Evidence Briefing 7: Adults

Need to know

- For the purposes of this briefing, adults have been defined as anyone aged 25-50 years old.
- 24% of adults in Scotland exceeded the low-risk weekly drinking guidelines in 2017[1]
- In 2014/15, 6% of people in Scotland had used one or more illicit drugs in the last year[2]
- Problem alcohol and drug use amongst adults are more prevalent in Greater Glasgow and Clyde than on average for Scotland[3]
- The rate of problem drug use amongst adults was highest in the 25 to 34 years age group in Scotland[4]
- On average, men consume alcohol on more days of the week than women in Scotland, and consume more units of alcohol[5]

Key findings

- There is strong evidence for the effectiveness of Alcohol Brief Interventions (ABIs) in primary care settings in reducing the weekly consumption of alcohol in adults[6]
- There is strong evidence for the effectiveness of well-planned psychosocial and developmental prevention interventions involving multiple services in reducing alcohol and drug related harms
- There is some evidence for the effectiveness of cognitive behavioural therapy, behavioural couples' therapy and pharmacotherapy in reducing alcohol and drug related harms, as well as clear alcohol and drug policies in the workplace
- There is an evidence gap relating to whether diversionary activities can be effective in preventing alcohol and drug use in adults

Good practice

- NHS Health Scotland resources on delivery of ABIs
- Oldham Borough Council pilots
- Brighton and Hove City Council 'named workers'
- Scotland's Take Home Naloxone Programme[7]
- Newcastle City Council roll-out of Naloxone
- Healthy Working Lives[8]

Potential Stakeholders

- Adult alcohol and drug services
- Allied health professionals
- Employers
- Scottish Prisons Service
- Recovery groups
- Local authority staff
- Social care staff
- Mental health professionals
- Community learning and development staff
- Police Scotland

1 Introduction

This is a briefing on what works for adults in alcohol and drug prevention. It relates to interventions for individuals between **the ages of 25 and 50**. However, it is important to note that there is a large crossover of what works with:

- The children and young people evidence briefing at the lower end of the 25 – 50 age range
- The older adults evidence briefing at the upper end of the 25 – 50 age range. In particular, individuals below 50 years of age may be presenting with alcohol and drug issues that may make the briefing on what works for older adults more appropriate.

There is evidence to suggest that sex and gender may affect how adults respond to alcohol and drugs, the risk and protective factors for reducing the likelihood of use, and the barriers to accessing support with this. Some studies have cited hormonal differences between the biological sexes as an important factor in use, recovery and relapse, with implications for what may work in intervention and treatment, particularly when pharmacological interventions are being considered[9]. Other differences are socio-cultural, and are thus more affected by societal structures[10]. The complexity of how gender and sex can affect alcohol and drug use and responses to treatment, as well as the overlap between gender and other risk factors (see At-risk briefing) make it difficult to determine how best to tailor alcohol and drug prevention programmes. However, it is clear that sex and gender should be taken into account in design and delivery of services.

2 Context

- 24% of adults in Scotland exceeded the low-risk weekly drinking guidelines in 2017[11]
- In 2014/15, 6% of people in Scotland had used one or more illicit drugs in the last year[12]
- 22 people die every week in Scotland because of alcohol[13]
- There were 1,139 deaths in Scotland due to a cause wholly attributable to alcohol (alcohol-specific)[14]
- There were 1187 deaths from a drug overdose in 2018 in Scotland[15]
- Around 1.7 million working days are lost per year due to alcohol-related absence in Scotland[16]
- On average, men consume alcohol on more days of the week than women in Scotland, and consume more units of alcohol[17]
- There were 1,060 alcohol-related hospital stays[18] and 238 drug-related hospital stays[19] in Greater Glasgow and Clyde in 2016
- There are an estimated 18,700 people in Greater Glasgow and Clyde with problem drug use, almost three-quarters of whom are men[20]
- One-third of people with problem drug use in Scotland are located in Greater Glasgow and Clyde[21]
- The rate of problem drug use amongst males and females was highest in the 25 to 34 years age group in Scotland[22]

3 Detailed analysis of what works

Key to evidence briefing

High quality and multiple source evidence to support this approach	(1)
Some evidence or emerging evidence to support this approach	(2)
Limited evidence for this approach or potential development area for further investigation	(3)

Primary Care	Workplace Based	Community Based
Brief interventions (1)	Brief interventions (1)	Brief interventions (1)
Integrated treatment programmes (1)	Integrated treatment programmes (1)	Integrated treatment programmes (1)
Pharmacotherapy (2)	Clear drug and alcohol policies (2)	Behavioural couples' therapy (2)
Behavioural couples' therapy (2)	Cognitive behavioural therapy (2)	Cognitive behavioural therapy (2)
Cognitive behavioural therapy (2)	Alcohol and drug testing with negative consequences (3)	Pharmacotherapy (2)
General counselling and psychodynamic therapies (3)	General counselling and psychodynamic therapies (3)	Diversionary activities (3)
Lived experience testimonials (3)	Self-help and mindfulness therapies (3)	Lived experience testimonials (3)
Self-help and mindfulness therapies (3)		General counselling and psychodynamic therapies (3)
		Self-help and mindfulness therapies (3)

Intervention Type	Description	Relevant group setting	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Alcohol Brief interventions (ABIs)	Brief interventions are short, evidence based, structured conversations between a patient/client and a trained professional. They can last as little as 5-15 minutes, but duration should depend on situation, including time available, level of drinking involved and what the client wants. The conversation should primarily concern motivating and supporting the individual to think about and/or plan a change in their drinking behaviour (and potentially environment) in order to reduce their consumption and/or their risk of harm.	**Primary Care** **Workplace Based** **Community Based**	Effective Transferable (to certain settings) Sustained impact Works particularly well in primary care settings, such as when delivered by GPs and nurses. Some emerging evidence for effectiveness in criminal justice settings More studies in community settings would be useful – Health Scotland are currently reviewing ABIs in primary care and wider settings as part of the Alcohol Framework 2018	✓ Non-confrontational[23] and person centred[24] ✓ Internationally validated assessment tools such as AUDIT-C or FAST[25] used to identify hazardous drinkers (where delivery is planned out with Primary Care, implementation should be tailored to the setting[26]) ✓ Age-appropriate ✓ Proportionate to vulnerabilities[27] and person-centred[28] ✓ Used opportunistically as part of routine visit to primary care services[29] ✓ Delivered face-to-face[30] ✓ Delivery staff are well-trained in ABIs[31] ✓ The patient is in control of their drinking and is helped to make changes for themselves[32] ✓ Motivational interviewing and asset-based techniques are employed[33] ✓ When used in the workplace or outside primary care settings, embedding ABIs in wider health and wellbeing initiatives works well ✓ Dedicated treatment staffing and funding streams[34] × Used with scare tactics and images [36] × Used in small workplaces where undertaking an ABI will affect employment × Requires separate visit[37] × Takes place more than 48 hours after initial visit[38] × There is no evidence to suggest that ABIs are effective in under 16s as this research has not been done[39] × Giving generic, unstructured advice	Alcohol Brief Interventions, Practitioner Training Alcohol Brief Interventions, Training for Trainers Delivery of Alcohol Brief Interventions resources, NHS Health Scotland[35]

Intervention Type	Description	Relevant group setting	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Integrated treatment programmes for alcohol and drug use issues	Well-planned psychosocial and developmental prevention interventions involving multiple services	**Primary Care** **Workplace Based** **Community Based**	There are more studies to suggest effectiveness than ineffectiveness, but intervention type requires more robust evaluation Many studies are based in Sweden thus more research is needed on transferability	✓ Integrated treatment programmes for women with problem alcohol and drug use appear to reduce use[40] ✓ Interventions are more cost-effective if embedded within wider, pre-existing programmes[41] ✓ There is general evidence that holistic programmes are more effective than singular interventions ✓ Partners should include social care, community learning and development[42], housing, homelessness and mental health services and prisons[43], and learning should be shared between these services[44] ✓ Stable housing and access to employment or training opportunities are important for sustaining recovery[45] ✓ Innovative programmes eg utilising technology[46] × No evidence for inhibiting factors	Oldham Borough Council pilots[47] Brighton and Hove City Council 'named workers'[48]

Intervention Type	Description	Relevant group setting	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Cognitive behavioural therapy (CBT) for alcohol and drug issues	"CBT is where the patient works collaboratively with a therapist to achieve specific treatment goals. These goals may include recognising the impact of behavioural and/or thinking patterns on feeling states and encouraging alternative cognitive and or behavioural coping skills and strategies to reduce the severity of target symptoms and problems."[49]	**Primary Care** **Workplace based** **Community Based**	Some evidence of effectiveness[50] compared to traditional alcohol and drug treatments	✓ Motivational interviewing approaches [51] ✓ Using contingency management (eg offering goods vouchers as an abstinence reward)[52] ✓ Assessed for feasibility and acceptability in the workplace, including option of referral to external counselling services[53] ✓ In combination with clear alcohol and drug policies in the workplace, and as part of a wider wellbeing initiative eg stress management × There is mixed evidence for the effectiveness of CBT in combination with other treatments such as pharmacotherapy for alcohol and drug use disorders or contingency management[54] × Confidentiality not guaranteed in workplace	
Behavioural couples' therapy (BCT)	Couples-based therapy involves the spouse or partner "expressing active support" for the person with alcohol or drug issues, in reducing use. The therapy itself operates similarly to CBT but has a greater focus on "effective communication skills"[55]. BCT requires sustained engagement from the couple, over several months[56].	**Primary Care** **Community Based**	Some evidence of effectiveness[57] compared to traditional drug and alcohol treatments, and to individual therapy[58] No effect at two months but abstinence improvements at six-month follow	✓ BCT is more effective when only one partner has an alcohol or drug issue[59] ✓ BCT sessions should be structured and evidence-based[60] × Not advised where relationship is found to be harmful or destructive, or where the couple is uncommitted to the relationship[61]	

Intervention Type	Description	Relevant group setting	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
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Pharmaco-therapy	Pharmacotherapy involves the use of prescription drugs to reduce alcohol and drug consumption and/or harm. Some, such as Disulfiram, are used as "aversion therapy"[62], creating unpleasant reactions to the consumption of alcohol. Others, such as Naltrexone reduce the "desire for alcohol"[63] instead. Naloxone serves a different function, reducing the likelihood of opioid overdose by reversing the effects[64].	**Primary Care**	Effect sizes are small, but better than control	✓ Acamprosate, Naltrexone, Nalmefene and Disulfiram have been shown to have some effect in reducing alcohol harm[65] ✓ There is some evidence to suggest Acamprosate and Naltrexone are more cost-effective when used in combination[66] ✓ There is some evidence to suggest that Nalmefene and other pharmacotherapies work best when coupled with CBT, behavioural therapies or social network therapies[67] ✓ The provision of take-home Naloxone has been shown in small-scale studies to be an important part of preventing opioid overdose[68] ✓ Pharmacological interventions need to be based on NICE guidelines[69]	Newcastle City Council roll-out of Naloxone[70] Barnsley Metropolitan Borough Council Naloxone pilot[71] Scottish Government Evaluation of Scotland's Take-Home Naloxone Programme[72]
		Community Based		× Lack of adequate training for staff and those with alcohol or drug use issues, particularly relating to Naloxone	

Intervention Type	Description	Relevant group setting	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Clear alcohol and drug policies	Alcohol and drug policies set out guidelines, principles and procedures for approaching alcohol and drug use in the workplace. They may include training manuals with step-by-step guides on how to deal with different situations.	**Workplace based**		✓ Embedded in wider health and wellbeing policies[73] ✓ Polices preventing discrimination in recruitment due to alcohol and drug use[74] ✓ Support for employers and employees on alcohol and drug use in the workplace[75] ✓ Ethos of improving workplace wellbeing[76] ✓ Guarantee confidentiality to all employees[77] ✓ Clearly communicated policies[78] ✓ Policies are developed with input from all stakeholders[79] × Stigmatising policies[82]	The health and safety executive have provided a number of resources for employers[80] Healthy Working Lives[81]
Diversionary activities	Diversionary activities can refer to any activity designed to prevent alcohol and drug use or related harm, for example physical, leisure or social activities. At present there is a lack of	**Community based**	There is very limited evidence on whether diversionary activities can prevent alcohol and drug use or related harm	✓ Develop new programmes and monitor for effectiveness	

Intervention Type	Description	Relevant group setting	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
	evidence as to whether diversionary activities can help prevent alcohol and drug use and related harm, and a concurrent need to develop and monitor innovative programmes with this specific aim.			× Insufficient evidence around enablers and inhibitors	
Alcohol and drug testing with negative consequences **General counselling and psycho-dynamic therapies** **Self-help and mindfulness therapies** **Lived experience testimonials**	Literature suggests that these four approaches are unlikely to reduce alcohol and drug use and related harms	N/A	There is very limited evidence that these approaches work in tackling alcohol and drug use and related harms	× Mindfulness meditation specifically for reducing alcohol and drug use and related harm[83] × Self-help based treatment specifically for reducing alcohol and drug use and related harm[84] × General counselling and psychodynamic therapies specifically for reducing alcohol and drug use and related harm[85] × Alcohol and drug testing with negative consequences and a negative focus[86] × Using lived experience testimonials is associated with “no,	N/A

Intervention Type	Description	Relevant group setting	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
				or negative, preventative outcomes”[87]	

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