

Local Routes:

Guidance for developing
alcohol treatment pathways



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Alcohol Treatment Pathways

The purpose of developing alcohol treatment pathways is to have the right people, doing the right things, in the right order at the right time, with the right outcome, right first time – all with attention to the service user's experience and allowing for comparison of the planned care with the care that was actually delivered.

(Adapted from: Scottish Effective Interventions Unit Integrated Care Pathways Guides, www.drugmisuse.isdscotland.org/eiu.)

Purpose of this guidance

Around two thirds of PCTs have identified the tier 3 Vital Sign, VSC26 “reducing the rate of alcohol-related hospital admissions” as a local priority in their operating plans and many, as a result, are undertaking review of the capacity, effectiveness and efficiency of their alcohol treatment systems. Even where alcohol is not an identified priority, PCTs and their partners may be considering improving service efficiency by designing or improving care pathways and there have been increasing calls from the NHS for Department of Health guidance on the subject.

This document provides good practice guidance on the development of integrated care pathways for people with alcohol problems – alcohol treatment pathways (ATPs). It is illustrated with a number of examples.

This guidance should be considered alongside *Models of Care for Alcohol Misusers* (MoCAM NTA, DH 2006) and *Review of the Effectiveness of Treatment for Alcohol problems* (NTA 2006).

Who is this guidance for?

This document is aimed at all those involved in the care of service users with alcohol problems: service providers, managers and commissioners.

What are alcohol treatment pathways?

Alcohol treatment pathways (ATPs) are locally agreed templates for best practice. They map out the local help available for alcohol-related problems at the various stages of a treatment journey. They are commonly made up of a flow diagram showing the particular pathway and decision points, alongside background

documentation giving explanatory narrative and clarifying details of criteria and protocols to be used in conjunction with the diagram. This allows for a wide variation in size, scope and detail.

The process of development of ATPs is often at least as important as the final product. This requires effective communication between all agencies, team members and other stakeholders involved. The process of obtaining consensus on inclusion criteria, on the agreed roles and responsibilities, on the optimal means of inter- and cross-agency working, and on the evidence of best practice, can all contribute to an effective final tool that supports the more explicit and effective delivery of care.

Specific alcohol treatment pathways can be identified and developed for particular needs and presentations or for particular groups.

The standardised and carefully developed treatment structure that the ATP outlines, can support the aims of optimal evidence-based treatment, equitable service provision and efficient and effective service utilisation by both service users and service providers.

ATPs can either illustrate the general routes into treatment for all potential service users, or may illustrate particular pathways for priority groups, for example those who are vulnerable, have complex needs or need specific help from a variety of sources.

Local partners should consider undertaking Equality Impact Assessments¹ against proposed pathways and, as a minimum, aim to ensure that service provision is culturally appropriate for those for whom the pathway is designed. In relation to alcohol it will be particularly important to consider the following:

alcohol use is a taboo in some religious cultures, which may lead to reluctance to discuss, openly recognise or seek help for, alcohol problems; Psychotherapeutic interventions are key for dependent drinkers, however, prevailing attitudes in some cultures may make those in need reluctant to discuss personal issues with someone outwith their religion, family or gender group.

1 http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4001740 – *Safe. Sensible. Social: The next steps in the National Alcohol Strategy (Equality Impact Assessment)*
http://www.aerc.org.uk/search/search.php?zoom_query=minority – *Alcohol Issues and the South Asian and African Caribbean communities – Improving education research and service development*, AERC, November 2006

To mitigate these and other potential barriers it will be necessary to consider the appropriateness of services within pathways for particular groups in terms of:

- cultural appropriateness for the client group – staffing profile and cross-cultural competence of counsellors
- communication – languages spoken, availability of interpreters, signers, etc
- physical access to services – both in terms of building accessibility, and geographical proximity to concentrations of target populations.

An individual's treatment journey may involve a number of smaller more specific alcohol treatment pathways and may describe care within a single service or care co-ordinated with several services.

Initially local partners may want to concentrate on developing specific ATPs that address areas that will particularly benefit them locally. This could include, for example, situations when obtaining a consensus on treatment of patients with comorbid problems could further improve care delivery, or where more standardised processes for the entry to and management of community or inpatient detoxification will be likely to improve patient experience and the efficiency of care delivery.

The development and prioritisation of particular ATPs will normally aim to ensure service users receive fair and timely access to treatment, with appropriate links made to all agencies that should be involved in their care.

What do alcohol treatment pathways look like?

An ATP can be represented by means of a flow diagram with a number of decision points. The aim of such a diagram should be to produce the most accurate representation of the pathway of care and where possible understandable at a glance.

An individual's overall treatment journey may involve a number of the more specific alcohol treatment pathways, which can run consecutively or in parallel. Thus, a single ATP will not always be the whole description of a person's journey through alcohol treatment.

In ATP example 2 below, the single step named 'inpatient detoxification programme' on the diagram, is itself represented by a separate full ATP (ATP example 3). The ATP examples 4 and 5, which are a dual diagnosis ATP and an ATP for homeless people needing treatment for alcohol misuse respectively, highlight the importance of co-ordination of care by a number of local services, including

the community mental health team, the community drug and alcohol team, hostels and the housing service. As noted earlier, the process of developing such treatment pathways will itself initiate important inter-agency communication, with agreements reached over roles, care responsibilities and optimal means of liaison and communication through the client's treatment journey.

The alcohol treatment pathway builds on locally agreed and developed treatment guidelines, supports more standardised local practice and provides practical help and guidance to less experienced workers. An ATP is not a substitute for management, supervision and training, but does offer a means to help ensure consistently high standards of treatment and care.

After clear, evidence-based treatment pathways have been developed as ATPs, it will be reasonable to expect they would normally be implemented, unless there are clear reasons for needing to deviate from the pathway. Locally, decisions to deviate from the ATP may be made by individual competent practitioners applying their judgement (which could be reviewed in supervision if appropriate), or may only occur following a team discussion or might require some exception reporting for clinical governance purposes. All such issues can be determined locally, based on the particular issue(s) involved.

The information provided with the ATP will normally include the local configuration and availability of relevant treatment services. Thus, the details of any ATP will often vary from place to place. However, a focus on developing evidence-based pathways and developing consensus on good practice locally should normally lead to equitable access to and delivery of treatment for those with equivalent needs across settings, or should at least make more explicit any reasons for variance between teams or agencies.

In each local area, ATPs will normally be developed both for all those engaging in the standard common elements of alcohol intervention and treatment, as well as for specific groups such as the vulnerable and those with complex needs.

Standard common elements or pathways can include:

- Identification and brief advice (IBA)), with or without extended brief interventions, delivered by non-specialist workers, for example by services providing interventions at Tier 1 and Tier 2.
- Assisted alcohol withdrawal – community-based
- Assisted alcohol withdrawal – inpatient-based
- Residential rehabilitation.

ATPs can also be developed for specific groups of service users who may experience difficulties or delays in gaining access to treatment because they have complex needs. Such potentially vulnerable or more excluded service user populations for whom ATPs should be developed will actually reflect local circumstances and need but may include:

- People with combined alcohol and mental health problems
- People with alcohol problems who also experience domestic abuse
- Homeless people who need alcohol treatment
- Service users in drug treatment who also have alcohol problems.

While these groups exist in every area and therefore pathways for all may be relevant in every locality, which pathways are developed will be dictated by local need and local priorities. Pathways may be developed in response to: a particular recognised local difficulty that needs to be addressed, agreed in liaison between different agencies; because of the expected likely benefits of a more explicit description of a pathway, for example where a new domestic violence support service has become available; or because certain groups locally may need to be prioritised, for example where there has been an increase in those presenting from a local minority ethnic community with particular communication or support needs. The way in which ATPs are developed locally will depend on the issues that have been identified as most important in the local community and for which the development of ATPs are considered a useful contribution.

This raises an important principle about planning priorities locally for services that currently have no or only a few ATPs. Planning over a sensible timeline will be needed in order to ensure that high quality and robust ATPs are developed rather than simply quickly achieving a comprehensive but superficial coverage of topics.

Developing a comprehensive, robust pathway for a complex issue such as the management of those with comorbid mental health problems is likely to require a focused multi-agency consensus-development process that may require more time and resource than developing simpler ATPs. Such a development may benefit from any work needed on protocol development, training between agencies and even organisational changes, for example around liaison working; and this could involve commissioners, different types of mental health teams, primary care services and other local alcohol agencies. Prioritising the development process for such a complex topic area may well be deemed a best use of resources but may then limit the speed of development of a number of other ATPs. Some areas may even limit scope of such a wide-ranging pathway, for example, by choosing to limit the scope

of such an ATP initially to obtaining agreement with CMHTs (rather than with all the specialised mental health teams), and may initially focus most on agreeing what are the criteria for routine referral pathways versus the criteria for joint and urgent assessments.

Even with a priority focus on complex cases, many services will still be likely to want to identify some simpler, more general, standard ATPs early on. This may include describing their pathways for assisted alcohol withdrawal in the community or inpatient settings, for example to ensure a consistent application of the criteria of risk and decisions about use of medication.

What the current and emerging balance of ATPs in an area will look like will depend on how long an area has been developing the pathways and how much ATP development is seen to contribute as an effective mechanism to improve quality and safety.

How to develop an alcohol care pathway in your service

It is important for all the key contributors to the care described in any particular ATP to be engaged in the development of that care pathway, at least at key development points and for final sign-off: Establishing effective treatment pathways can therefore also involve developing and strengthening partnerships between relevant local organisations. Increasingly, there also exist mechanisms to involve service users and carers in governance processes and these can be used to enhance ATPs as well. However, this does not have to be unwieldy or unduly bureaucratic.

Different ATPs may require different processes for development: However, it is important to recognise that simple techniques, such as identifying a lead champion, a 'lean' development group and using learning from best practice elsewhere – can enable fast and efficient development of ATPs that still engage the full multidisciplinary teams at key points. Engagement of stakeholders does not have to mean large meetings and groups developing pathways by committee, but rather can involve smaller groups identifying issues to be addressed in consultation with the key stakeholders and then the lead or the core group presenting draft solutions for amendment or sign-off to the wider stakeholders.

Some ATPs with a narrow technical focus may only require agreement within the local multidisciplinary clinical team. For example, a pathway may be proposed by just one or two of the staff that clarifies what is, de facto, the already agreed practice for most of the staff and is approved through the normal team governance mechanisms.

Other, more complex ATPs will require a clear lead coordinator for the project with support from a core multi-agency team made up of some key representatives of stakeholders who have an interest and could influence success of the ATP. It will be essential to identify the right membership for any local team convened to help develop the ATPs, in order to deliver the task efficiently and to avoid a loss of focus. The development team will normally need clear terms of reference, a list of tasks and a timetable for completion, and always needs to be focused on practical delivery of the ATP. The core team does not need to include all the stakeholders as long as the relevant stakeholders who can influence the success of the ATP are involved through appropriate mechanisms at key points, and so participate in the final consensus. It is crucial not to exclude any stakeholders who can influence success.

This process will normally require good planning, support from the team governance structures, leadership and appropriate resource allocation but much of the effective delivery often relies on an effective individual who leads the project, and as noted previously, with good planning skills this can be quite a simple process. Planning over a sensible timeline will be needed for services to ensure that high quality and robust ATPs are developed rather than simply achieving a comprehensive but superficial coverage of topics. Developing a comprehensive, robust pathway for a complex issue such as the management of those with comorbid mental health problems is likely to require a focused multi-agency consensus-development process that may require more time and resource than developing simpler ATPs. Such a complex development may benefit enormously from any work needed on protocol development, training between agencies and even organisational changes, for example around liaison working; this could involve commissioners, different types of mental health teams, primary care services and other local alcohol agencies. Prioritising the development process for such a complex topic area may well be deemed a best use of resources but may then limit the speed of development of other ATPs. Some areas may even limit scope of such a wide-ranging pathway, for example, by choosing to limit the scope of such an ATP initially to obtaining agreement with CMHTs (rather than with all the specialised mental health teams), and may focus on agreeing what are the criteria for routine referral pathways versus the criteria for joint and urgent assessments.

Before mapping out the details of the new ATP, it is usually necessary to map the alcohol treatment journeys that local service users' currently experience. Designing local alcohol care pathways involves analysis of the available treatments for alcohol related problems, including within what timeframes and in what sequence they are currently locally offered and who contributes to them, and identifying and analysing potential improvements that could be made. Clarity and pragmatism are important elements of effective pathways.

ATPs are often identified with the diagrammatic summary of the pathway. Well-developed ATPs will often encapsulate and condense the local available paths and the decision points succinctly through such a diagram. But it is important to recognise that it is the overall consensus development process behind the diagram and any attached explanatory narrative or protocols as well as any locally or nationally agreed best practice guidelines referred to for the specific client group, that constitute the whole of the ATP.

ATPs are focused on optimising the experience of the service user, and are intended to be evidence-based, and so should be kept under ongoing review. For some alcohol treatment pathways, key audit criteria could be identified, and if this were an audit priority for the service, these criteria could be used for a planned audit. For others, alternative forms of review may be planned. This may simply include a review by the multidisciplinary team after an agreed period of time using the normal team processes. Alternatively, in some circumstances, a multi-agency review date may be agreed.

Useful checklists for ATP development

Alcohol treatment pathways should be:

- agreed and developed locally, taking account of local service configuration and priorities;
- evidence-based;
- client-focused; and
- agreed and championed so as to ensure ownership by managers, practitioners and the key stakeholder who can influence success.

The key elements of the process involved in developing ATPs include:

- reviewing the existing documentation and the processes and pathways currently in use;
- developing or revising local treatment guidelines and protocols;
- deciding on the content of the ATP document – what we need to know and what would be helpful to know and include;
- producing clearly written documents that are easy to understand and are user-friendly (so an effective editorial control from the ATP lead or champion is needed alongside involvement of all stakeholders on drafts); and
- comparing new drafts with existing paperwork, removing duplication and including essential new content.

An accompanying narrative to an ATP may contain the following elements, where relevant and where it is not already apparent from the diagrammatic form:

- a definition of the treatment interventions provided (referencing any key guidance or guidelines);
- aims and objectives of the treatment interventions;
- a definition of the client group served;
- eligibility criteria (including priority groups);
- exclusion criteria or contraindications;
- the referral process;
- screening and assessment processes;
- the process for agreeing the treatment goals;
- a description of the treatment process or phases;
- description of the co-ordination of care;
- the nature of departure planning, aftercare and support;
- relevant onward referral pathways; and
- description of the range of services/agencies with which the interventions interface.

The narrative elements are designed to provide clarity as to the type of client the alcohol treatment intervention caters for, what the client can expect treatment services to provide – including important detailed practical arrangements when appropriate, and the roles and responsibilities of the service within the integrated care system and towards the individual client.

Example Alcohol Treatment Pathways

Shown below are five specimen template alcohol treatment pathway diagrams. The diagrams will rarely make complete sense out of the local context.

The aim of the examples is to identify the shape of some typical ATPs whilst recognising the scope and level of detail will vary markedly from place to place. They are not intended to be prescriptive or to advise on actual local clinical practice/preferred processes – but rather to be illustrative of issues that may be of relevance in developing different ATPs.

In addition to the diagrams, some narrative commentary is given for each pathway, pointing out some issues that may need to be considered or addressed in that case. The examples are not full specimen ATPs with all the background documentation, as this will vary from place to place. In practice, more explicit practical lists of inclusion or exclusion criteria, links to key protocols and identification of specific services involved (and their details) may populate the background documentation; and this may be extensive or may be relatively short depending on the need.

Each exemplar diagram is, however, followed by a narrative describing or commenting on steps or a group of steps in the diagram, numbered to illustrate certain issues. Local ATPs may or may not number steps in this way.

An example of the importance of local context, in ATP example 1, the 'new GP registration' step, is given as a potential point of entry to the 'identification and brief advice' ATP, but this would be included only if it reflected the local GP services' protocols on new registration assessments, for example if the practices were involved in the providing care under the 'alcohol' Directed Enhanced Service for new registrations.

The ATP example 1 will need sufficient additional information to be comprehensible to new staff and to all stakeholders using it, whilst being a practical tool for everyday use.

ATP examples 1 and 2 provide more general overviews of the whole treatment journey, within primary care and within structured community treatment, respectively. This is from the screening or initial referral stage, through clinical management – including psychosocial interventions and to onward referral to subsequent additional pathways.

ATP example 3, which describes specialist inpatient assisted alcohol withdrawal, is an example that expands into a dedicated ATP of its own what is shown only as a single step in the ATP example 2.

The subsequent two diagrams give ATP examples 4 and 5 for two specific groups of vulnerable service users with more complex needs: the management of harmful or dependent alcohol use with comorbid mental health needs; and the management of homeless people needing treatment for alcohol misuse.

ATP example 1: identification of alcohol problems in primary care and initial management

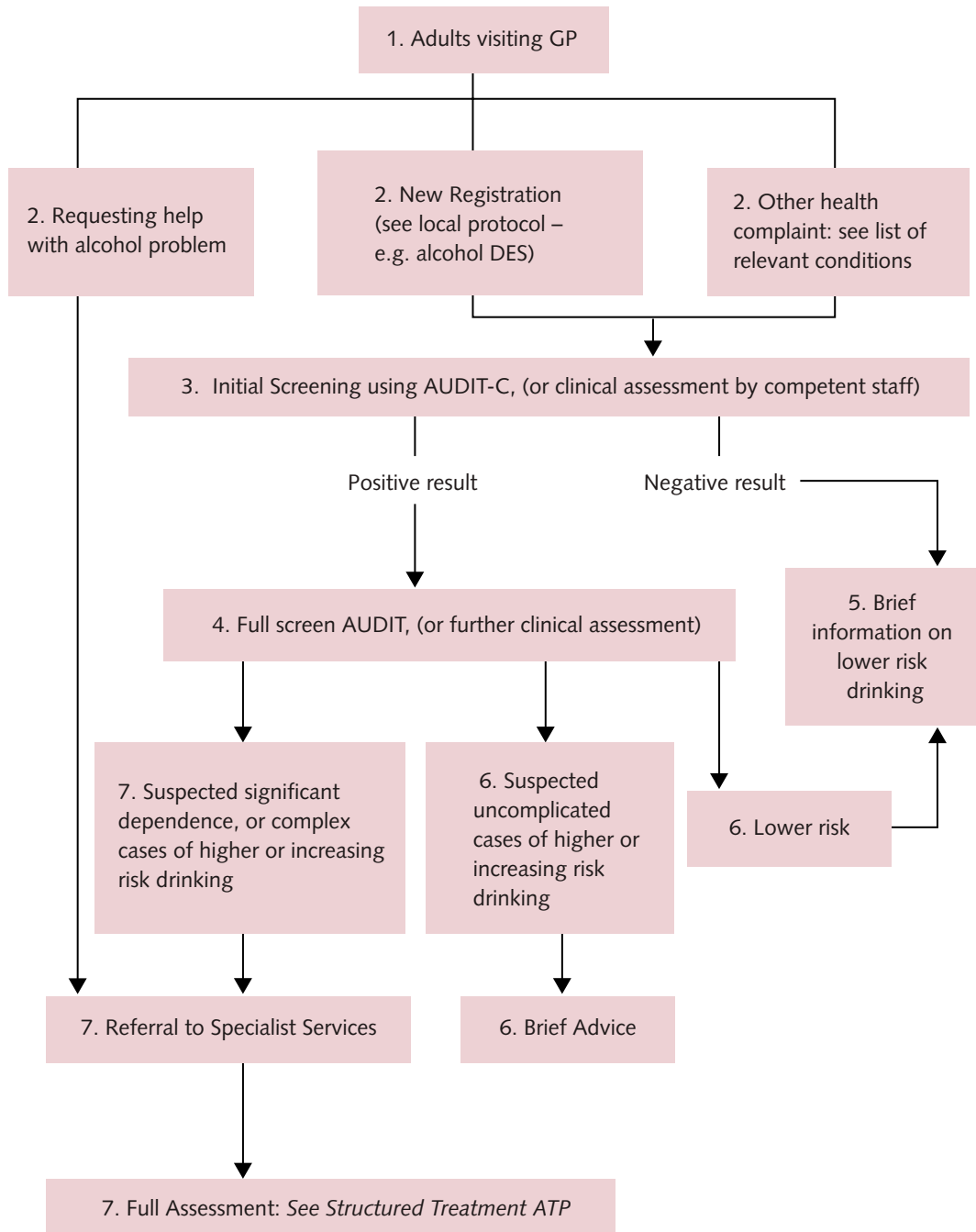
This primary care pathway illustrates the paths for identification of alcohol related problems, provision of information and advice, the provision of further assessment where needed and referral to specialist services for the management of increasing or higher risk drinking linked to problems or for alcohol dependence.

This ATP could have a clear aim expressed that includes identifying those at risk, providing information and advice where patients present in primary care to promote well-being and lower risk drinking; and using a stepped care approach for referral to more specialised assessment and treatment for those who may need this.

Key guidance on identification and brief advice (including reference to/inclusion of the protocol for a locally agreed Directed Enhanced Service for alcohol, if relevant), as well as the agreed self-help and support materials to be used, may all be explicitly referenced or included in the background documentation. Links to the available DH web-based training for primary care may be provided (particularly for new staff).

If agreed locally, the AUDIT (or SADQ) scores chosen to indicate a likely category of drinker for particular decision points within this ATP may be explicitly stated. Such scores may also be part of the factors included within eligibility or exclusion criteria for entry or referral to specific local services – and this may link to details of referral procedures or contact details for such services.

ATP example 1: Primary care alcohol treatment pathway – identification and brief advice or referral for specialist assessment



1-2: Adults visiting the GP, entering the ATP: A patient visiting the GP for any reason may be screened for alcohol problems. This may include those specifically requesting help in this area, those presenting with a health complaint which may be related to alcohol (a list of key conditions could be agreed locally as part of this protocol) or, depending upon the GP practice's protocol, newly registering patients (for example, the Directed Enhanced Services protocol for alcohol could be used).

3-4: Screening tools, such as those derived from AUDIT, are useful here and one or a number may have been agreed to be promoted and supported locally. If the GP has a special interest in alcohol misuse, they will also be able to use their clinical competence to assess for alcohol problems – and this option is included in the screening step. Some services with appropriately competent staff or particular mechanisms of care delivery may choose to omit the initial screening or the full AUDIT.

5: Those at lower risk will be given **information** on their lower risk status, and can be offered information leaflets on lower risk drinking and risks of alcohol-related harm.

6-7: Those uncomplicated cases at increasing or higher risk (or possibly with mild dependence, but not substantially dependent) will be given brief **advice** and may be marked for follow up, with complex and more dependent cases considered for referral to specialist services. Some protocols use simple test scores and clinical factors to determine such cut-offs.

Those requesting help with an alcohol problem that are not considered suitable for brief advice or extended brief advice and review, will be **referred to specialist services**, especially in the case of higher risk or dependence – *refer to ATP example 2 for structured treatment*. There may be information about which services locally may be the best to refer to depending on evidence of severity or complexity – and such criteria would be included here or referenced to ATP example 2 or equivalent.

ATP example 2: structured treatment in specialist community alcohol services

The 'structured treatment in specialist community alcohol services' ATP, illustrates points of entry, including via primary care, linking ATP example 1 above with this ATP example 2. This example also describes assessment processes; clinical management; psychosocial intervention; and referral routes back to primary care when and where needed, further highlighting the clinical interface and continuity of care between the primary and specialist care services.

1. Referral route: A client may be referred to structured treatment (a service providing Tier 3 interventions) by a number of routes, depending upon local referral arrangements. These may include self-referral, referrals from primary care, referral from criminal justice services and referral from other specialist services, such as mental health services (*see also ATP example 3 – alcohol and comorbid mental health treatment*). This can reflect any agreements on referral procedures. The varied mechanics of the referral process can also be clarified and highlighted in the background documentation or diagram: for example, differences between primary care referrals, other referrals and self-referral; and common process issues, such as information on common contact points, system of notification to referrer of progress of a referral or the need for any specific further information.

2. Screening to assess the urgency of the referral: all referrals may be considered on receipt by a competent practitioner for any very urgent actions needed and otherwise are processed through the routine triage system (step 3).

3-5: The initial **triage** assessment is a brief assessment focusing on identification of alcohol problems and other key areas of risk and concern. It may usually occur on the day the client presents, depending upon local service provision and may include telephone assessment against an agreed protocol, which can be described if appropriate. The initial triage assessment provides an opportunity to identify those with a level of drinking that requires only simple information and advice and then provision of information and leaflets on maintaining or achieving lower risk drinking and reducing risks of alcohol-related harm, but with no follow-up. The triage assessment also provides an opportunity for identifying eligibility or exclusion criteria for the available services. Where differing minimum eligibility and exclusion criteria have been agreed, for example with and for the local alcohol counselling service and for the local community specialist clinical alcohol service, these details can be included in the documentation and may be referenced in the diagram. These could be based on reaching a suitable threshold of severity of AUDIT score or level of assessed regular weekly/daily consumption or degree of dependence scored on SADQ and will be different for the counselling and clinical service. Eligibility will also be moderated by the presence or absence of certain co-morbid conditions, which can also be made explicit in the background documentation and their presence may cross-reference to additional ATPs.

If criteria are met for the counselling service on this example – step 4 is followed: to explain to the client how to self-refer or to be referred directly, depending on local service policy.

Other factors of importance can be noted at triage, such as any serious or immediate risks and the presence of dependents at home, such as children. Such factors may warrant further assessment and liaison with other agencies, either immediately or further down the treatment pathway depending upon the urgency of the need or level of concern. It is quite possible to link to separate generic, non-alcohol care pathways such as for the identification and assessment of children at risk or for the identification of vulnerable adults.

6. Comprehensive assessment: Those clients who meet the eligibility criteria identified at triage, or those presenting with other concerns, are then assessed fully by a member of the team, who may be a nurse, alcohol worker or doctor, depending upon the facilities and local protocols. There may be a waiting list for full assessment following triage, depending upon local service provision. A mechanism for informing the referrer of the intended date of assessment may be included in the ATP. Use of standardised assessment forms may be referenced.

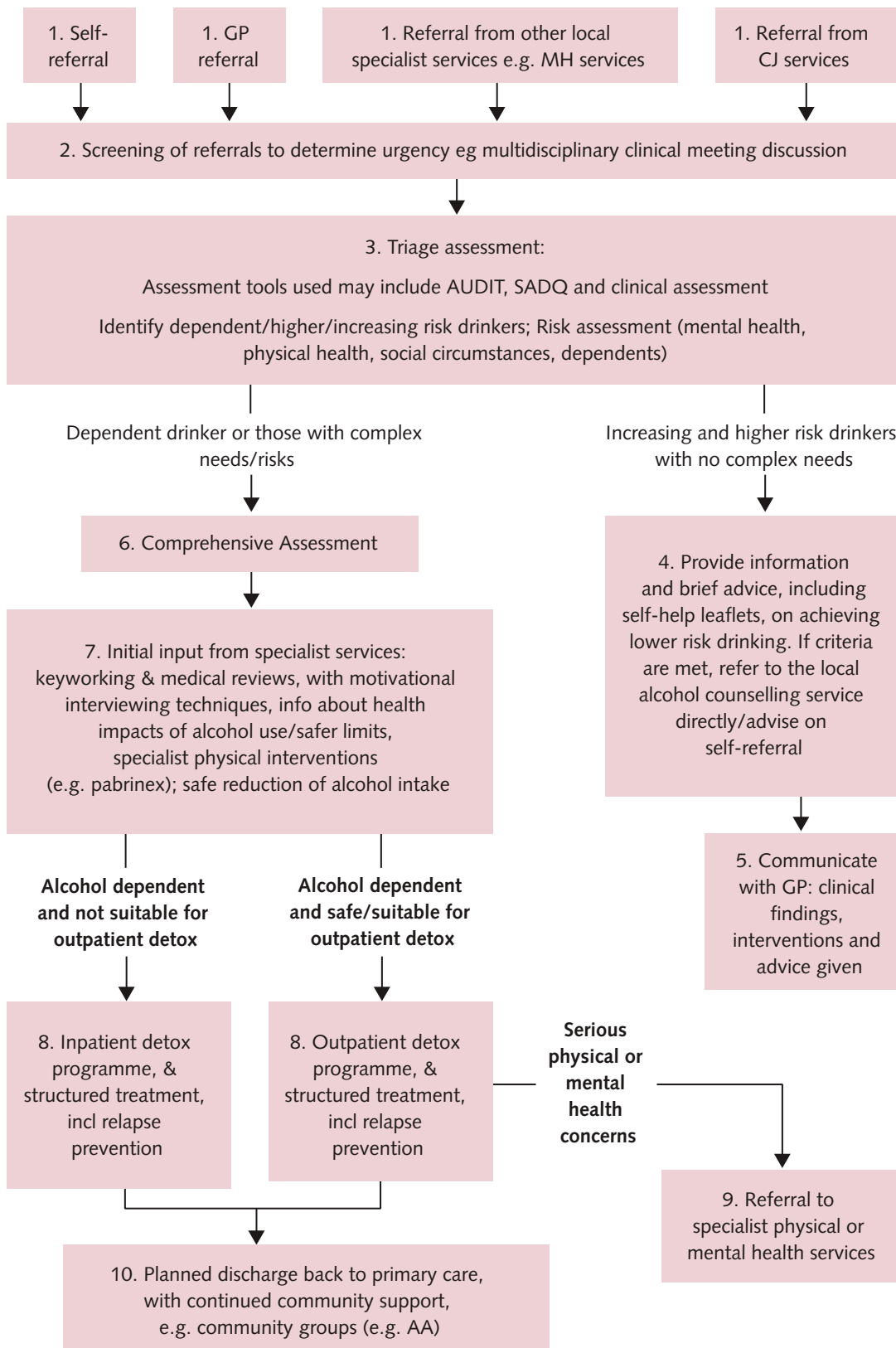
7. Interventions: Having identified the client's needs through comprehensive assessment, the service may offer a variety of Tier 3 interventions, depending upon the local protocols and facilities, including advice and education, and physical interventions such as intramuscular Pabrinex (as per agreed protocol); and agreed paperwork on care planning, risk management and keyworking may be referenced.

7-8. Assisted alcohol withdrawal ('detoxification'): Those identified as dependent upon alcohol and wishing to enter an assisted alcohol withdrawal programme will be assessed as being suitable for outpatient detoxification (home or ambulatory detoxification) or inpatient detoxification depending upon whether they meet the agreed criteria for home or ambulatory detoxification, which will be listed as part of the linked protocol. (*For an exemplar inpatient pathway see ATP example 3.*) Criteria are normally based on factors such as home support, physical and mental well-being, dependence severity, history of problems with fitting and other factors that would make home or ambulatory detoxification too unsafe: these could be listed in a linked protocol.

9. At any stage, if **serious physical or mental health concerns** are identified, the team providing Tier 3 interventions will liaise with specialist physical or mental health services and refer the client to their care if and as needed.

8 & 10. Following assisted alcohol withdrawal, the client is transferred to **structured treatment** either in the community or in a residential rehabilitation setting and **ultimately discharged back to primary care with a period of community support** either from organisations providing Tier 2 interventions, such as community support groups or from mutual aid groups or other non-alcohol support services when appropriate.

ATP example 2: Structured treatment in Community Specialist Clinical Alcohol Services



ATP example 3: specialist inpatient assisted alcohol withdrawal

The inpatient assisted alcohol withdrawal treatment pathway is used to illustrate the variations in care pathways that will be seen between localities. While many features of the care pathway shown are core, the exact details of some local protocols, such as giving Pabrinex, GP shared-care arrangements on discharge, and referral routes may vary between locality. The team responsible for developing the care pathway will need to consider the relevant local protocols and policies.

In the pathway illustrated, the details shown describe the journey that a client would take from admission to a specialist inpatient detoxification unit, their assessment at admission, their subsequent days undergoing detoxification, with additional psychosocial and pharmacological interventions described, the initiation of relapse prevention therapy and their transfer to continued structured treatment – which later could itself be described in another pathway. The duration and content of the interventions would vary depending upon clinical need, local facilities, and local protocols, as noted at various points in the pathway. A branch is included for any medical emergencies that may develop during admission, requiring assessment by a doctor/psychiatrist and referral to another unit if and as needed. The pathway concludes with discharge from the unit and mention is made of the essential transfer arrangements, to encourage seamless continuity of care, as a key element of the detoxification and throughcare support package.

The steps in the diagram are described below and continue after the diagram:

1. Referral: Depending upon local policy, the client may be referred to specialist inpatient assisted alcohol withdrawal ("detoxification") via a community alcohol team or other referral source in some localities, using relevant exclusion criteria for home or ambulatory detoxification – as per ATP example 2. There will be clear documentation of the agreement of the role of referrer/key-worker for the client in the community: their role during admission; prior to and after a planned discharge date; in the case of early, unplanned discharge or dropout; and their responsibilities for ongoing communication about progress during the patient's stay. The roles and responsibilities of the inpatient 'named nurse' for ongoing communication about progress during the patient's stay will also be clearly documented: Agreement at the point of referral on the effective support and communication expected from both inpatient and community staff (for waiting list, engagement, retention and throughcare management) is the rationale for linking this issue to the point of referral in this pathway.

2-3. Assessment of referral by inpatient team and **discussion with the key-worker:**

The receiving inpatient team may review the written referral and if the patient is not currently suitable for inpatient detoxification on the ward, contact the key-worker to discuss the reasons for this. Any additional input that maybe provided in the community prior to inpatient detoxification, if applicable, can also be discussed.

4. Initial familiarisation and engagement: Those patients referred who are suitable for inpatient detoxification may be invited to visit the ward for an initial familiarisation process to aid engagement prior to their admission.

5. Assessment on admission to the inpatient detox' unit: The client will undergo a comprehensive assessment by a member of the receiving team – usually a doctor and a nurse or alcohol worker. Their alcohol history and history of other substance use, current circumstances, physical and mental health and their current physical presentation including signs and symptoms of alcohol withdrawal and blood alcohol level (BAL) will be assessed and recorded. The BAL will be repeated after one hour to determine that their alcohol level is decreasing.

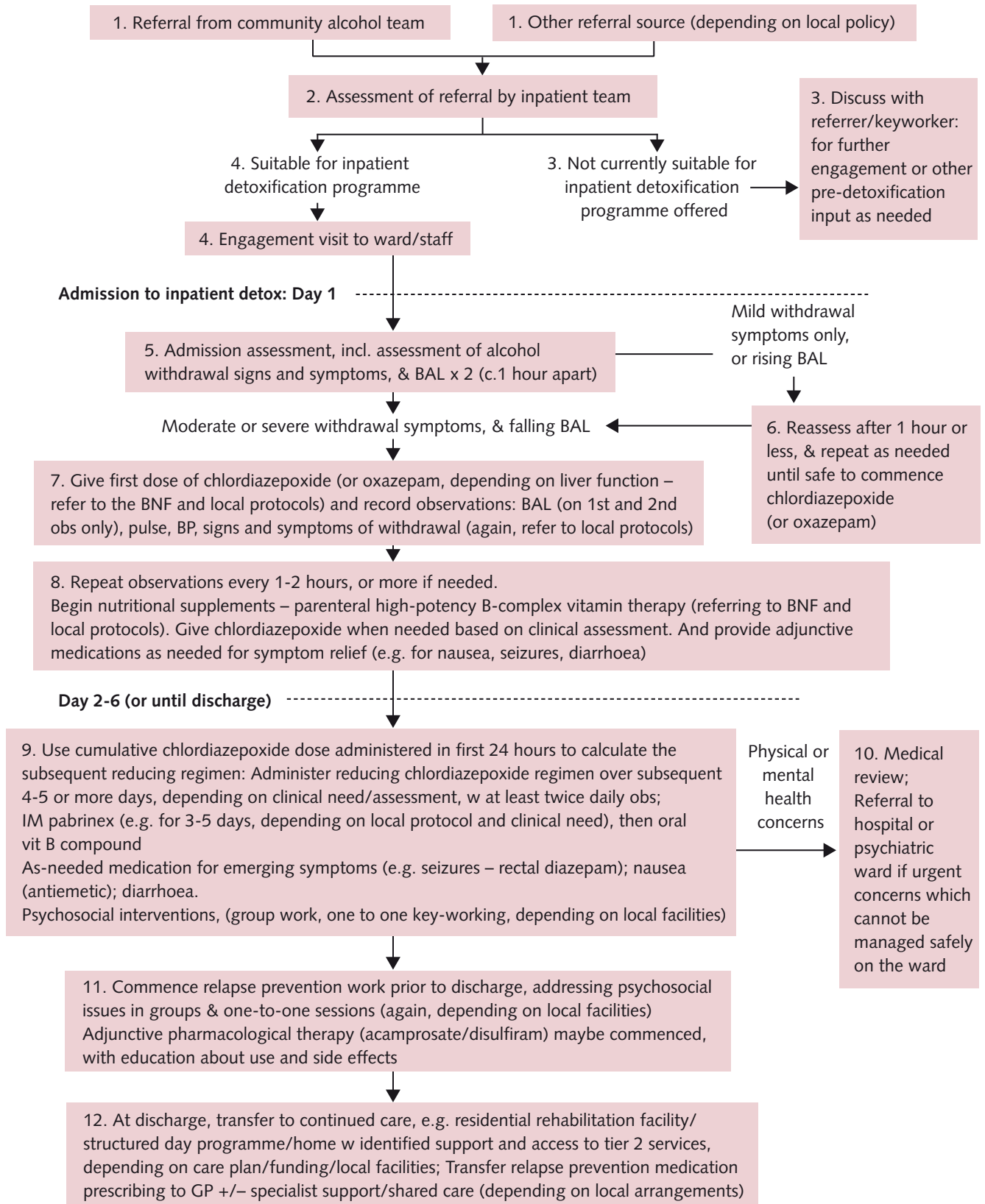
6. Waiting until it is safe to prescribe: If their BAL is in fact rising, or they present at admission with mild withdrawal symptoms only, the team will continue to monitor them until their BAL is falling and it is then safe to proceed to prescribing and administering the detoxification medication.

7. Commencing the detoxification medication regimen: When it is safe to do so, as described in step 6, the first dose of, for example, chlordiazepoxide (or oxazepam where there are particular concerns about liver function – referring to local protocols and to the British National Formulary for details) can be administered; and observations on the client's physical state recorded, such as pulse, blood pressure and signs and symptoms of withdrawal. The BAL need only be measured and recorded twice if it is falling.

8. Observations and medication over the first 24 hours: Observations, as described above, are repeated every 1-2 hours over the first 24 hours of admission, although as with all aspects of the treatment pathway, this will vary in accordance with agreed local protocol. Chlordiazepoxide is given when needed in the first 24 hours, based on the clinical observations and assessment. Parental, high-potency B-complex vitamin therapy can be commenced, again in accordance with local protocols and BNF guidance; and adjunctive medications, such as anti-emetics, prescribed as needed – as per linked protocol.

(Continued after diagram)

ATP example 3: Specialist inpatient assisted alcohol withdrawal ('detoxification')



9. The reducing regimen and other medications prescribed over the subsequent c.

5 days: A reducing regimen of chlordiazepoxide (or oxazepam when appropriate) is administered over the remainder of the detoxification period, which will usually be around 5 days in total, but may occasionally be increased by one or two days where needed, based on clinical judgement; vitamin B therapy continued; and adjunctive medications prescribed as needed; as detailed in the ATP diagram. During this period, in addition to the pharmacological management, psychosocial interventions, such as group work addressing triggers and relapse prevention strategies, dependent again upon local service provision/availability.

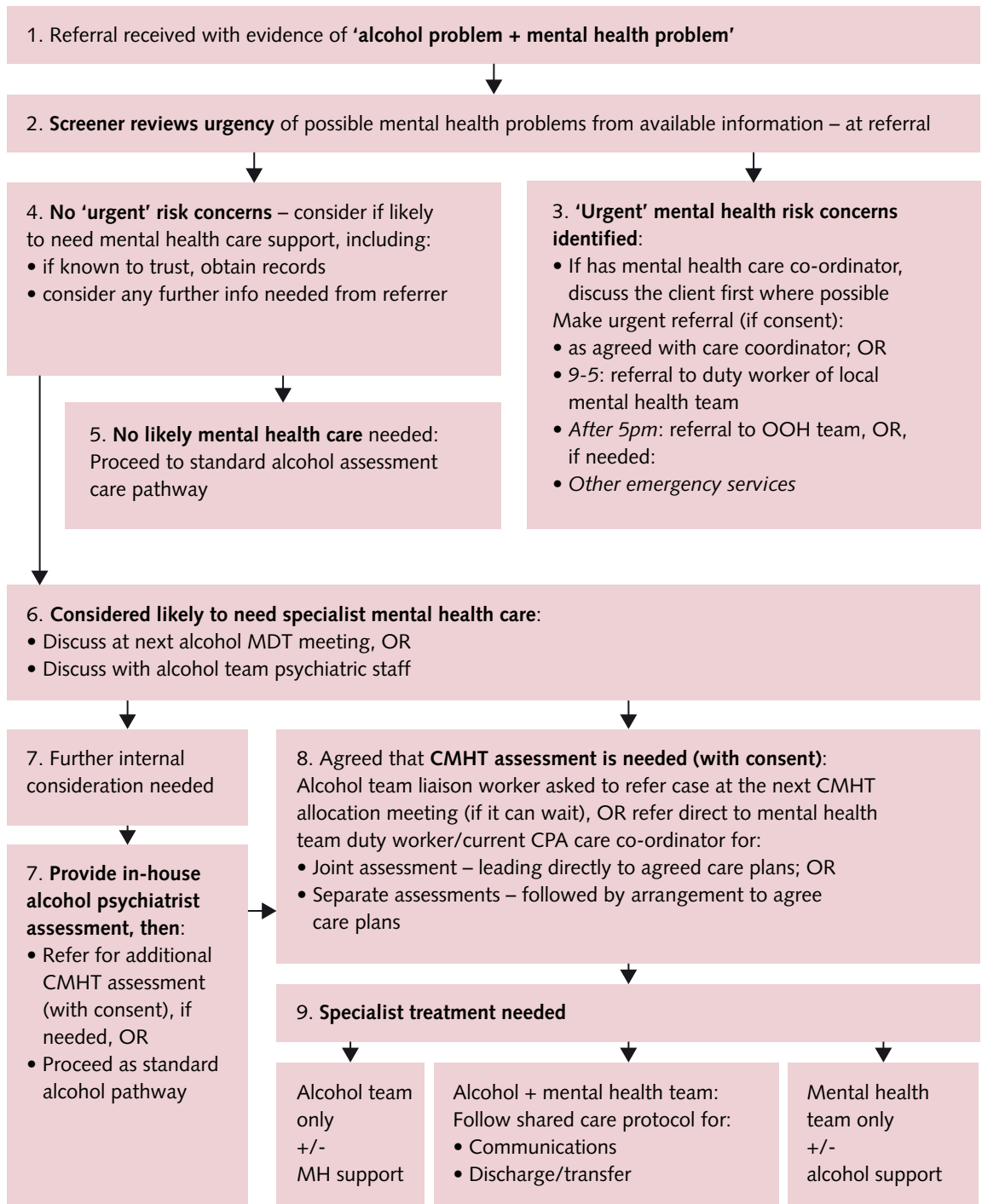
10. Referral to other specialist services when needed for physical or mental health

problems: At any stage during admission, physical or mental health concerns will precipitate a medical review on the ward, with onward referral if the presentation requires further specialist management not available on the ward – for example, if they develop an acute physical emergency requiring immediate transfer to the Emergency Department.

11. Relapse prevention medication: In addition to ongoing pharmacological therapy, following detoxification and prior to discharge, anti-craving medication (Acamprosate), and/or 'Antabuse' (disulfiram) may be offered, if they meet agreed criteria and there are no medical contraindications; with education given about use and side effects – as per linked protocols.

12. At discharge, the onward discharge care plan will vary according to the client's wishes, their prescribing needs and other medical needs, funding provision and local facilities and will involve any intended community key-worker in agreeing the discharge care plan. This may include seamless transfer to a residential rehabilitation unit, or discharge home with support and a structured community day programme in place or other structured Tier 3 interventions. Any relapse prevention medication commenced will require prescribing after discharge by the GP, community alcohol team, or through a shared-care arrangement, depending on local agreements, which would have been established prior to discharge. Some may be suitable for early discharge to aftercare support and attendance at mutual aid groups such as AA that would be agreed in the discharge the care plan. Where appropriate any agreed protocols could be referenced.

ATP example 4: specialist clinical alcohol service assessing referrals for those with evidence of comorbid alcohol problem and possible mental health problems



ATP example 4: specialist clinical alcohol service assessing referrals for those with evidence of comorbid alcohol problem and possible mental health problems

The fourth exemplar ATP describes an assessment and treatment pathway for referrals of people with alcohol problems considered likely to have comorbid mental health problems; a potentially vulnerable service user population whose care pathway often requires the liaison of several agencies, most notably the mental health services and alcohol services. Responsibilities around urgent mental health risk assessment and adequate systems for ongoing assessment, delivery and communication of separate or joint care are key issues for typical treatment pathways. The processes for developing effective care pathways for this group will include agreement between both sets of teams on principles of care, mechanisms for communication and opportunities for mutual support; and may be reinforced by mutual training and regular liaison working. The ATP will fit within such a wider process.

This particular pathway is predicated on the understanding that any potentially severe and acute mental problems will be referred directly to emergency services, either emergency psychiatric services or more general emergency services (e.g. ambulance, A&E or GP) as appropriate in the circumstances. In this case, protocols with the psychiatric services for urgent and non-urgent referrals will have been agreed in formulating the ATP, with details of key contacts and processes included in the background protocols.

The main part of this pathway, assuming any urgent mental health problems are addressed by following that arm of the pathway, deals with the internal alcohol team processes to be followed for determining the need for non-urgent mental health team involvement in the assessment process. This path also describes the referral mechanisms for obtaining separate or joint mental health assessments and determining the joint or separate management of the comorbid problems.

1-2. Review of referrals: Screening of all team referrals takes place by a senior clinician to assess for urgent risk issues. If a potential comorbid alcohol problem and mental health problem is identified, the key issue is firsts to assess for evidence of risks requiring urgent response. If urgent risk identified, proceed to step 3. Where no urgent risk identified, proceed to step 4. The service standard referrals protocol document will make clear who routinely reviews all referrals for any urgent risks and for any high priority cases and how this information is fed back to the MDT meeting.

3. Urgent mental health risk concerns: Immediate risk assessment takes place on the information available. It will normally also be useful to identify and obtain information from other sources, for example from the mental health records, the GP or a treating clinician if there is time. This step could involve specific reference to local procedures for obtaining mental health records as a matter of urgency. Where feasible, liaison with any mental health care co-ordinator will have been agreed in protocol development and possible urgent assessment but in many cases it will be expected that urgent mental health assessments will be provided by the local CMHT duty worker (9-5) or by the OOH (out of hours) team, as appropriate. The background urgent referrals protocol previously agreed with the mental health teams will provide contact details and any additional information agreed.

4. No urgent risk concerns: At each stage of the assessment process, it has been agreed that for those with evidence of comorbid mental health problems, a decision is needed as to whether the client with alcohol problems is likely to need or benefit from specialist mental health assessment and treatment. Hence, at the earliest stage, any further information that is available should be collected to assist in this decision. This step is explicit in identifying responsibility at the screening stage for asking for any additional information. In some cases, with a triage step, this responsibility could be shared between referral screening and triage stage. If the information received suggests no substantial mental health problem, the standard alcohol assessment path would be followed, step 5.

6-7. Considered likely to need specialist mental health care: To minimise unnecessary delays and to minimise burden on all staff, it has been agreed locally that decisions about referral for an additional or joint comprehensive assessment involving a mental health team practitioner (or CPA key-worker) will only normally be considered, after discussion with the alcohol team psychiatrists or at the alcohol service MDT meetings (and this can include a request for alcohol team psychiatric assessment if needed, as per step 7). The background protocol would make clear that most minor or common mental health problems would only be referred for mental health team assessment after an initial triage or comprehensive assessment by an alcohol team practitioner. On the other hand, referral for more substantial or severe comorbid mental health needs would first be discussed with the relevant mental health team, to attempt to agree a process for early additional or joint mental health assessment.

8. Agreed that CMHT assessment is needed: This step makes clear the paths of referral for a separate, additional or a joint mental health team assessment. This clarifies that the alcohol team CMHT liaison worker will discuss cases at the mental health MDT meeting if this is suitable or the referral will be made via the CMHT

duty worker (or identified CPA care co-ordinator when relevant) as per background protocol. The background protocol will have contact details for all teams.

9. Specialist treatment needed: This step identifies the three typical options for treatment with comorbid patients, treatment by the specialist alcohol team (with mental health problem support only if needed and as agreed in the alcohol team care plan), treatment by the specialist mental health team (with alcohol problem support only if needed and as agreed in the mental health team care plan or CPA) and shared care by both the alcohol team and mental health team, each with a clear keyworker or care co-ordinator and agreed care plans. A lead co-ordinator may be agreed in some cases, depending on the clinical situation, but the protocol for shared care working is referenced to ensure adequate ongoing communication and arrangements for liaising on any pre-discharge planning.

ATP example 5: an ATP for homeless people needing alcohol treatment

Example 5 is an alcohol treatment pathway for homeless people needing alcohol treatment. It describes a route from identification of need for this vulnerable population, to enhancing service access and providing treatment. The needs of this client group highlight the importance of interagency liaison and provide an opportunity to illustrate the breadth of agencies that may be involved in developing a care pathway: Here, the professionals potentially involved include hostel staff, specialised alcohol workers within the hostel, housing officers, community drug and alcohol services, satellite community drug and alcohol services, specialised drug and alcohol services for the homeless, the GP service for the homeless and carers that may be involved or accessible. In addition, local services that provide Tier two interventions, ambulatory or hostel-based detoxification units, inpatient detoxification units, community mental health teams and the local general hospital staff may have involvement. This will depend upon the client's needs within the pathway and on locally available facilities. Thus, to formulate this care pathway, hostel staff, the local services providing Tier 3 interventions, the GP service and housing providers must liaise, communicate and establish an agreed pathway: If, for example, the alcohol team were to formulate a care pathway in isolation, without communication with the other agencies, triage by the hostel would not have been agreed, a system for liaising with the housing service would not have been established and so on: the ATP without consensus, co-operation and agreement would be of limited value.

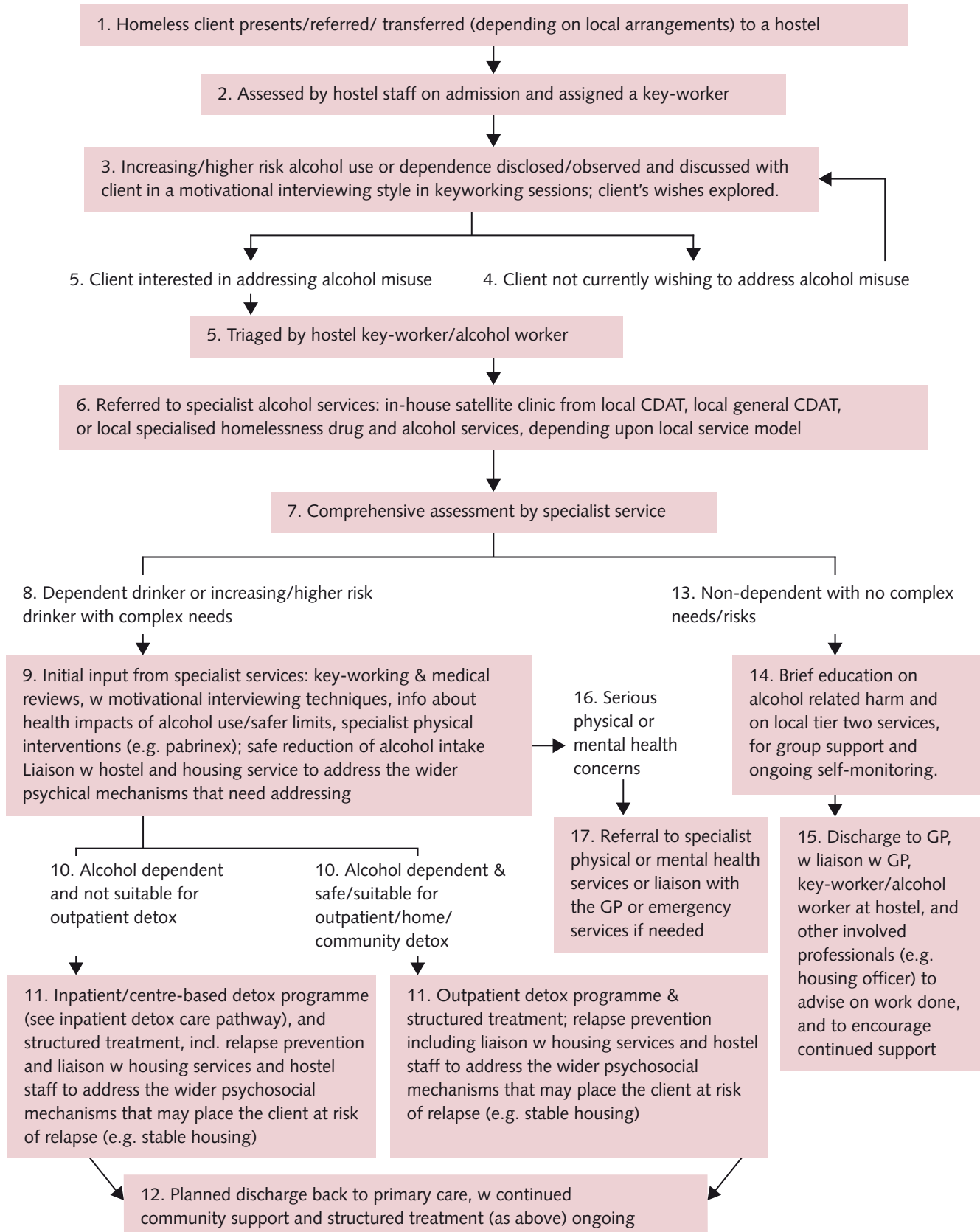
Thus, as previously highlighted, the manner in which the pathway is developed can be at least as important as the pathway's content. In formulating a care pathway such as this one, the agencies involved will need to ask, discuss and establish:

Who is the client? Who will be eligible? What will the treatment aims be? What services are available/accessible to achieve this? What funding is available/needed? Which services will play which roles? How will the agencies communicate and liaise at each step? Where there is more than one branch/option, what criteria will need to be met for each and how much flexibility will there be?

This care pathway also provides an illustration of the overlap of some care pathways. Following triage by the hostel alcohol worker, the client is referred for a comprehensive specialist assessment. At this point, the care pathway is similar to the structured treatment care pathway, with some variation reflecting this group's particular needs and service provision. The decision regarding level of need may be made following comprehensive assessment, involving expertise available at the hostel and taking into account the degree of collaborative working possible in the case. The care plan highlights collaboration with housing and the need to address the service user's wider psychosocial issues including future stability of housing because of the inevitable impact that failing to do so may have on relapse.

(Continued after diagram)

ATP example 5: an ATP for homeless people needing alcohol treatment



The steps in the ATP are explained below; as with the other ATPs, the steps do not always follow sequentially, since there are a number of possible branches described:

- 1. Arrival at a hostel:** The homeless person may reach a hostel by various means, dependent upon local protocols, e.g. transfer from a temporary hostel or referral from a homelessness outreach team.
- 2.** On arrival, the client may be assigned a **key-worker** within the hostel (again, depending on local protocol) and an initial formal or informal assessment will take place.
- 3. Concerns around alcohol misuse:** At any point from arrival, the key-worker or other hostel workers may make observations that precipitate concerns around the client's alcohol use or the client may disclose concerns themselves. Depending upon the client's initial motivation to address any concerns, the key-worker will use a motivational style to explore the issues involved (such as triggers for alcohol misuse) and their wishes and will encourage the client to move to the next step in the treatment pathway.
- 4.** If the client does not express any interest in addressing their alcohol misuse at this time, the motivational style and exploration of issues can continue to be revisited; but any key **harm reduction strategies** can still be addressed, such as discussing some reduction of alcohol intake where this may endanger a continued placement.
- 5. Triage:** The consenting client will then be formally triaged by an alcohol worker at the hostel or by a hostel key-worker trained in taking a brief alcohol history, depending upon local protocol and provisions. If such trained hostel staff are not available, it may have been agreed with the local alcohol service that a hostel client can be referred for comprehensive assessment without an initial triage beyond the identification of a problem by hostel staff, which variation would be incorporated in the ATP diagram or attached protocol.
- 6. Referral to a service providing Tier 3 structured alcohol treatment interventions:** The client will then be referred to specialist service, the format of which will again vary with locality: It may comprise a local generic community drug and alcohol team, a specialist hostel-based satellite clinic from the local alcohol service, or a specialist homelessness drug and alcohol team at a separate location. This will have been explored during development of the ATP to be clear in the diagram or in the background documentation.

7. Comprehensive assessment: The service will then provide a comprehensive assessment of the client's alcohol use, current situation and previous history and will explore the client's wishes to address their alcohol problem,

8-9. Continued input from the service offering Tier 3 interventions: If the client is found to be alcohol dependent (or their alcohol misuse to be of increasing or higher risk, especially in the presence of other complex needs) that meets the eligibility criteria for treatment, the specialist service may then take the client on for structured care-planned treatment and keyworking, as detailed in the diagram box 9; see also ATP example 2. The detailed criteria for accepting clients for ongoing treatment will depend upon local protocols and this would have been clarified and agreed at the stage of development of the ATP.

10-11. Assisted alcohol withdrawal: Those who are alcohol dependent will then be helped to move to the next steps in the ATP – commonly assisted alcohol withdrawal ('detoxification') and structured psychosocial treatment with development of plans at an early stage for the appropriate aftercare likely to be needed at a later stage, when they are ready to engage in these. The location chosen for the detoxification – outpatient (hostel-based or ambulatory) or inpatient unit – will depend upon the client's history, risks and other needs and will be decided following comprehensive assessment and discussions with the client, the doctor involved in their care, their alcohol treatment key-worker, their hostel alcohol worker (with consent) and other professional involved in their care. Specific exclusion criteria may exist for inpatient care for those who are currently homeless and the actions to be taken in such circumstances may be detailed in the documentation of the ATP. In some cases the decision will then be reviewed further by a funding team as to the options available – see ATP example 3 for details of a specialist inpatient assisted alcohol withdrawal treatment pathway.

12. Discharge back to primary care: Following successful completion of step 11, the team will discharge the client back to the care of a GP, the hostel staff or other social and community support systems, such as group work, mutual aid organisations (such as AA) and social support interventions. Of particular importance for this vulnerable population at this stage is effective final liaison with the hostel and housing services, to ensure that the planned support is in place to address the client's housing needs, since a return to homelessness will place the client at increased risk of relapse.

Many of these issues and options will have been addressed during the ATP development phase, so that clear and agreed pathways for communication and liaison are already in place for addressing the complex needs of this vulnerable population following detoxification with lists of key contacts. Named liaison workers for oversight of such a complex ATP (both within key hostels and within the alcohol services) can be useful where early adjustments may be needed to the ATP with experience of practical implementation.

13-15. Those clients not meeting eligibility criteria for structured treatment, are offered information and brief education on lower risk drinking and reducing risk of alcohol-related harm, soon after the comprehensive assessment.

They too will then be discharged back to primary care and the hostel staff. As detailed in step 12, the alcohol team will need to communicate clearly with the hostel and housing services to encourage continued support, monitoring and to ensure that steps are in place to manage the risks to their possible alcohol misuse imposed by continued homelessness.

16-17. Physical or mental health concerns: At any stage in the ATP, the client or any health-care professional involved in the client's care may note physical or mental health concerns, which may precipitate transfer or referral to specialist physical or mental health services or liaison with the GP or emergency services, depending upon the level of concern.

Glossary

A&E	Accident & Emergency
AA	Alcoholics Anonymous
ATP	Alcohol Treatment Pathway
AUDIT	Alcohol Use Disorders Identification Test
AUDIT-C	Alcohol Use Disorders Identification Test – Consumption
BAL	Blood Alcohol Level
BNF	British National Formulary
CDAT	Community Drug and Alcohol Team
CJ services	Criminal Justice services
CMHT	Community Mental Health Team
CPA	Care Programme Approach
DES	Directed Enhanced Service
DH	Department of Health
GP	General Practitioner
IBA	(alcohol) Identification and Brief Advice
MDT	Multi-disciplinary Team
MH	Mental Health
OOH	Out of Hours
SADQ	Severity of Alcohol Dependence Questionnaire



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