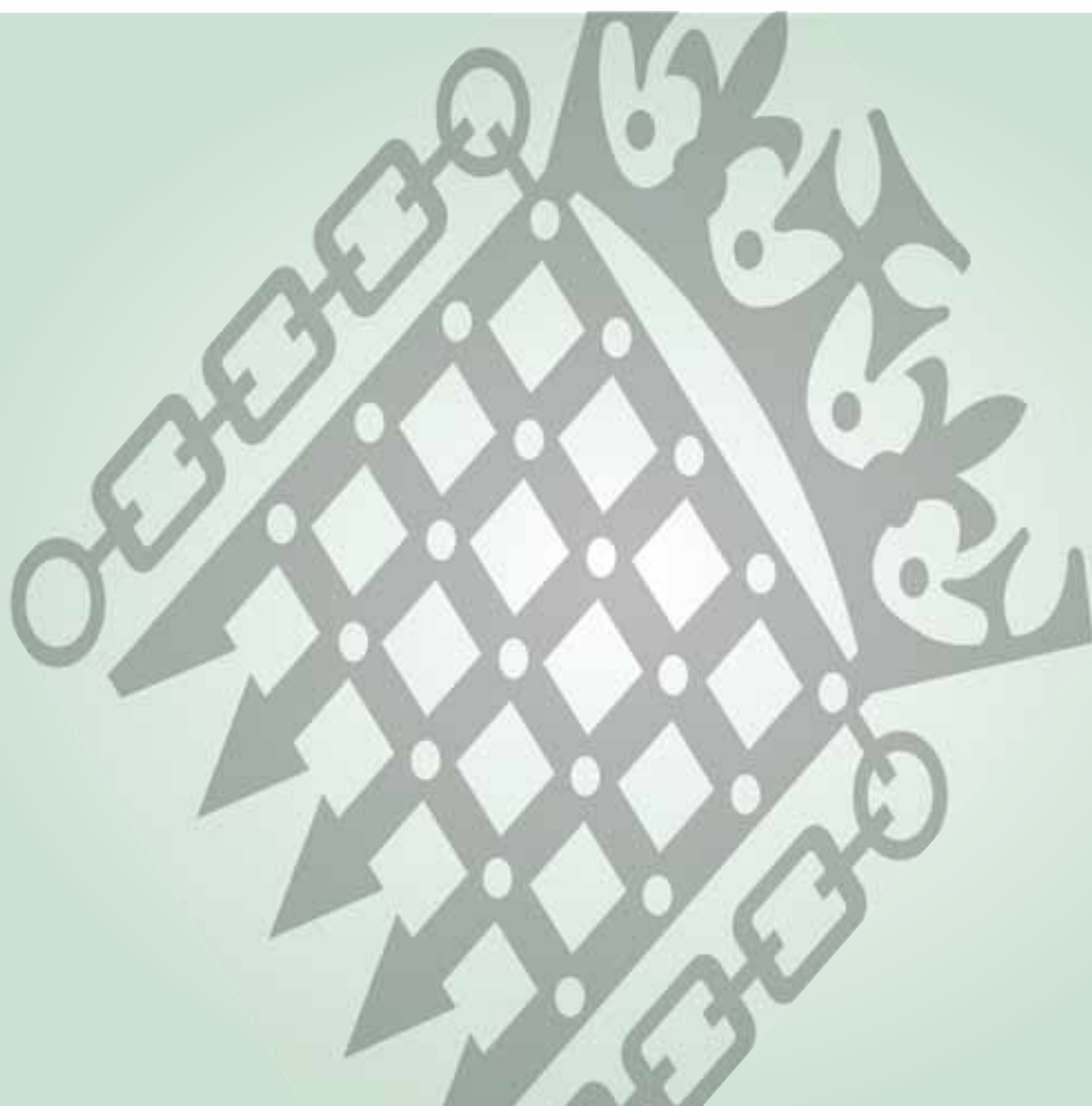


# All Party Parliamentary Group on Alcohol Misuse

The future of alcohol treatment services



## **Alcohol Concern is**

The national agency on alcohol misuse. We work to reduce the incidence and costs of alcohol-related harm and to increase the range and quality of services available to people with alcohol-related problems and their families.

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## Foreword



*I am delighted to introduce this inquiry report, which is the first to be published by the All Party Parliamentary Group on Alcohol Misuse. The Inquiry into the Future of Treatment Services was inspired by the insights provided by last year's reports from Alcohol Concern and the National Audit Office into the landscape of the alcohol treatment in England. Both were high profile critiques of the perceived lack of strategic planning and investment for the care of alcohol misusers. The Inquiry was launched in October 2008 in order to understand, beyond the statistics, the real challenges and difficulties facing those working in alcohol commissioning and treatment.*

*The simplest objective of alcohol treatment can only be to improve the quality of life of those who misuse alcohol and assist in reducing harmful consumption. By listening to those who work closely with alcohol misusers, the All Party Group has made considered recommendations designed to achieve this end.*

*I would like to take the opportunity to thank all those who made the effort to provide evidence during the course of the Inquiry and Alcohol Concern for secretarial support. Finally, I would like to thank Mimosa Healthcare Group Ltd for funding the report's publication and launch. As the report shows, those working at the forefront of the alcohol harm reduction agenda provide an invaluable resource. For this reason their contributions are all the more appreciated.*

**Lynda Waltho MP, Chair**

May 2009

## Executive summary

The Inquiry into the Future of Alcohol Treatment Services was called by the All Party Group in 2008 to investigate and understand the current state of alcohol treatment services in England and their future. Specifically, the APPG focused on whether and how recent policy developments have made an impact on treatment delivery, what the challenges are for a range of people working in the system and which actions need to be taken to widen access and place the system on a stable and sustainable footing.

The Inquiry heard that a variety of problems, constraints and challenges face those working in the treatment system. While some respondents reported that the profile of alcohol treatment had been raised in some areas, there were inconsistencies in the level of funding, the participation of Primary Care Trusts (PCTs) and the use of strategic guidance from Government. The majority of respondents reported a general lack of capacity and variety in alcohol treatment services, due to poor levels of funding and, in some cases, a harm reduction agenda driven largely by crime and disorder rather than health considerations.

Key recommendations of the All Party Parliamentary Group:

- Government needs clear cross-departmental leadership to tackle England's growing alcohol problem.
- Government needs to measure alcohol harms differently, by targeting a reduction in heavy drinking amongst all age groups and a reduction in alcohol-related crime as well as hospital-related admissions.
- All primary healthcare services should understand and be able to deliver Screening and Brief Interventions (SBI).
- All PCTs areas should have effective specialist alcohol services which are accessible to local communities.
- Specialist alcohol treatment must meet the needs of all those affected by alcohol misuse.
- There needs to be clear protocols and pathways in place to tackle alcohol misusers with more complex needs.
- In order to tackle alcohol harms, PCTs must understand the scale of the problem they are facing and share data as required.
- The Department of Health should update and reissue existing guidance and support implementation with regional training.
- There needs to be an ongoing training programme for alcohol commissioners.
- Strategic Health Authorities must ensure that PCTs are assessing need in their area and commissioning alcohol treatment commensurate with that need.
- Clear guidelines are required about how different parts of the alcohol treatment sector are to work effectively together.
- The National Institute for Health and Clinical Excellence (NICE) should look at how the Quality and Outcome Framework (QOF) for GPs can be amended to help tackle alcohol misuse.
- Access to accurate alcohol misuse and dependency data must become a priority for the Department of Health.

## Introduction

Alcohol misuse represents a major burden to the NHS and the wider health and social care systems. The Department of Health estimates that nationally, 6% of men and 2% of women can be classified as alcohol dependent. This equates to 1.1 million people. Among them there is a large discrepancy between the number of those who need alcohol treatment and those who actually access services, with approximately only 1 in 18 (5.6%) alcohol dependent drinkers entering specialist treatment nationally every year<sup>1</sup>.

While there is clearly considerable potential to increase engagement with services through a variety of means, consideration will also need to be given to the capacity of treatment services to meet any increase in demand generated by such initiatives. This is the proposed focus of the inquiry.

### Why conduct an inquiry now?

A growing interest in alcohol misuse and its treatment has highlighted the neglect of alcohol misuse as a public health issue in past years. The Inquiry started in late 2008 following the publication of significant reports which emphasised the need for an in-depth, qualitative study of the future of the treatment system, from the point of view of those working within it.

The first significant report in 2008, produced by Alcohol Concern<sup>2</sup>, showed that treatment services had received very little benefit from the government's *Alcohol Harm Reduction Strategy for England*, published by the Cabinet Office four years previously with the objective of preventing further alcohol-related harm in society<sup>3</sup>.

The organisation carried out a freedom of information survey of all PCTs to establish

levels of investment on a regional basis. Overall, the survey highlighted a number of shortcomings in alcohol treatment commissioning and showed that the reality fell far short of the vision laid out by the Department of Health in *Models of Care for Alcohol Misusers (MoCAM)*<sup>4</sup> two years previously.

Published later in 2008, a study by the National Audit Office (NAO) of health services for alcohol misuse<sup>5</sup> provided a high profile public rebuke of the current state of treatment services in England. The study found that, while PCTs are now responsible for setting their own local health priorities, a quarter had not accurately assessed the alcohol problems in their area, despite such assessments being necessary for PCTs to be able to understand what services they should be providing and whether the services they commission are adequate and cost-effective.

Furthermore, the NAO report found that despite having access to the data held in the Local Alcohol Profiles for England, which are generally acknowledged to be the most reliable data available on local need, around 20% of PCTs do not make use of them.

Where spending was known, it showed PCTs spent an average of £600,000 on commissioning alcohol services in 2006-07 (including, for example, the provision of brief advice from GPs, weekly alcohol clinics, or more involved specialist treatments). This expenditure represents a little over 0.1% of a typical PCT's total annual expenditure of around £460 million.

### Terms of reference of the Inquiry

The Inquiry's terms of reference were as follows:

- What has been the impact of recent policy

developments on the alcohol treatment system?

- What are the challenges for practitioners, policy makers, the NHS and other stakeholders in achieving alcohol treatment's potential?
- What actions need to be taken to widen access to alcohol treatment programmes and places the system on a more stable, sustainable footing?

### Objective

The objective of the Inquiry was to investigate and understand, using a qualitative approach, the current state of alcohol treatment services and their future. Through the submission of evidence, both written and oral, from practitioners in the field, the APPG hopes to understand more fully the challenges facing those involved in alcohol treatment. In doing so it hopes to be able to make positive recommendations for the improvement of alcohol treatment services in the future.

### Methodology

Three oral evidence hearings took place on 11 November 2008, 10 December 2008 and 28 January 2009 respectively.

Giving evidence were:

*1st Hearing, 11 November 2008*

Annette Fleming, Chief Executive, Aquarius

Anthony Massouras, Chief Executive, The Linwood Group

Dr Lynn Owens, Clinical Lead for Alcohol Services, Liverpool Primary Care Trust

Peter Steel, Chief Executive, Inglos

*2nd Hearing, 10 December 2008*

Professor Colin Drummond, Professor of

Addiction Psychiatry, St George's Hospital Medical School

Paul Hayes, Chief Executive, National Treatment Agency

Nick Lawrence, Head of Alcohol, Drugs and Tobacco Policy, Department of Health

Mark Prunty, Senior Medical Officer –

Substance Misuse, Department of Health

Dr Nick Sheron, Head of Clinical Hepatology, University of Southampton

*3rd Hearing, 28 January 2009*

Eric Carlin, Chief Executive, Mentor UK and Chair, Drug Education Forum

Vivienne Evans, Chief Executive, Adfam

Sandra Machado, Director, Ethnic Alcohol Counselling Hounslow

Dr Tony Rao, Consultant Psychiatrist, South London and Maudsley NHS Trust

The Inquiry received 40 written submissions (listed in the Appendix).

### Why is treatment important?

Treatment for alcohol misusers is cost-effective. As alcohol misuse represents a significant cost to the economy, major savings can be made by investing in treatment for alcohol misusers. Overall, for every £1 spent on treatment, £5 is saved elsewhere<sup>6</sup>.

## The current situation

### Government policy

Government has issued several documents under the Alcohol Harm Reduction Strategy intended to reduce health harms in relation to alcohol misuse.

In 2004 the Department of Health (DH) and the National Treatment Agency (NTA) released guidance to help local commissioners develop more integrated and effective alcohol treatment systems. The main toolkit within this set, Models of Care for Alcohol Misusers (MoCAM), establishes PCTs as the primary commissioner and purchaser of alcohol services. Without central Public Service Agreement (PSA) targets to reduce alcohol harm until 2007, further guidance from the Department of Health such as Alcohol Misuse Interventions<sup>7</sup> attempted to persuade PCTs that it could meet other national targets on reducing stroke, cancer and heart disease via alcohol treatment.

However, the Department has been powerless to insist that local alcohol treatment is either considered or provided, even where the need has been most transparent. This lack of strategic focus has meant that alcohol treatment provision at the local level has been left largely unplanned, under-funded and undervalued.

In the last two years, with the introduction of PSA targets 14 and 25, the new Local Area Agreement indicator set and the NHS Performance Framework, the Department has attempted to tighten the focus for commissioners, ensuring that alcohol-related hospital admissions reduce by 11%. However, the central push to achieve this stems from an over-focus on SBI for hazardous and harmful drinkers, with little mention of the value of alcohol treatment for dependent drinkers as part of an integrated system, in spite of the call for this in MoCAM.

In the absence of counter signals from the Department and targets for dependency treatment, there is a risk that decentralisation, the SBI agenda and the NHS reform ideology may render MoCAM's call for integrated care obsolete before it has had a chance to have a positive impact.

### Types of treatment

There are a variety of interventions and treatments for alcohol misusers, suitable for individuals with differing types of alcohol misuse and levels of consumption.

#### The 4 Tiers of interventions:

*Tier 1:* information and advice about alcohol; screening, simple brief interventions and referral

*Tier 2:* open access facilities and interventions which do not require planned care

*Tier 3:* provision of community-based specialised assessment and alcohol treatment that is structured and requires planned care

*Tier 4:* alcohol specialist inpatient treatment and residential rehabilitation.

### Roles

*Department of Health* - responsible for the health aspects of alcohol policy in England, including researching alcohol services, providing guidance to local commissioners, improving medical training on alcohol and increasing public awareness of the health aspects of drinking alcohol and how to access help.

*Regional Government Office* - acts as the Department of Health's representative in the regions, working with regional representatives of government departments on alcohol issues.

*Strategic Health Authority (SHA)* - responsible for developing plans for improving health services in their local areas and ensuring that national priorities are integrated into local plans. They manage the performance and review the operating plans of Primary Care Trusts.

*Primary Care Trusts* - responsible for assessing local need and commissioning local health services to prevent and treat alcohol related harm, also for ensuring that the needs of alcohol misusers are met. Commissioning involves planning, funding and performance managing of services to provide help for alcohol misusers. PCTs can also work with Drug and Alcohol Action Teams (DAATs) to commission specialist treatment services for dependent drug and alcohol users.

*Drug and Alcohol Action Teams (DAATs)* - bring together local authorities and other public bodies (including PCTs, police, private and voluntary sector providers) to address problems caused by both drugs and alcohol in a local area.

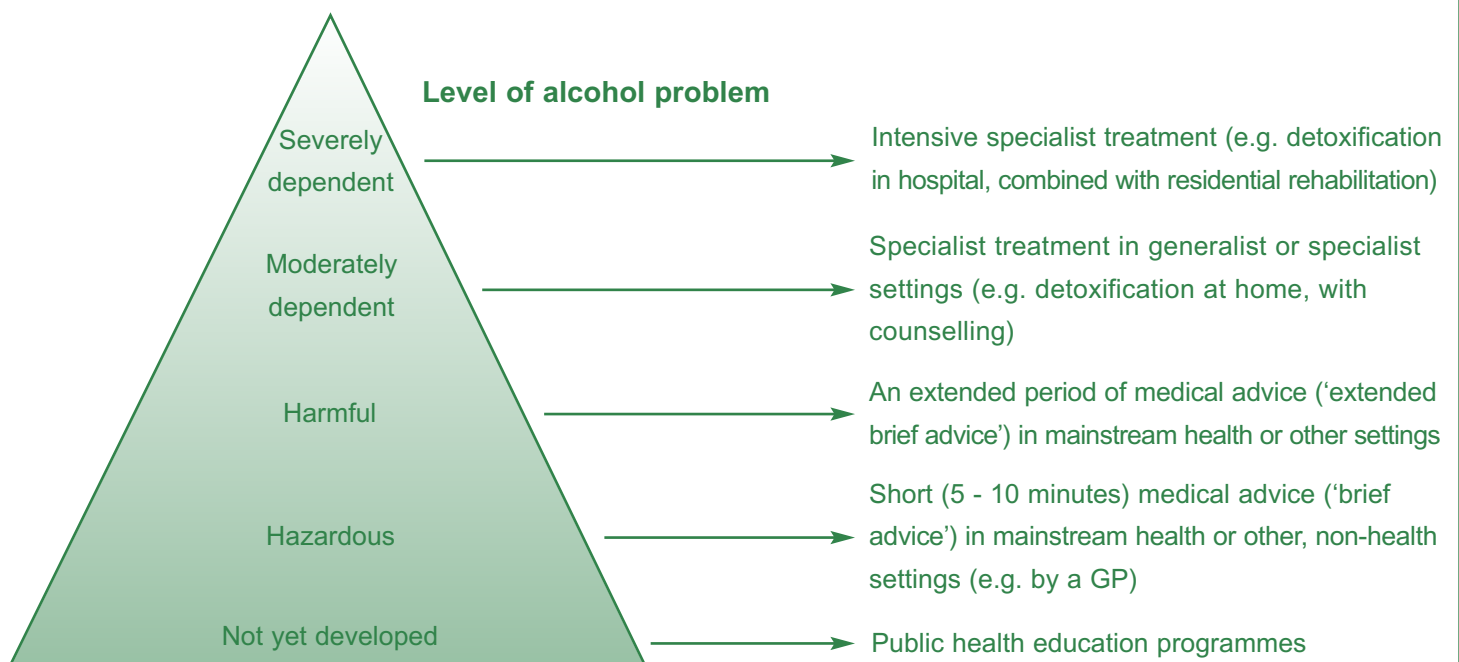
DAATs also receive funding from PCTs but the NAO report found that only a small proportion of this funding is intended for alcohol services.

Alcohol Concern's report *The Poor Relation*<sup>2</sup> found that there are still varied levels of service provision for harmful, hazardous and dependent drinkers across areas.

### How do PCTs and DAATs work together?

PCTs are usually involved in managing and overseeing the work of DAATs, however this varies between areas. In some areas there is a single PCT and single DAAT, while other areas comprise groups of PCT and DAATs who work together through joint commissioning arrangements. There is also variation between where DAAT staff are placed, some being operated from local authority offices and others sitting within the PCT. DAATs may also be part of larger local commissioning bodies, such as Safer Community Partnerships.

### The range of alcohol treatments and interventions



Source: Adapted from *Broadening the Base of Treatment for Alcohol Problems*, Institute of Medicine, 1990

## The impact of policy: Q1. What has been the impact of recent policy developments on the alcohol treatment system?

Many respondents reported that recent developments in national policy, as described in 'government policy' above, have led to a welcome recognition of alcohol misuse as a public health issue and the importance of alcohol treatment in general. Some respondents considered that this had resulted in a raised profile for alcohol misuse at a local level.

*It appears that only over the last year is alcohol being acknowledged as a serious health problem, as opposed to a crime and disorder issue, that affects all sections of society, not just young people binge drinking in city centres.*

**Treatment service provider**

*The increased national profile of alcohol along with national guidance and strategy documents has made it much easier to raise the profile of alcohol related harm at a local level.*

**Drug and Alcohol Action Team**

However, there was a mixed reaction to this question, indicating that the effect of national policy on local delivery has varied between areas, leading to inconsistencies in approach to the treatment of alcohol misusers.

*Our members appear to agree that recent policy developments have made no difference at all to services at grass roots level.*

**European Association for the Treatment of Addiction UK**

Yet there was a general consensus that while any focus on developing national policy was welcome, this could have the knock-on effect of increased demand for services in those areas which had seen a raised profile for alcohol treatment.

*There has been too much emphasis on the strategic models of care in terms of the referral pathways into treatment and not enough on a treatment system that is groaning at the seams and unable to take the demand created by these referral systems.*

**Anonymous**

Non alcohol-specific policy has also had an impact on the sector. The publication of *Hidden Harm* (Home Office, 2003) and *Every Child Matters – Change for Children: Young People and Drugs* (Department for Education and Skills, 2005) both highlighted the paucity of focus on alcohol and the need for similar strategies to apply to families with alcohol misusing members.

Some areas reported that a needs assessment had been undertaken as a result of strengthening of national policy around alcohol treatment. One DAAT reported an increase in commissioning of services for hazardous and harmful drinkers. A few respondents reported the creation of working groups, however one noted a confusion over roles between those involved. Some DAATs reported having assisted towards the development of a multi-agency strategy and others had developed joint residential projects with other agencies.

### The involvement of Primary Care Trusts

There was a mixed response with regard to the participation levels of PCTs. One DAAT noted that the local PCT had made very little effort to participate with other agencies. Others noted that their PCT had been heavily involved and had identified alcohol as a priority. One DAAT reported the provision of new funding

for alcohol nurses and an inclusion for alcohol treatment in commissioning decisions, which had not previously been present.

National Indicator 39 (reducing hospital alcohol-related admissions) has been taken up widely and is deemed useful in focusing attention on prevention and treatment.

The Joint Strategic Needs Assessment (JSNA) core dataset, however, published by the Department of Health in 2008, was reported by one DAAT as not being useful. This DAAT had instead used the North West Public Health Observatory data, and the Rush model, to assess need in its area.

### **Models of Care for Alcohol Misusers**

Models of Care for Alcohol Misusers (MoCAM) was published by the Department of Health and the National Treatment Agency in 2006. It provides guidance on best practice for local health organisations (particularly PCTs) and partners in delivering a planned, orderly and integrated local treatment system for alcohol misusers. MoCAM is considered by government to be a significant milestone towards achieving the second aim of the Alcohol Harm Reduction Strategy for England<sup>3</sup> 'to better identify and treat alcohol misuse', within the overall objective of reducing alcohol harm in society.

The Inquiry's respondents showed a range of mixed reactions to MoCAM. Some respondents reported that MoCAM had helped to focus on need for better alcohol provision in their area. Other responses indicated that MoCAM had made little difference to the work of their organisation and had failed to be effective. Another common complaint was that the guidance included in MoCAM had been difficult to apply practically.

*Models of Care for Alcohol is very significant in streamlining alcohol services and to meet specific local targets whilst providing the wider range of treatments, interventions and prevention of alcohol misuse.*

**Drug and Alcohol Action Team**

*MoCAM does not have any teeth and local implementation has been a challenge.*

**Drug and Alcohol Action Team**

*The connection between the ideal model presented and the practical reality of delivering services is sometimes loose.*

**Anonymous**

A recurrent theme reported was that while MoCAM offered a useful framework, without sufficient resources and funding its impact would be limited.

*It has made little difference to the treatment landscape locally as once again there are no resources attached.*

**Treatment service provider**

Other criticisms of MoCAM were:

- The terminology in MoCAM for the definitions of drinkers is already becoming dated - Drug and Alcohol Action Team
- MoCAM appears to provide a workable model for alcohol treatment. However, it contains very little about aftercare and our experience is that many service users need support to 'fill the gap' left by alcohol - Treatment service provider
- MoCAM has made no direct reference to the acknowledged links between alcohol and anti-social behaviour/criminal damage; or to the links between alcohol misuse and violent crime - Commissioner.

## Funding

There was a real concern among respondents that nationally developed policy and strategy had not been followed by adequate funding in order to action the guidance issued.

*It was also disappointing that the National Alcohol Strategy published in 2007 failed to even reassure the treatment sector that their funding would be maintained.*

**European Association for the Treatment of Addiction UK**

Almost all respondents noted that lack of funding was a primary issue and responses showed variation in the amount of funding released by PCTs across the country. The result in many areas has meant that demand simply cannot be met.

*Limited finances have meant a real struggle to commission services to meet need.*

**Drug and Alcohol Action Team**

*The publication of MoCAM had no bearing on the alcohol treatment system, since it carried no new resources and also no surprises in terms of what it recommended.*

**Drug and Alcohol Action Team**

The NAO report in 2008 found that although 81% of (as formerly known) Drug Action Teams had taken on the responsibility of reducing alcohol related harm in their area, illegal drugs remained their focus. Their main source of direct government funding is the Pooled Treatment Budget (PTB) which is ring-fenced for treating illegal substance misusers and cannot be used for over 18s who are alcohol dependent with no use of illegal drugs. It can be used for under-18s who only misuse alcohol, or for over 18s who misuse both alcohol and drugs.

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## The challenges: Q2. What are the challenges for practitioners, policy makers, the NHS and other stakeholders in achieving alcohol treatment's potential?

Responses indicated that a wide variety of difficulties and challenges face those working within the sector. These ranged from a perceived large-scale, historical lack of interest in alcohol treatment from the government to more specific concerns, for example surrounding difficulties of access for certain groups within the population.

*The DH accepts that not enough priority has been placed on provision of alcohol treatment.*

**Nick Lawrence, Department of Health**

*The underinvestment over many years historically prior to the PCT's inception requires a great deal of catching up.*

**Commissioner**

### Defining the problems

A challenge reported by those involved in alcohol treatment was confusion with regard to what comprises alcohol misuse and definitions of types of treatment and types of drinker, with one respondent for example reporting misunderstanding of the terms 'brief intervention' and 'brief advice' among those in the sector.

*One of the biggest challenges is not having a common language that covers agreed definitions and practices.*

**Treatment service provider**

Similarly, a lack of research was highlighted,

in terms of both identifying 'what works' for different types of alcohol misuse and 'what's needed' within differing areas.

*There is a paucity of good research to demonstrate the most effective treatment for a distinct alcohol problem.*

**Commissioner**

*Very few areas have undertaken needs assessments and where they have they have discovered inadequate data systems and a lack of strategic planning.*

**Treatment service provider**

## Commissioning

Commissioners responding to the Inquiry commonly reported that a significant challenge was being able to meet the needs of alcohol misusers in their areas, in terms of both scale and variety of need.

Commissioners also raised frustrations in developing collaborative working, for example building partnerships and designing detailed pathways with mental health services and Accident & Emergency departments. A lack of national guidance for dealing with patients who are intoxicated and presenting with mental health problems at Accident and Emergency Departments was emphasised.

*It has been a struggle to get staff within hospital settings to consider alcohol screening and brief interventions.*

**Commissioner**

A common concern among commissioners responding to the Inquiry was that there are huge expectations at ground level due to the degree of policy activity at a national and regional level. This has led both those in the field and

members of the public to expect a whole host of new services to be developed. However, commissioners complained that it is not a simple exercise to put into practice the comprehensive, stepped care model described in MoCAM.

Another obstacle emphasised by commissioners is the lack of a national/regional performance management framework, for example a vital signs indicator, to help inform performance.

A frequent challenge for commissioners, highlighted by those working in treatment services and DAATs, was to develop more services for people with both alcohol misuse and other problems, for example mental health problems or poly substance misuse. They also pointed to a need for the commissioning of more specialist support services for hazardous and harmful drinkers, as well as services which provide specialist support for certain population groups, such as younger people, older people, women and BME (Black Minority Ethnic) communities, thus widening access.

## Services

One large treatment provider observed differing challenges across local areas within their region. In one area, they noted, funding for interventions was largely driven by the physical health and crime agendas, resulting in a lower consideration being placed on the family/social and mental health issues resulting from alcohol misuse.

Another area reported difficulty working with mental health services, which often refused to treat clients with alcohol dependency. As a result, the care of such clients is made more difficult without the input of specialist mental health workers.

*Often there is difficulty accessing mental health services, the view being that mental health needs cannot be addressed until the drinking is under control.*

**Treatment service provider**

*We are getting people in their 50s and late 40s with brain damage, e.g. dementia, who neither service will consider as their responsibility.*

**Tony Rao, oral evidence**

Another area reported a simple lack of capacity to be able to cope with the demand for alcohol treatments of all types. This was a common complaint from service providers – across the country – who responded to the Inquiry.

*The overwhelming message that (the organisation) has received from its members on the alcohol treatment system, particularly with regard to recent policy developments, is frustration that there still exists a huge gap between the demand for alcohol treatment and the actual provision of services.*

**European Association for the Treatment of Addiction UK**

Within the need for capacity development, some providers pointed to the need for increased brief interventions within primary care settings, for example GPs' surgeries. The general consensus held was that such approaches could provide many advantages, namely the ability to access the wider population, the absence of stigma to attending primary care facilities and the high credibility of GPs to members of the public.

*Screening for and brief interventions for alcohol misuse should be a day-to-day occurrence rather than the outcome of an alcohol worker requesting it.*

**NHS Rotherham**

*I would suggest a requirement for primary care to screen their patients on an annual basis if possible.*

**Commissioner**

Above all, it was highlighted that there is a need for increased funding.

*The lack of central government alcohol-specific funding is a major challenge in achieving alcohol treatment potential as developments can be sporadic and inconsistent across boroughs.*

**Drug and Alcohol Action Team**

Drug and Alcohol Action Teams' main source of direct Government funding, a PTB (£398 million in 2008-09) is ring-fenced for treating misusers of illegal substances rather than alcohol.

This arrangement, and the history of government focus on illegal substance misuse, has contributed to a continuing concern within the alcohol sector that treatment for alcohol misuse tends to be overshadowed by treatment for drug use, particularly in terms of funding arrangements. These anxieties were prevalent in the submissions received. One DAAT and one Advisory group specifically noted that resources, including staff, had been diverted to drug treatment in their area.

*Alcohol treatment is still the poor relation compared to drug treatment.*

**Commissioner**

*The lack of central government alcohol-specific funding is a major challenge in achieving alcohol treatment potential, as developments can be sporadic and inconsistent across boroughs.*

**Drug and Alcohol Action Team**

*There is consensus over the fact that alcohol treatment has continued to be overshadowed by drugs, particularly the amount of funding that is 'poured' into that area in comparison with alcohol.*

**European Association for the Treatment of Addiction UK**

*There was a 'drain' of staff over to drug services.*  
**Treatment service provider**

*The problem we have at a local level is that, even with the substantial growth in investment on behalf of the PCT, drug misuse will always take priority because the funding is linked directly to targets for outputs.*

**Local authority**

Also considered highly necessary was the development of services for specific groups in order to widen access. Most commonly highlighted groups were younger people, older people and those from BME communities, whom it was often considered would benefit from culturally-sensitive approaches to treatment.

*Alcohol-specific treatment services for young people aged 14-19 would be a welcome addition.*

**Treatment service provider**

*Even with additional capacity we will struggle to meet the needs of particular groups, e.g. the housebound or elderly who are unable to come to us.*

**Treatment service provider**

*Because of the restrictions on alcohol use due to religious and cultural norms, it is a big hidden problem...one user recently reported to her doctor and he was almost in denial that a young woman from an Asian community could have a problem.*

**Sandra Machado, oral evidence**

There was also concern among treatment providers that commissioners held unrealistic expectations of what alcohol treatments services could achieve.

*Members commented that, as with all addictions, outcomes and progress are difficult to measure and that markers for progress and recovery need to be established at several points along a treatment journey.*

**European Association for the Treatment of Addiction UK**

Others working in the field pointed to what they perceived to be a lack of experience among commissioners.

*Commissioners with little clinical experience and providers with very little say in the commissioning process can result in elliptical decision-making.*

**Anonymous**

## **Actions needed: Q3. What actions need to be taken to widen access to alcohol treatment and place the system on a more stable, sustainable footing?**

### **Actions needed from society**

A number of respondents took a whole-society approach to make recommendations for action, emphasising the fundamental challenges for people with alcohol misuse problems and their place in society. Many felt that while changes to the treatment system were urgent and necessary, there were wider problems needing to be addressed. These were, most notably, continuing prejudice and misconception surrounding people with alcohol misuse problems.

*We need to demystify addiction and break down shame and blame around alcohol.*

**Sandra Machado, oral evidence**

*The final challenge faced in achieving effective alcohol treatment is effecting a change in the attitudes towards alcohol misuse of the community, some professionals and some services so that alcohol misuse at all levels and in all settings is taken seriously.*

**Drug and Alcohol Action Team**

*Further work is needed in breaking down the barriers about acceptability of engagement with treatment services, with both clinicians and the public.*

**Drug and Alcohol Action Team**

Also commonly highlighted was a need for a renewed outlook on alcohol misuse which would place it on a level with other public health issues, such as obesity and smoking.

*It is vital to link with children and young people's services and also other public health priorities (e.g. obesity) that link with alcohol.*

**Drug and Alcohol Action Team**

*Alcohol misuse needs to be seen as a mainstream concern that is everybody's business. We would like to say to health colleagues that 'drinking is the new smoking', that people should be asked about their drinking at every presentation to a health care professional – just as we are asked about smoking.*

**Local authority**

*Another vital challenge for practitioners, policy makers, the NHS and other stakeholders is the need for a culture change. Currently there is an overwhelming focus on tackling drugs and ensuring access to treatment and not enough on alcohol issues.*

**European Association for the Treatment of Addiction UK**

It was commonly mentioned that in order for the system to be sustainable, the Department of Health and National Treatment Agency need to strengthen an approach to alcohol which sees alcohol misuse as part of the substance misuse agenda, and which fully recognises the importance of treating alcohol misuse as a problem affecting a significant percentage of the population.

In terms of funding, almost all respondents agreed that funding needed to be increased simply in order to meet demand. This would also allow for a wider variety of services as well as their expansion, for example increased outreach work and further training (particularly) in brief interventions for the workforce, in addition to specialist treatment services for population groups who may benefit.

*There needs to be a shift in thinking to a more flexible way of providing services.*

**Peter Steel, oral evidence**

DAATs were also keen for a review of the funding system for alcohol treatment and possibly the introduction of a 'ring-fence' for alcohol services within the PTB . This would allow for improved resources for treatment of adults with alcohol-only problems.

*Ring-fenced funding for alcohol would assist immensely on a local and national level to widen access to services.*

**Drug and Alcohol Action Team**

*A 'ring-fenced' funding commitment to establish a base of local alcohol services, covering all tiers, young people, older people, hard to reach groups, public awareness, criminal justice schemes, structured programmes, outreach, inreach etc, would enable the treatment system to solidify and outcomes be monitored before funding was once again mainstreamed.*

**Drug and Alcohol Action Team**

*More flexibility to use the Pooled Treatment Budget for primary alcohol users would be helpful, since the current segregation of services is inefficient.*

**Drug and Alcohol Action Team**

*The decision by our local authority to adopt an alcohol-related performance target has unlocked additional joint investment funds between the LA and PCT of £10 million.*

**Lynn Owens, oral evidence**

**Actions needed from national policy makers**

An emergent theme among the recommendations for central government was an increased priority on alcohol treatment, although many respondents also recognised that the situation had improved in recent years. Once again, the low priority on alcohol

treatment in comparison to drugs was highlighted as an area needing improvement.

*Access and provision of alcohol treatment needs to be equal to drug treatment. It should be as high on the agenda as drug treatment.*

**European Association for the Treatment of Addiction UK**

*It is imperative that central government issues clear directives that prioritise responses to alcohol related issues which match its significance as the 3rd most common cause of preventable illness.*

**Treatment service provider**

In doing so, it was felt that the Department of Health should place higher expectations on PCTs and local authorities to set and deliver adequate treatment services, using the establishing of national targets – for example on access levels – to allow PCTs to assess need and performance against a national baseline.

On a wider scale, respondents were willing to suggest how revenue could be raised in order to fund alcohol treatment.

*Engage with the drinks industry at a national level to realise the targets set on the alcohol industry about the financial contribution they give to alcohol treatment.*

**Drug and Alcohol Action Team**

*National government should legislate to ensure the alcohol industry through tax provides funding for alcohol treatment.*

**Treatment service provider**

Of the respondents who mentioned government awareness campaigns on alcohol, one reaction was that the campaigns had been too narrow in targeting specific groups, and as a result

had no appeal for the majority of the alcohol-using population. Another respondent reported that the units campaign had been confusing, indicating that this campaign has perhaps not increased understanding of sensible drinking guidelines in a uniform manner. One respondent felt that a public awareness campaign with the objective of breaking down stigma surrounding alcohol problems and barriers to treatment was imperative.

### **Actions needed from local policy makers**

At the local as well as national level, a need to push alcohol misuse higher up the agenda was identified.

On a local level, it was consistently observed that there is a need to recognise the importance of investing in early and brief interventions and advice as a preventative measure. Many respondents claimed that they would like to see primary care become a more central part of the treatment process, this could be done by improving the training of GPs, emphasising the importance of brief interventions and settings targets for screening and brief interventions for GPs. There was also felt to be a need for all types of healthcare professionals to increase their understanding of the connection between alcohol issues and other healthcare problems. One method of making such improvements, it was suggested, would be to include questions about alcohol consumption and use in the QOF for GPs.

*Further work is needed with clinicians to make links e.g. most would ask someone with a chest infection if they smoke – but how many of us would ask someone with a stomach upset if they drink?*

**Drug and Alcohol Action Team**

It was felt that savings made from reducing alcohol-related crime and health harms should be redirected towards the prevention of alcohol misuse problems.

Respondents also indicated a need for improved working partnerships with children and family and mental health services. It was also suggested that developing the link between alcohol and obesity would be beneficial for alcohol misusers – this would perhaps encourage those presenting with obesity problems to consider their alcohol intake as a contributing factor.

### **Actions needed from commissioners**

A number of respondents, commissioners included, felt that there needs to be a clearer view of what should be done and by whom, along with the development of a protocol for information sharing and monitoring and review mechanisms. The systems of planning and commissioning used for drugs were viewed by some treatment services as a model which could be applied to the alcohol sector in order to improve the commissioning process.

Specifically, it was noted that there was a need for commissioners to design a system of support for clients leaving Tier Four services, with the objective of preventing future treatment needs for those individuals. As previously mentioned, the need to bolster Tier One services was viewed as paramount.

*Primary care is rightly where emphasis should lay together with clear pathways for secondary and acute care.*

**Drug and Alcohol Action Team**

### Actions needed from practitioners

Among practitioners in services and other respondents, the greatest need quoted was for wider access to services, in terms of both population groups who may require specialist support and providing round-the-clock care.

*Getting information out there is a necessity, getting information into mosques, temples, community centres and so on.*

**Sandra Machado, oral evidence**

*More developments in community locality based services, drop ins and out of hours provision.*

**Commissioner**

*Services need to be mindful about their opening times – Friday and Saturday evening/night opening is a trigger time for many people struggling with alcohol. Services should pilot opening hours that meet this need.*

**Drug and Alcohol Action Team**

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## The Recommendations of the All Party Parliamentary Group

### Inquiry questions

- 1 What has been the impact of recent policy developments on the alcohol treatment system?
- 2 What are the challenges for practitioners, policy makers, the NHS and other stakeholders in achieving alcohol treatment's potential?
- 3 What actions need to be taken to widen access to alcohol treatment programmes and to place the system on a more stable, sustainable footing?

### APPG recommendations

#### Strategy and Policy

The evidence presented to the APPG demonstrated that a lack of clear central political leadership has led to confusion at local commissioning and service delivery level. Whilst the challenges presented to the Inquiry were substantial they can be overcome. Appropriate investment, funding and political will is necessary and urgently required and clear and decisive action is needed:

- *Government needs clear cross-departmental leadership to tackle England's growing alcohol problem.*

Government needs greater clarity and leadership: crime and disorder, licensing, pricing and taxation, children and young people, advertising, traditional culture as well as health are key components of this complex problem. National policy must be clear, consistent, evidence based and workable. A cross-departmental consensus about how to balance the economic needs of the drinks industry whilst minimising public health harms is essential to make meaningful progress.

- *Government needs to measure alcohol harms differently.*

Alcohol-related hospital admissions is a useful but ultimately limited proxy measure of the overall alcohol harms the country faces. A health-based measurement encourages silo working and makes it hard to tackle this problem holistically. In the next comprehensive spending review Government needs to target a reduction in heavy drinking levels amongst all age groups as well as a reduction in alcohol-related crime.

## Improving Treatment

There can be no doubt that the current range of treatments and intervention for alcohol misusers saves lives, prevents harms for escalating and can rebuild the lives of individuals to become functional and healthy members of society. This Inquiry believes that the current PSA around reducing alcohol-related hospital admissions should increase funding for services, however this is not guaranteed. PCTs should be encouraged to dig deeper in to their coffers to ensure that the full range of treatment tiers as set out in MoCAM are in place, accessible at a local level, and working effectively. The APPG makes these recommendations about how to improve treatment and its accessibility.

- *All primary health care services should understand and be able to deliver SBI.*

The sooner health services are able to identify those that are drinking too much and help them to reduce their consumption the more likely it is that they will not need increased medical care due to excessive consumption. SBI has been shown to be effective in a variety of settings. Alcohol is a major public health issue and health professionals need to acknowledge and tackle its effects head on. Through SBI programmes those that can be helped to reduce their consumption will do so and those that need more intensive help can be referred to appropriate specialist services. SBI should therefore be available in all primary health care settings.

- *All PCT areas should have effective specialist alcohol services which are accessible to local communities.*

For a full and effective treatment system to work we must have effective treatment for the 1.1 million dependent drinkers in the country. There is no area in the country which does not have part of the population which is alcohol dependent and in need of specialist treatment. Yet many local areas have inadequate services

with long waiting times and in some cases there are no locally accessible services. Specialist treatment, whilst normally not delivered within a traditional healthcare setting must be seen as an extension of the health service. These services tackle a complex and often difficult problem using skills which do not exist within primary healthcare settings. PCTs must recognise specialist alcohol services as a vital component in meeting PSA 25 as they can support those with alcohol dependency to become healthier members of society with a reduced likelihood of needing alcohol-related medical care in the future. If these services are not in place there is little likelihood of the Department of Health achieving its commitment to reduce alcohol-related hospital admissions.

- *Specialist alcohol treatment must meet the needs of all those affected by alcohol misuse.*

The paucity of funding for alcohol services means that families affected by alcohol misuse, older people, those with a dual diagnosis and BME communities often do not have the same level of access to services. Commissioners should look at how community based services can work more effectively with these often more marginalized groups that have an ongoing need for support in their own right. The inquiry took evidence from services that were able to work effectively with these groups and recommend that this best practice be shared widely by the Department of Health to improve understanding amongst commissioners about what services can achieve.

- *There needs to be clear protocols and pathways in place to tackle alcohol misusers with more complex needs.*

Many people that have a substance dependency problem often also have a mental health problem. Such individuals can be challenging to work with and often services do the best they can with the resources and expertise they have. Commissioners should ensure that there

are services accessible locally for those that have both an alcohol and mental health problem. Regional Alcohol Managers should ensure that all local areas within their region can identify and understand the needs of these individuals and refer them to appropriate services. Currently the health care net is letting too many of these vulnerable service users fall through the gaps. Crucially, there needs to be far better links between statutory mental health teams and alcohol services. Refusing to offer a service either on the basis of mental ill-health or recent/current drinking should not be an option open to any service provider. Rather, services need to work together to share expertise.

### **PCTs and Performance Management**

This Inquiry has been struck by the real confusion that exists in the commissioning of services and the implementation of policy aimed at reducing alcohol-related harm. This confusion permeates the strategic and operational development of treatments for a broad spectrum of alcohol-problems. Some of these issues are caused by the decentralised PCT structure, whilst others highlight the lack of appropriate performance management frameworks that often plague services on the fringes of the NHS. These problems can be overcome and action is recommended to prevent them from becoming more entrenched.

- *In the current operational context PCTs must take responsibility for tackling alcohol related-harms.*

PCTs must demonstrate that they are committed to tackling alcohol harms by translating commitments to targets to increased spending and a broader strategic approach. If PCTs are to be successful they cannot view alcohol-related hospital admissions in isolation. They are part of a wider agenda in which PCT commissioners must lead. By showing clear direction, transparent decision-making and leadership local partners and agencies can

work together more effectively.

- *In order to tackle alcohol harms PCTs must understand the scale of the problem they are facing.*

All PCTs must carry out JSNAs and act on the evidence they collect. This is further reinforced by the need to make rational commissioning decisions for treatment where there is an identified need as set out in the NHS Constitution. This new right came in to force through regulations on the 1 April 2009. This inquiry welcomes this additional onus on PCTs to make clear choices and encourages them to apply this evenly across all health needs. In order for PCTs to commission services that are appropriate and commensurate to the scale of the problem the Department of Health must provide clear guidance and robust evidence about the cost effectiveness of different treatment types and modalities. PCTs should ensure that the full range of treatment tiers is available to meet the needs identified in the JSNA.

- *The Department of Health should update and reissue existing guidance and support implementation with regional training.*

The inquiry found that most practitioners and commissioners in the field were largely happy with MoCAM. However, there was some disappointment about its implementation in some areas, the overall sense is one of inconsistency at best. Further, whilst useful, MoCAM is becoming out of date in what is a rapidly developing field, and does not tackle the full spectrum of care to be an entirely comprehensive document. For example it has insufficient information about family support or how to commission services for those with complex needs. In consultation with stakeholders the Department of Health should update MoCAM, reissue it, and support its consistent implementation with regional training for commissioners.

- *There needs to be an ongoing training programme for alcohol commissioners.*

Inconsistency in commissioning practice is to be expected as commissioners are often under-resourced and have insufficient access to relevant training. Commissioners of alcohol services need greater support in the form of ongoing training which should include a thorough grounding in the complexities of commissioning services to tackle alcohol misuse. The Department of Health should draw up a core curriculum of knowledge based around existing commissioner competency frameworks and then ensure that commissioners have access to training to develop knowledge where this is lacking.

- *Strategic Health Authorities must ensure that PCTs are assessing need in their area and commissioning alcohol treatment commensurate with that need.*

Strategic Health Authorities (SHAs) must play a greater role than simply assessing delivery against self-elected targets. Of course those PCTs which have chosen to be assessed against the target of reducing alcohol-related hospital admissions, should be held to account, and SHAs must understand the importance of treatment in delivering that target. However, SHAs must also look at all PCTs and find out if JSNAs are being carried out and how commissioners are responding to the assessment. Where PCTs are not carrying out accurate assessments, or are not commissioning commensurate alcohol services SHAs should have appropriate powers to sanction the PCT and refer negligent commissioning decisions to an independent health panel.

### **Collaboration and Partnership Working**

The inquiry was struck by the range of different types of services and professionals that are

working with real dedication to tackle alcohol misuse. However, the evidence showed that tensions do exist between partners, that there clearly are competing priorities, and those working with alcohol misusers are not always of one mind as to how to tackle the issue. PCTs must take ownership of the agenda, understand the important role that community and voluntary sector providers play and ensure that accurate data is gathered and shared.

- *Clear guidelines are required about how different parts of the alcohol treatment sector are to work effectively together.*

With a range of service providers from GPs through to drop-in centres which in turn straddle a range of performance management and funding structures there needs to be guidance and best practice protocols about how services can work together. Primary health care in the form of GPs and hospitals are likely to increase the amount of screening and brief intervention work they do. They must understand how to access and refer alcohol dependent patients to treatment. In addition commissioners must make sure that there is appropriate treatment which people with alcohol dependency can be referred to. Community based interventions must work in partnership with the medical profession and by demonstrating the outcomes for service-users will convince the medical profession of their worth. Tying all this together needs guidance and strong management about how these different players can and should work together. The regional offices and the new Regional Alcohol Managers should lead on this work helping to build partnerships and collaboration. In particular, the criminal justice agenda in respect to offender health must be addressed by PCTs who are responsible for ensuring that alcohol misusing offenders are provided with sufficient support. This requires a re-appraisal

by PCTs as to how they link with and commission alongside criminal justice funds.

- *NICE must look at how the QOF for GPs can be amended to help tackle alcohol misuse.*

GPs as primary healthcare gatekeepers are potentially at the forefront of alcohol and public health issues and yet unless they are given an incentive they frequently do not take action to intervene early in what is one of the largest public health challenges facing the country. The independent role NICE is due to play in the review and prioritisation of the QOF is a real opportunity. GPs can play a pivotal role in identifying and advising heavy drinkers and referring those that are at higher risk to specialists. The QOF should recognise this and help direct GPs towards asking the right sort of questions in order for them to fulfil their responsibility to tackle patients' alcohol problems.

- *Access to accurate alcohol misuse and dependency data must become a priority*

*for the Department of Health.*

The Local Alcohol Profiles compiled by the North West Public Health Observatory provides useful information for commissioners and is considered the most accurate in the field. However, it does not yet contain estimates of alcohol dependency within a local area (nor has the NTA yet published meaningful data on alcohol treatment episodes) and this needs to be addressed urgently to ensure that an appropriate level of treatment is commissioned. Equally there needs to be consistency about how hospitals record alcohol-related admissions and greater transparency locally, with this information being shared with local partners to gain a rounded perspective of the issues facing a locality. There seems to be a cultural gap between medical practitioners and community based services. A common vision that both are tackling the same problem and that sharing of data and information across teams must be championed by the Department of Health.

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## References

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6. National Treatment Agency (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*

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## Glossary

**AHRSE** – Alcohol Harm Reduction Strategy for England (Cabinet Office, 2004)

**ANARP** – Alcohol Needs Assessment Research Project (Department of Health, 2004)

**DAAT** – Drug and Alcohol Action Team

**JSNA** – Joint Strategic Needs Assessment

**MoCAM** – Models of Care for Alcohol Misusers (Department of Health, 2006)

**NICE** – National Institute for Health and Clinical Excellence

**NTA** – National Treatment Agency

**NAO** – National Audit Office

**PCT** – Primary Care Trust

**PSA** – Public Service Agreement

**PTB** – Pooled Treatment Budget

**QOF** – Quality and Outcome Framework

**SBI** – Screening and Brief Interventions

**SHA** – Strategic Health Authority

## Appendix

### Written submissions were received from:

#### *Organisations*

Addiction Dependency Solutions  
Aquarius  
Barnsley Drug and Alcohol Action Team  
Bracknell Forest Drug and Alcohol Action Team  
Bradford Drug and Alcohol Action Team  
Brent Drug and Alcohol Action Team  
Cornwall and Isles of Scilly Drug and Alcohol Action Team  
Derbyshire Drug and Alcohol Action Team  
Drugs and Alcohol Service for London  
Ealing Drug and Alcohol Action Team  
European Association for the Treatment of Addiction (UK)  
Gloucestershire Drug and Alcohol Service  
Hampshire Alcohol Partnership Board  
Hammersmith and Fulham Drug and Alcohol Action Team  
Haringey Drug and Alcohol Action Team  
Haringey Advisory Group on Alcohol  
Harrow Drug and Alcohol Action Team & PCT  
The Linwood Group  
London Borough of Enfield  
Manchester City Council & NHS Manchester  
NHS Rotherham  
Norfolk Drug and Alcohol Action Team  
Oxfordshire Drug and Alcohol Action Team  
Safer South Gloucestershire  
Sheffield Alcohol Advisory Service  
Somerset Drug and Alcohol Action Team  
Tower Hamlets Drug and Alcohol Action Team  
Turning Point  
Wirral Drug and Alcohol Action Team

#### *Individuals*

Dr Lynn Owens  
Jonathan Goodliffe  
Anthony Massouras

Eight anonymous submissions were received.



## **The All Party Parliamentary Group on Alcohol Misuse**

The All Party Parliamentary Group on Alcohol Misuse exists to promote discussion of alcohol-related issues, raise issues of concern and to make recommendations to government and other policy makers.

All-party parliamentary groups are made up of backbench MPs and peers from all political parties in Parliament. They provide an opportunity for cross-party discussion and co-operation on particular issues.

The Officers of the APPG on Alcohol Misuse are:

Lynda Waltho MP (Chair)  
Sandra Gidley MP  
Tim Loughton MP  
Robert Flello MP  
Kelvin Hopkins MP  
Lord Avebury

The Inquiry Working Group members were:

Lynda Waltho MP  
Sandra Gidley MP  
Kelvin Hopkins MP  
Baroness Masham

The APPG on Alcohol Misuse has been approved by the Parliamentary Commissioner for Standards.

Alcohol Concern provides the secretariat to the APPG on Alcohol Misuse.

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## **The Inquiry into the future of alcohol treatment services**

The inquiry into the future of alcohol treatment services was jointly chaired by Lynda Waltho MP and Sandra Gidley MP.

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Lynda Waltho MP

# All Party Parliamentary Group on Alcohol Misuse

The future of alcohol treatment services



**Alcohol Concern**  
Making Sense of Alcohol



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