mandatory service requirements, balanced with the need to accurately measure target symptoms for change.

#### **Case example. Ensuring access to MI**

A local area decides to implement a programme to ensure that all service users have access to high-quality MI delivered effectively by practitioners in the substance misuse team.

The local Alcohol and Drug Partnership (ADP) and managers work together to identify the finances and administrative support needed and identify strategies to ensure staff-release time for training, coaching and supervision. A competency framework is agreed upon (such as MIA-STEP) that provides a structure for quality assurance and clinical governance, as well as a strengths-based format for enhancing MI practice.

Practitioners in the service who are highly experienced in MI are identified as potential trainers and/or coaches as the plan rolls out. The trainers, who have workplace experience in delivering and coaching MI, are commissioned to roll out a programme of training in MI which consists of an initial e-learning module providing the foundation of knowledge, principles and attitudes, followed by a three-day training that emphasises the practice of skills and direct feedback. A follow-up training is provided two months later, allowing

practitioners to apply learning in the workplace and bring their challenges back to the trainers.

Practitioners who have already had training in MI participate in the training as a refresher course and are encouraged to engage with skills-based practice exercises at their more experienced level, with the goal of encouraging the most experienced practitioners to become trained and develop their skills as coaches. A programme of coaching is rolled out, with practitioners attending monthly coaching sessions. Refresher training with the latest developments is offered yearly and a rolling programme of training is developed to meet the needs of new staff, with local practitioners offered the opportunity to be trained as trainers.

## 6. When should different interventions be provided?

If individuals wish to address their substance misuse, services should support and build motivation to change, enable the development of belief in the person's ability to make changes, emphasise the value and importance of the changes, and offer access to a range of interventions at different stages of the recovery journey.

Specific competencies that will support people to engage in treatment, prepare for change, make changes, consolidate the changes and reintegrate into a new lifestyle are outlined in Table 1. When integrating these with other psychological therapies, a number of questions arise. How stable does someone need to be before engaging in a psychological therapy? Do we need to consider dosage of opiate substitution therapy and other medications? How best to integrate psychological and medical interventions? These questions will be considered in this section.

### How stable does someone need to be to engage in psychological therapy?

It is recommended that interventions for substance use and co-occurring mental health difficulties are integrated, so that any exacerbation of problematic emotional difficulties caused by stabilisation of substance use can be managed within the same package of care. This means that timing of interventions can be important. To engage in a psychological therapy, some stability in substance use is recommended, but an individual does not need to be completely drug- or alcohol-free.

In general, dependent or chaotic substance use needs to be addressed prior to engaging in psychological therapy. Regular and frequent use will also interfere with psychological therapy by adding to emotional and physical dysregulation, but psychologically informed care will support engagement and motivation. If use has reduced to the point where the individual is able to stay free of illicit drugs or alcohol for most of the time, beginning some higher-tier intervention is appropriate and may enable the individual to consolidate stability to engage with further interventions as appropriate.

### Do we need to consider medication dosage?

The research literature is clear that psychological therapy enhances opiate replacement therapy (ORT) outcomes: how ORT and other medications impact on psychological therapy is less clear, however.

There is some research indicating that methadone and buprenorphine maintenance treatments impair cognition, particularly attention, learning and memory. Benzodiazepines such as diazepam are also known to impair cognition, especially memory functioning. Expert consensus suggests that methadone doses over 70 mg and diazepam doses over 15 mg tend to interfere with the therapeutic process. Flexibility is required around this, however: in the context of psychological interventions, the impact of medication on engagement and progress may come down to clinical judgement on whether an individual's dose interferes with his or her ability to experience, tolerate and process emotions and thoughts, along with the individual's motivation to reduce medication. Where people feel that their medication

is a 'crutch', building confidence in using psychosocial strategies to manage emotions may support decisions around dose reductions.

### **Integrated interventions**

Psychological interventions should be integrated as part of a recovery care plan and delivered closely with medical, pharmacological, non-medical and social care interventions. Self-directed support may provide a framework in which to enable individuals to choose a range of psychological and social interventions. For this to happen, waiting times for interventions should be reduced as far as possible, in line with national standards.

## Appendix 1. Example audit tool to identify recommended level of training and supervision

Skill	Recommended good practice: training		Recommended good practice: supervision/coaching	Suggestions for audit
Motivational interviewing (MI)	NES MI e-learning module Coordinated by: service managers Accessed via: online	Introductory level (two-day) training for all new staff Coordinated by: service managers Accessed via: local ADP/local addiction psychology (AP) service/NES/SDF/other	Staff attend monthly coaching group to reflect and practice skills* Coordinated by: local AP service Accessed via: local AP service	<ul style="list-style-type: none"> <li>- % staff completing online training</li> <li>- % staff completing introductory/intermediate/advanced training</li> <li>- number of staff attending regular practice development groups</li> <li>- service user feedback</li> </ul> <p>Where practice development groups assess competence (e.g., through use of assessments such as MIA-STEP), objective outcomes of competence may also be measured</p>
		Refresher, intermediate or advanced training for all experienced staff Coordinated by: service managers Accessed via: as above	Staff attend regular high-quality clinical supervision Coordinated by: service managers Accessed via: offered in-house or accessed via the local AP service	
Basic CBT skills for relapse-prevention and recovery management**	NES Core Skills e-learning module Coordinated by: service managers Accessed via: online	Two/three-day core skills training for all new staff (NES or bespoke) Coordinated by: local AP service Accessed via: local AP service	Staff attend monthly coaching group to reflect and practice skills* Coordinated by: local psychology service Accessed via: local AP service	<ul style="list-style-type: none"> <li>- % staff completing online training</li> <li>- % staff completing face-to-face training</li> <li>- number of staff attending regular practice development groups</li> <li>- service user feedback</li> </ul>
			Staff attend regular high-quality clinical supervision Coordinated by: service managers Accessed via: offered in-house or accessed via the local AP service	

\* It is not necessary for staff to attend separate coaching sessions for MI and Core Skills – high-quality coaching should include elements of both, so attendance at one monthly coaching group is sufficient.

\*\* These skills should include the following elements of skill/knowledge: node-link mapping, motivational enhancement, functional analysis, relapse prevention, recovery management and awareness of cognitive impairment

Skill	Recommended good practice: training		Recommended good practice: supervision/coaching	Suggestions for audit
Trauma-informed approaches	NES trauma e-learning module Coordinated by: service managers Accessed: online	Training package (bespoke – approx. two days) for all new staff Coordinated by: local AP service Accessed via: local AP service	Staff attend regular high-quality clinical supervision which provides an opportunity to reflect on trauma-informed approaches to clinical practice Coordinated by: service managers Accessed via: in-house or accessed via the AP service	<ul style="list-style-type: none"> <li>- % staff completing online training</li> <li>- % staff completing face-to-face training</li> <li>- service user feedback</li> </ul>

## Appendix 2. Outcome measurement

The use of validated outcome measures or, when not available, regular structured evaluation is advised to determine whether a specific intervention is effective. These provide a useful overview of added value for commissioners, and help to guide service delivery and development. The table below provides examples of commonly used outcome measures. Please note that this does not represent a prescriptive or exhaustive list. Measures for therapeutic interventions should be selected on the basis of the target symptoms or disorders for change via therapy.

### Examples of commonly used outcome measures

Type of intervention	Recommended outcome/evaluation measures	Recommended frequency
Direct psychological intervention	CORE /CORE – 10 (Clinical Outcomes in Routine Evaluation) HADS (Hospital Anxiety and Depression Scale) BDI (Beck Depression Inventory) BAI (Beck Anxiety Inventory) MHCS (Mental Health Confidence Scale) WEMWS (Warwick Edinburgh Mental Wellbeing Scale) WSAS (Work and Social Adjustment Scale) Brief COPE DERS (Difficulties in Emotion Regulation Scale) Impact of Events Scale - Revised	Pre- and post-therapy  Regularly during therapy as per local guidelines/clinical need
Trauma-focused group work	CORE/CORE – 10 (Clinical Outcomes in Routine Evaluation) DERS (Difficulties in Emotion Regulation Scale) MHCS (Mental Health Confidence Scale) WEMWS (Warwick Edinburgh Mental Wellbeing Scale) WSAS (Work and Social Adjustment Scale)	Pre- and post-group
Supervision – general	The Division of Clinical Psychology (DCP) <sup>24</sup> recommends that supervision can be monitored in a variety of ways, including formal audit and via annual appraisal	Annual (at a minimum)
Coaching – Motivational Interviewing (MI/core skills)	Local psychology services will utilise bespoke evaluation measures to determine the effectiveness of individual coaching sessions; these will typically include a mixture of qualitative and quantitative items	After each coaching session
MI practice	An individual staff member's competency in MI can be assessed using measures such as: <ul style="list-style-type: none"> <li>• MIA –STEP (Motivational Interviewing Assessment – Supervisory Tools for Enhancing Proficiency)</li> <li>• MITI (Motivation Interviewing Treatment Integrity)</li> <li>• MITS (Motivational Interviewing Target Scheme)</li> </ul> These measures are used by an experienced MI practitioner to assess an individual's competence in delivering MI either via direct observation or audio/visual session recording	As per local supervision and coaching policy

<sup>24</sup> British Psychological Society. (2014) DCP policy on supervision. Leicester: British Psychological Society. ([http://www.bps.org.uk/system/files/Public%20files/inf224\\_dcp\\_supervision.pdf](http://www.bps.org.uk/system/files/Public%20files/inf224_dcp_supervision.pdf)).

## **Glossary of terms**

### **Attachment**

This concept is rooted in developmental psychology and the broad idea that the ability for an individual to form an emotional and physical 'attachment' to another person gives a sense of stability and security necessary to develop personally. Children who are securely attached generally become visibly upset when their caregivers leave and are happy when their parents return. When frightened, these children will seek (and accept) comfort from the parent or caregiver and prefer parents to strangers.

### **Cognitive Behavioural Therapy (CBT)**

This is a 'talking therapy' which suggests the ways we think and interpret situations are important in how we feel and behave. CBT proposes that we often have unhelpful negative or unrealistic ideas about ourselves and the world around us that can detrimentally affect psychological wellbeing. Therapy is structured and focuses on recognising the thoughts we have and how they relate to what we feel or do, and developing strategies to think more positively or realistically.

### **Clinical neuropsychology**

This is a specialty in psychology concerned with the applied science of brain-behaviour relationships. Clinical neuropsychologists have an in-depth knowledge of neuroanatomy and neurobiology and use this knowledge in the assessment, diagnosis, treatment and/or rehabilitation of patients across the lifespan who have neurological, medical, neurodevelopmental and psychiatric conditions, as well as other cognitive and learning disorders.

### **Clinical psychology**

Clinical psychology is a branch of psychology that aims to reduce psychological distress and enhance the promotion of psychological wellbeing. Clinical psychologists deal with a range of mental and physical health problems, including addictions, anxiety, depression, other mental health difficulties and learning disabilities. They use a variety of methods to assess people and develop an understanding of their difficulties, which usually leads to planning treatment using a range of therapies.

### **Dual diagnosis**

This is the term used when a person meets the diagnostic criteria for a mental health disorder and for an addictive disorder.

### **Motivational Interviewing (MI)**

A collaborative, person-centred form of guiding to elicit and strengthen motivation for behavioural change.

### **Node-link mapping**

A simple technique for presenting verbal information in the form of a diagram. It has been shown to have positive benefits for counselling interactions with clients.



Scottish Government  
Riaghaltas na h-Alba  
gov.scot

© Crown copyright 2018

**OGL**

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at [www.gov.scot](http://www.gov.scot)

Any enquiries regarding this publication should be sent to us at  
The Scottish Government  
St Andrew's House  
Edinburgh  
EH1 3DG

ISBN: 978-1-78851-917-5 (web only)

Published by The Scottish Government, June 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA  
PPDAS300766 (06/18)

W W W . G O V . S C O T