

Final Report: The Recovery Partnership Review of Alcohol Treatment Services

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Executive Summary

This is the report on the Recovery Partnership review of the current state of alcohol treatment in England. The project was funded by the Department of Health and undertaken by Alcohol Concern. It examined how recent changes in health and social care have impacted on:

- the service user journey through services,
- commissioning,
- the training of staff and
- the needs of specific groups, especially carers.

Three national surveys were run with a high level of engagement. In addition, 46 people were interviewed and 14 workshops took place, covering a mixture of commissioners, service providers, service users and non-specialist staff.

The research highlighted the enthusiasm of the alcohol field to discuss these issues. The responses to the surveys and the enthusiasm to be interviewed and involved in workshops were all testaments to the desire to have a voice on the future of alcohol services, indicating that a huge and largely untapped pool of expertise is waiting to be drawn on.

This report does not make recommendations; rather its aim is to identify key issues in current service provision which should be considered by commissioners, providers and others. The following are the key points:

The alcohol treatment system has been through a period of great change in the last three years.

Almost 70% of respondents reported that their local services had been recommissioned in that period. Nonetheless, the majority of respondents felt that alcohol services were improving.

- Alcohol treatment appears to have benefited from joining with drug services and accessing the resources in the former pooled treatment budget.
- Alcohol treatment is starting from a low baseline.
- Investment in alcohol hospital liaison has increased.

- Public health commissioners across the country consider alcohol a priority.

Nonetheless, the research identified a number of areas of concern which stakeholders need to consider.

- Problems with the tendering process suggest the need for a review and guidance on how to balance competition and service user needs when tendering in the alcohol field.
- Linkages are breaking down between agencies because of the turnover in provision. Non-specialists may be uncertain about the local provider.
- Agencies are being turned into competitors with a detrimental effect on care pathways. Previous providers may continue to run parts of the treatment system and may feel reluctant to share their proprietary material with a competitor.

A relatively positive view also prevailed regarding the internal operation of alcohol services for example waiting times, length of intervention, assessment and care planning as well as the interventions available.

- Public education / social marketing was identified as a gap but not a major priority.
- Access to residential services was the biggest gap among the key treatment modalities. Access to these resources is variable and respondents highlighted many areas where community care funding was very hard to secure.

The clearest message has been the challenge of meeting the needs of more complex service users.

- The most powerful of these was the failure to meet the needs of the dually diagnosed. The view was that this ongoing problem may be worsening because budgets have been cut in mental health services and they are now commissioned by a separate body (CCGs) from alcohol services (Public Health). This represents a real blockage in the pathway of care for problem drinkers. Moreover it is not one that can easily be resolved at the local level. Concern was also expressed about Alcohol Related Brain Injury / Korsakoff's Syndrome.
- A widely held view was that the physical health of alcohol service users is worsening. This links to national concerns about the rising rate of alcohol related liver disease. This raised questions about professional training and whether the pressure to reduce costs is reducing knowledge about physical ill-health.

- Chaotic, change-resistant service users have higher rates of both mental and physical health problems and because they are treatment resistant can be missed in target driven re-commissioning structures. The feedback was clear that this is a priority group that needs to be addressed.
- The needs of eastern European drinkers were frequently highlighted but the emphasis was dependent on the size of the local population. However, this was the single most frequently mentioned change in the alcohol field and one which is clearly presenting problems to local treatment providers.
- The needs of carers and concerned others were also seen as a group that received too little help and would benefit from further support.

Concerns about various aspects of professional training were identified:

- Much effort has been invested in the training of non-specialist staff: particularly training in alcohol Identification and Brief Advice. The importance of this was not challenged but respondents and interviewees were clear that far more work is required. Most commonly concern was expressed about the challenge of engaging GPs and primary care.
- A treatment system that faces frequent recommissioning will need a strong system of professional accreditation to ensure the maintenance of standards. In general respondents felt that more training and a system of professional accreditation is required.
- A more subtle theme to emerge is not simply to train staff but also to understand and capture what they do. Although much work has been done to capture competencies, many of the techniques and approaches used by workers have never been captured, analysed or disseminated. This wealth of experience will be lost as workers move on. This is a particular concern in the context of regular agency change.

Underpinning all of these findings is a single theme which emerged in the interviews and workshops:

- The need for a greater level of national guidance. It will be hard and economically inefficient for local commissioners to find solutions separately to the national problems identified above such as the frequency of tendering, the needs of the dually diagnosed, professional training structures and the investment in Identification and Brief Advice (IBA).

1. Introduction

1.1 Purpose

DrugScope, the Recovery Group UK and the Substance Misuse Skills Consortium formed the Recovery Partnership in May 2011 to provide a new collective voice for the sector on the achievement of the ambitions set out in the 2010 *Drug Strategy*. It now consists of Adfam and the Recovery Group UK. The Recovery Partnership draws on the expertise of a broad range of organisations, interest groups as well as service user groups and voices.

The Recovery Partnership asked Alcohol Concern to undertake a review of the current state of alcohol treatment in England. This was a six month project to look at how recent changes in health and social care have impacted on:

- the service user journey through services;
- commissioning;
- the training of staff; and
- the needs of specific groups, especially carers.

The research aims to inform a national debate about alcohol treatment and inform Public Health England's thinking on alcohol treatment.

1.2 Methodology

At the core of the project were:

- Three consecutive online surveys covering the themes above.
- Interviews with a sample of service providers, commissioners, users and carers and people working in other health, social care and criminal justice services. In most cases these were phone interviews.
- A series of stakeholder workshops.

In addition, the project team sent out a weekly email bulletin and ran a blog which aimed to elicit comments from people who could not be interviewed or attend a workshop. The blog posts, which mirror the weekly emails, are still visible at <http://rpreviewofalcoholervices.wordpress.com>

A seven person steering group directed and monitored the work, and acted as a

sounding board as the project findings emerged.

1.3 Activity

In total, the project amassed a database of over 1000 people who were receiving the weekly bulletin. The surveys received a strong response:

Survey 1: The service user journey – 244 responses

Survey 2: Commissioning – 222 responses

Survey 3: Professional development and carers' needs – 177 responses

The project team interviewed 46 people and ran 14 workshops, representing a mixture of commissioners, service providers, service users and non-specialist staff.

1.4 Who responded to the surveys?

The surveys included questions about both the role of the respondent and where they worked by region, giving a reasonable profile of the participants. These questions were not compulsory for respondents in case of concerns about confidentiality.

Area of the country

	Survey 1	Survey 2	Survey 3	Total	Total %
North East	6% (15)	10% (18)	21% (31)	64	11%
North West	14% (35)	18% (33)	14% (20)	88	15%
Yorkshire & Humberside	5% (11)	8% (14)	9% (13)	38	7%
West Midlands	20% (48)	13% (23)	11% (16)	87	15%
East Midlands	12% (29)	11% (21)	9% (13)	63	11%
Eastern	8% (19)	7% (13)	6% (8)	40	7%
London	12% (30)	12% (22)	8% (11)	63	11%
South East	10% (24)	11% (20)	12% (17)	61	11%
South West	12% (28)	10% (18)	10% (14)	60	11%
Other	1.2% (3)	0.6% (1)	1.4% (2)	6	1.1%

Role

	Survey 1	Survey 2	Survey 3	Total	Total %
Not working in alcohol services	11% (26)	15% (26)	11% (16)	68	12%
Service user or carer	4% (90)	5% (8)	0.7% (1)	18	3%
Commissioning/planning of alcohol services	20% (48)	23% (40)	14% (20)	108	20%
Specialist alcohol worker (paid or volunteer)	14% (33)	6% (11)	15% (21)	65	12%
Manager in alcohol services	21% (49)	18% (32)	24% (33)	114	21%
Medical staff in alcohol services	3% (8)	3% (6)	8% (11)	25	5%
Other	27% (63)	31% (54)	27% (38)	155	28%

No specific conclusions have been drawn from this data, although it is noted that the West Midlands and the North West are over-represented, as are commissioners and service managers, while service users and carers are under-represented. The latter issue was addressed in the workshops and interviews.

1.5 Analysis and presentation of the findings

This process has generated a huge amount of material, of which the surveys are used as the key source. They are the most wide-ranging and representative dataset and as a result are most likely to reflect the views of those working in, commissioning and engaged with alcohol treatment services. The interviews and workshops are used to triangulate these findings and to identify local practice or problems which illustrate or deepen our understanding of the surveys.

Therefore, we are publishing two documents. The main public document will be this report: a summary and discussion of the key findings. The second will be a collation of the data gathered which will allow people with a specific interest to review the material gathered, draw their own conclusions and compare them to the published findings.¹

For example, in the sections below we quote comments that were made alongside survey answers, inevitably these are simply a sample of the comments made to a

question – some questions had over 100 comments. The comments are available in full in the supporting evidence document, along with comments from the interviews and workshops: these are all referenced.

1.6 Recommendations vs key points

This report does not make specific recommendations. Its aim is to identify the key issues in the current provision which should be considered by commissioners, providers and others. The *Discussion* section (12) sets out these themes.

1.7 Acknowledgements

The project team would like to thank the Recovery Partnership members: Noreen Oliver, Viv Evans and Marcus Roberts, the other members of the steering group: Annette Fleming, Dr. Jane Marshall, Glen Jarvis and Jez Stannard. We would also like to thank those who reviewed the final report including Mike Ashton, Dr. Peter Rice, Carole Sharma, and both Oliver Standing and Lauren Garland of Adfam. Above all we would like to thank the many interviewees, workshop participants, survey respondents and others who simply expressed an opinion as the process evolved.

2. Four key findings

2.1 Introduction

This research has produced a huge number of findings. However, four key themes stood out:

- The enthusiasm of the alcohol field for being involved in a debate about its future;
- The huge gap in meeting the needs of people with a dual diagnosis of alcohol and mental health problems;
- The related issue of managing change resistant problem drinkers with chaotic patterns of behaviour;
- The problems being experienced in the residential rehabilitation sector.

2.2 The thirst for involvement

The most striking thing to emerge from this process was the thirst for involvement. People in and around alcohol services were very keen to be involved in the surveys, interviews and group processes. The chance to express a view about how things should move forward was actively sought out by many respondents. Some of these views were negative but generally there was a positive desire for better services for an underserved group. The voices of many people will have been missed, particularly those who have recently left the field, perhaps due to service closure, but this survey does provide a reasonable picture of the current state of thinking in the field.

Rightly, emphasis has been placed in the past on listening to the voices of service users and carers, but this exercise has highlighted the parallel requirement to listen to the voices of those who work in the field. This process suggests the need for an ongoing regional or national process to listen to the voices of workers in alcohol services and feed this material into strategic thinking.

2.3 Dual diagnosis

Consistent and urgent concern was expressed about the lack of a coordinated response to people with a dual diagnosis of mental illness and alcohol problems.

Are there appropriate care pathways for people with both mental health and alcohol problems?

Yes	31.15% (57)
No	54.64% (100)
Don't know	14.21% (26)

This was one of the strongest themes in the whole review process. 55% felt pathways for people with a dual diagnosis were inadequate with 31% feeling they were adequate.

This message was reiterated in other survey questions: in particular, about training needs (see chapter 10 below). In the group sessions the struggle to access help from mental health services was consistently mentioned by alcohol service staff. (It is possible that mental health staff have similar views on the failings of alcohol services, but the scope of this research did allow these views to be investigated).

The question elicited a very large number of comments. Below is a sample that

underlines the strength of feeling on this issue.

- *I can't get support from mental health services; when I have been to hospitals, I have felt like I have not been treated with much respect.*
- *Where alcohol and mental ill-health are concerned there are still some GPs who maintain that they can't address the mental health problems until the person stops drinking.*
- *There is still a struggle with the dual needs of people with alcohol and mental health issues; this becomes very frustrating as people seem to fall into a gap between services. It seems that services can only work with a person either with mental health or addiction - not with the whole person.*
- *There is no specific 'dual diagnosis pathway'.*
- *This group often don't get support.*

A case study from primary care

"We have been working with a young man who is a repeated relapsing drinker in the care of alcohol services. He was told he was not drinking enough to be considered for detox so because of his worsening paranoia, panic attacks, depression and anxiousness we asked for him to be referred to the early intervention mental health team. He was made an appointment but on arrival was told he was drinking too much to be assessed. He has now become homeless and placed into a hostel."

One interviewee reported:

*"We have had problems with the Community Mental Health Team. They won't touch clients until six months after they have stopped drinking. We don't even bother with the mental health services now."*²

Another said that:

*"We have a dual diagnosis strategy but it is not put into practice."*³

More significantly, respondents to all parts of the research highlighted this as an issue that is worsening as a result of cuts in mental health services. The alcohol field is sending a clear message that help is needed in this area.

This is something that appears both hard and inefficient to resolve at a local level because almost every area faces the same problem. National guidelines⁴ do exist but these do not often appear to be followed and work is needed to clarify responsibilities.

2.4 Chaotic and change resistant service users

Many dually diagnosed service users will present as chaotic and treatment resistant. However, the research highlighted a specific concern about service users who are difficult to engage. These views were expressed in response to a number of questions in the survey as well as in the interviews and group sessions.

The most telling comment is that 72% of survey respondents felt that working with treatment resistant service users was a training gap: easily the largest identified training need.

However, this was not simply about training. Hundreds of comments focused on this group in one way or another. Examples of positive practice were offered but these were outweighed by acknowledgements of a gap in service:

- *Outreach support is poor.*
- *Drop out is usually a result of not being able to get a hold of the client. The number of new clients in the system usually means that there are not the resources to fully follow-up those who drop out of the service.*
- *Commissioned targets mean that such clients cannot be followed up. If someone is identified as having specific vulnerabilities then they will be followed up – otherwise they will not be.*
- *The workers are overloaded and too busy with the client load they have already.*
- *The alcohol agency relies on clients being motivated, however motivation can go up and down and I feel part of their work should be about increasing and maintaining motivation. Often if people don't attend a couple of appointments their case is closed.*
- *Following up clients who drop out is notoriously difficult and time-consuming. However, we have found that the use of text messaging has improved the number of responses and re-engagements we are able to achieve.*

A number of respondents argued that motivation to change was still an important marker for services:

- *The services available have little capacity to re-engage people who fall out of services. To be fair, this is because they are trying to devote their very limited resource to increasing access to people who are trying to get into services.*
- *If people drop out they are deemed to have chosen that - we can't insist on continuing treatment.*
- *...we are trained to make the patient demonstrate motivation so I generally leave them alone until they next present.*

Service user comment

*"Drinkers are left to their own devices too much. If I had been seen at home in my own environment I may have changed my drinking quicker. I have agoraphobia so getting out can be difficult. I missed appointments not because I was not motivated but because I was 'bricking it'. It got better after time though. Being seen at home would have made the early bit of support more comfortable. It may have meant that I would have had blood tests earlier that motivated me to reduce my drinking."*⁵

Some workers outside the alcohol field were critical of a motivation based approach. One non-alcohol specialist wrote:

"The impression given is that this is the client's fault. There still remains a culture of 'those missing appointments do not require help or can't be bothered to turn up'. Little consideration is given to the dysfunction this client group exhibits and addressing this. I had to ask a specialist worker from an agency to see a client who turned up late. She was sitting doing nothing at the time and moaned about having to see him. One client committed three additional crimes as staff merely looked at him as someone in the revolving door. There was no revised care plan or consultation with Police and Probation. The man was a serious risk of harm to members of the public."

Perhaps the best conclusion is the simple survey comment: *"More outreach work is needed."*

One interviewee noted that: *"With young people we do work more in the assertive way."*⁶ Outreach is not questioned because of the level of risk and vulnerability involved. However, many of the service users focused on in this section are also very risky or very vulnerable and would benefit from a similar approach.

2.5 Residential rehabilitation services

The survey asked about access to specific interventions. Nearly 47% of respondents felt that there was insufficient access to residential rehabilitation in their area. This was the most significant gap identified in the modalities of alcohol treatment.

In your area is there sufficient access to:

	Yes	No	Don't know
Residential rehabilitation?	44.26% (108)	46.72% (114)	9.02% (22)

The comments are included more fully to emphasise the strength of feeling:

- *Council will not fund rehab.*
- *Due to funding restrictions there are limited places for clients to access rehab.*
- *No budget set up, rehab process complicated and long.*
- *Residential rehabilitation has been shortened therefore clients are not getting the full benefit.*
- *With regard to Tier 4 interventions the budget is extremely tight.*
- *No residential rehab except for a 12 step and there is a waiting list.*
- *Residential rehab budgets are being limited in the local authority.*
- *Residential rehab - really hard to get the people who really need it and last resort.*
- *There are no residential rehabs in our county.*
- *Rehab currently restricted due to funding reduction & process of referral held by another service.*
- *Funding is restricted for inpatient detox and residential rehab and therefore very few clients can access this.*
- *Numbers into residential rehab have always been low.*

This negative view was not shared by everyone: one local authority officer said: *“I am busier than I have ever been. Since April I have sent 50 people into rehab and only 4 failed to complete. The reason for that is that we put the work in beforehand.”*⁷

However, another presented a starker view: *“The weekly amount we can pay has*

dropped from £1000 to £450-£550 per week. This has resulted in the loss of some rehabs. The other is the length of time people can stay. We used to fund 9-12 months placements but now it is 12 weeks unless the service user is complicated. In 12 weeks you can only scratch the surface of the problem.”⁸

Community care legislation and subsequent guidance on Fair Access to Care Services clearly delineated the right to assessment and the need for funding to be available which could be used on residential care. However, these rights do not appear to be accessible in some areas. Although the Community Care legislation is being replaced by the Care Act a right to assessment for funding still exists.

A small number of interviewees raised concerns about the presence of brokers in the residential sector who identify service users to rehabs for a 15-20% placement fee.^{9 10} This was an issue that was very limited to the residential sector and one which does not affect every service in that sector.

3. The current state of the alcohol treatment system

3.1 Overview

The starting point for this research was the recognition that alcohol services have been through a period of huge change. A key aim was to identify the state of services in the wake of that process.

The extent of the turnover in services was readily identified in the survey. 68% of respondents said that services had been retendered in the last three years in their area: a phenomenal rate of turnover.

Have your alcohol services been retendered in the last three years?

Yes	68.47% (152)
No	14.86% (33)
Don't know	16.67% (37)

The changes due to tendering and recommissioning were frequently highlighted:

- *We have a new tier 3 and 4 contract beginning in April 2015; with a greater focus and resource for alcohol.*
- *New services are about to start. We could always use more resources. We*

await some measurement before saying services are 'good and efficient'.

- *(Services) have just been recommissioned.*
- *It remains to be seen what the situation will be following recommissioning with a considerably reduced budget.*
- *Recent austerity cuts have meant that alcohol services within the borough have suffered. There have been a couple of resources that have been de-commissioned.*
- *We currently have a fragmented system...Hence, we are moving towards procuring an Integrated Service in the next year.*

These changes appear to be ongoing with areas identifying further changes in the future. This degree of change cannot be underestimated and has clearly had a huge impact on local systems. The question is whether these changes have been for the better.

A liver specialist outside mainstream alcohol services:

It has changed radically. We need stable services so all this change and retendering is unhelpful. It takes time for services to get established but then they are changed to a different one. Overall this has been a very poor outcome for liver disease patients.¹¹

3.2 Tendering

The survey did not ask any questions about the tendering process. However, this was a theme that emerged frequently in the groups and interviews. No-one explicitly said that the competitive approach embodied in tendering was inappropriate. However, concerns were expressed about some aspects of tendering.

The main concern was the uncertainty and consequent staff turnover that it creates, especially with short term contracts.^{12 13 14 15} One interviewee asked: “*When an able doctor can have an NHS job for life in other branches of medicine, why go into addictions with three year contracts?*”¹⁶ The process can also lead to inconsistency in approach and to caution and wariness in relations between stakeholders.¹⁷

Tendering is leading to the loss of smaller local services because either contract values are too high to be secured by small services or the weight placed on price in the tender outweighs the value placed on local experience and expertise.^{18 19 20} Concern was expressed about how the content of a bid is checked. One service was named as a

partner in a rival’s bid without their permission. It was asked what process exists for checking false claims. Concerns were also aired about commissioners pulling out of tendering processes without compensating bidders for the potentially large amount of work already undertaken.²²

Interviewees also discussed a narrowing focus of who can access treatment. *“The third sector are very specific about who they will accept on the pathways. Clients have to fit into a particular category.”*²³ *“The danger is that it becomes one size fits all.”*²⁴

3.3 Are services improving or worsening?

Two questions were asked to identify whether services are improving as a result of this period of change:

- 1. Have alcohol services improved or worsened in the last three years?**
- 2. Have services improved as a result of the tendering process?**

The project team expected a negative answer to the first question. However, 40% of respondents felt that services had improved in the last three years with 22% feeling they had worsened. 29% felt they had stayed the same. Whether this is viewed as a positive picture depends on how you view “staying the same”. In a period of restricted funding that could be considered a success.

Similarly, the views on the outcome of the tendering processes were relatively positive. Only 14% felt services are becoming worse as a result of tendering:

Services have improved as a result of tendering	19.08% (25)
Services are in the process of improving as a result of tendering	27.48% (36)
Services have stayed very much the same as a result of tendering	16.03% (21)
Services are becoming worse as a result of tendering	13.74% (18)
Don’t know	23.66% (31)

This question received a large number of comments. These were very mixed, a number saying that change was under way and it was too early to say, but a range commented either positively or negatively: the split was fairly even.

- *We have increasing numbers accessing services, which is good, but treatment outcomes are still below what we would like to see, though they are improving, and numbers engaged in effective treatment are improving.*

- *I have not seen evidence to indicate improved services.*
- *Services have substantially improved with big increases in numbers of clients. The service has become popular.*
- *Perhaps tendering needs to be for a longer period, I feel it's disruptive to service users when new takeovers are concerned with making the service work by spending time looking at what they have inherited.*

Two main areas of improvement emerged which may explain the more positive view. Firstly, the joining of alcohol and drugs means that alcohol services have benefited from the resources previously restricted to drugs.

- *We have a drug and alcohol treatment system, greater Public Health England (PHE) and National Drug Treatment Monitoring System focus and support around alcohol has improved our local response*
- *There is now an integrated alcohol and drug treatment system for clients where previously this had not existed.*
- *Closer integration with other drug services; better integration across health systems. Improved access overall.*
- *Alcohol related problems are now being recognised; previously attention was given almost exclusively to drug related problems.*

The impact on their service was described statistically by one of the larger residential rehabs in the country who said: *“The creation of PHE in 2013 had a massive effect on the organisation. In 2012/13 43% of referrals were for alcohol. In 2013/14 57% were for alcohol.”*²⁵

Non-specialist provider comment

*Alcohol treatment was poorly funded but now we can secure assessments more easily. There have been no issues around getting treatment and we couldn't have done that 5 years ago.*²⁶

Second, a frequently identified area of improvement was alcohol liaison services in the hospital.

- *Introduction of alcohol liaison service (ALS) in our general hospital has improved the working relationship between the ALS and the community alcohol service.*
- *We now have an Alcohol Liaison Nurse at the local hospital and we have been commissioned to provide alcohol health workers at A&E.*

- *Alcohol treatment has improved for many who wouldn't have accessed support with the introduction of hospital alcohol liaison nurses who try and engage frequent attendees at A&E.*

A third area of benefit was in the criminal justice system where one interviewee noted that the loosening of the restrictions on Drug Interventions Programme (DIP) money, which was formerly specifically for drug interventions, has led to “an increase of alcohol arrest referral.”²⁷

Another interviewee identified that because services now “*have fewer opiate and crack users, there is time to do alcohol work.*”²⁸

It should also be noted that alcohol services are starting from a low baseline.²⁹

At the strategic level alcohol treatment has also benefit from changes to the public health system. Research for Alcohol Concern has identified that alcohol is featuring widely in Joint Strategic Needs Assessments (JSNAs).³⁰ Interviewees felt that the advent of the Health and Wellbeing Boards and a national target about alcohol related hospital admissions has enabled and encouraged a better dialogue about alcohol.^{31 23}

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Interviewee comment:

*The commissioning going into public health is a positive thing for alcohol services. In public health alcohol is ticking far more boxes. There will be far more scope for delivering public health outcomes.*³⁴

A final positive came from a worker who felt that joint services offered alcohol workers “*better career development.*”³⁵

Despite the huge period of change that the alcohol field has experienced it can be argued that alcohol services have benefited to some extent. Nonetheless, this evidence needs to be treated with caution. The danger exists that “history is being written by the victors”. Those who currently commission and provide services are more likely to have a positive view of the systems they are developing. The voices of those who have lost contracts are harder to find.

One person commenting on the data wrote: “*The providers who have no say are the 18+ rehabs which closed since the coalition government came to power. That is on top of the 24 rehabs which closed in the 24 months leading up to the previous general election. If they were contactable to be canvassed, they would not be as happy as your figures indicate.*”

The researchers were also able to break the evidence down by role and this proved instructive. Only 4% of commissioners and 6% of service managers felt services were poor but 27% of people who worked outside the treatment field felt they were poor.

One of the interviewees approached the issue from the other direction and felt that the growing prominence of “alcohol was having a negative impact on drug users”.³⁶ This was a view shared by others:

- *The area is now managing clients with alcohol addictions as well as opiates and non-opiate drugs on the same budget as had previously been assigned to drug users.*
- *Our service is connected with drugs (I) think these might benefit from being split.*
- *There is more of an integration of drug and alcohol services: generally that is a step back. People will be deterred by it.*³⁷
- *Somebody who is misusing alcohol does not identify with drug users.*³⁸

3.4 Resourcing

Despite the relatively positive view about the changes 55% of respondents felt that alcohol services were under-resourced.

How would you characterise specialist alcohol services in your area?

We have a good and sufficient range of alcohol services	14.34% (35)
We have good alcohol services but they are under resourced	49.18% (120)
Alcohol services are adequate in terms of quality and resources	16.39% (40)
We have poor local alcohol services in terms of quality and re-sources	14.75% (36)
Other	5.33% (13)

It was noticeable that commissioners (4%) and service managers (6%) were far less likely to think that services were poor than those outside the treatment system (27%), users and carers (22%) and even alcohol workers (18%).

Questions about this elicited a very large number of comments, for instance:

- *Funding cuts have resulted in waiting lists and a reduction in the options that we offer.*
- *These services need better co-ordination from a commissioning*

perspective and there needs to be an increase in overall capacity.

- *Insufficient service for the size of the problem.*
- *We have good services but they are at full stretch.*
- *The area has a very limited service.*

3.5 Other concerns

Two other concerns about the changed landscape emerged:

1. Multi-agency working is worsening;
2. Insufficient national guidance is available.

Neither of these were examined in the survey; however, comments emerged in the interviews and workshops.

3.6 Multi-agency working

The links between services were felt to have worsened or broken down due either to the changes in provider services or the competition between services:

- *Services should actually work together instead of criticising each other.³⁹*
- *My paperwork isn't accepted by other services so service users get the same questions time and time again. This is ridiculous.⁴⁰*
- *To a degree the retendering has led to a fracturing of the partnerships and multi-agency working. But the single provider model should make it easier.⁴¹*
- *Communication between agencies can be undermined.⁴²*

Recommissioning had led to confusion among non-specialists about the local provider: in one area a GP was still referring to a service that had been decommissioned two tenders previously. Some specialist services expressed anxiety about competition between services, leading them to be unwilling to share data and tools.

3.7 The lack of national guidance

This theme came out very clearly in the workshops and the interviews. People wanted more national guidance on a range of themes, from commissioning to working with

dually diagnosed clients. Interviewee comments included:

- *Lack of leadership at a national level. No one is steering us in what we do.*⁴³
- *Leadership: We need direction and strategy. There are calls to use National Institute for Health and Care Excellence (NICE) guidelines, we need someone to set the agenda.*⁴⁴

This message about leadership was reiterated in the recent PHE *Review of Drug and Alcohol Commissioning*.⁴⁵

Interviewees also commented on the lack of input from the Clinical Commissioning Groups (CCGs)

- *I think the split over CCG and public health is confusing regarding who should fund it, for example. the alcohol liaison nurses. CCGs are leaving to this for the local authorities.*⁴⁶
- *Where is the CCG?*⁴⁷

4. Other parts of the care pathway

The previous chapter gave an overview of the current state of the treatment system. A range of questions were asked about other aspects of the service user care pathway including:

- Public education / social marketing
- The accessibility / publicity of services
- Assessment and care planning
- Waiting times
- Time limits on interventions
- The range of interventions
- Aftercare
- Joined up care pathways.

The following sections review the data. In general, respondents were positive about these elements. However one interviewee commented on the wider concept of a pathway:

“We are obsessed with pathways. The thing that is lacking is someone taking overall

ownership for coordinating care. Sometimes there are so many agencies involved there is lots of repetition. One person should coordinate and commissioners should respect that this will affect your face to face contacts. Someone said to me this week “you have been on the phone all morning and not seen any patients” but by talking with other agencies I had avoided two hospital admissions.”⁴⁸

4.1 Public education / social marketing

The respondents were very clear that insufficient work was being done on alcohol related social marketing.

Is there public education / social marketing re alcohol in your area?

Yes there is sufficient public education / social marketing	5.86% (13)
Yes but more needs to be done	59.91% (133)
No and this should be a priority for action locally	20.72% (46)
No but this should not be a priority for local action	1.35% (3)
Don't know	12.16% (27)

The comments were very varied ranging from the need for more education in schools, the need for a joint and integrated approach due to the lack of funding, with occasional examples of positive practice. No single theme emerged from the comments other than the need for more investment and coordination in this area.

- *A stronger high level lead.*
- *More awareness in schools and students.*
- *Survey for over 50's as I think they are being overlooked.*
- *More coordinated approach with fuller support from Local Authority communications departments.*
- *Our patients tell us that they want less preaching about alcohol and more information on diet and exercise. I think that alcohol problems, excessive calories, damaging effects on body etc, might therefore be best packaged as part of the diet/exercise/weight loss information.*

4.2 Are services sufficiently accessible / well publicised in your area?

Views were quite closely split on this issue with 48% stating services were accessible and well publicised and 44% saying they weren't. All these views may be correct and reflect the practice in different areas. However, 44% feeling services are accessible is not a positive result in a service industry: especially as a great deal of work has been put into developing pathways across the country.

It should be noted that the phrase “sufficiently accessible” may have led to some false positives. Some respondents seem to have interpreted this as “sufficiently accessible for the available (limited) resources”.

Are services sufficiently accessible / well publicised in your area?

Yes	47.95% (117)
No	43.85% (107)
Don't know	8.20% (20)

One area of concern emerged from the comments more clearly than any other – the need for publicity of alcohol services in primary care settings:

- *Needs greater engagement with primary care to localise delivery further.*
- *Some services are promoted – others are not and within GP practices, some GPs appear to have little knowledge.*
- *More publicity is needed especially in GP surgeries and hospitals.*

Otherwise no single theme emerged except a generalised concern about publicity and, in a few cases, the physical accessibility of services. However some people pointed out that greater publicity could lead to a flow of service users that would be unmanageable for services.

The views of people in different roles varied considerably. Those not working in alcohol services were least likely to feel that alcohol services are accessible and well-publicised (35% felt they were accessible and well-advertised and 54% felt that they were not). Surprisingly the group least likely to feel services were well-publicised were specialist alcohol workers (58% said ‘no’). However, service managers, medical staff in services and commissioners all felt that services were well advertised and accessible (58% said yes).

4.3 Assessment and care planning

The headline survey responses were fairly clear with 61% feeling that assessment and care planning worked well and only 16% feeling it worked badly.

Is assessment and care planning in specialist alcohol services working well?

Yes	60.66% (148)
No	15.98% (39)
Don't know	23.36% (57)

The comments did not contradict this view although a few made negative comments about local systems:

- *Recovery plans are not SMART, feels like a tick box exercise for targets at times.*
- *Limited care planning other than 'try and cut down'.*
- *Too much focus on completing at first appointment and opportunity for real engagement is lost. Then paperwork is not referred to at each one-to-one session by all workers.*
- *Too much paperwork / statistics.*
- *Not enough staff to do proper assessments and there is too much reliance on form filling. Many workers do not have the skills to do a verbal assessment and ask questions that are not on a form. As a result assessments are just tick box exercises.*
- *Care planning is poor.*
- *No because it is not person centred enough: it is what the service wants and not what the client needs.*

Service user comment:

Middle aged professional women are put off by questions such as: are you a street worker, are you gay or bisexual...It is impersonal, it doesn't look at the person behind it. The important thing is to build rapport first.⁴⁹

4.4 Waiting times

39% of respondents felt that waiting times affected services. 40% rejected this view. This is likely to reflect varying local situations.

Are there waiting times for services that affect the pathway in your area?

Yes	38.93% (95)
No	40.16% (98)
Don't know	20.90% (51)

Some of the comments presented positive local practice:

- *Individuals can be seen within 5 days for the Single Entry and Assessment Point. Maximum waiting times of 3 weeks are applied and monitored on a quarterly basis.*
- *14 days maximum wait.*
- *Less than 2 weeks for all substances.*

However, others identified systems that may not appear to have waits or where the waits are seen as acceptable by the services / commissioners but are still a barrier for service users:

- *Services require clients to 'drop in' for assessment, but only see the first four attendees, leaving the rest frustrated. These people do not always make a second attempt.*
- *You cannot access help at the point you really require it; by the time it becomes available things have moved on and patients may then be reluctant to accept the support.*
- *Drop in. If you are not there half an hour before - you will not get seen.*
- *The key waits are at the point of patient wanting to get support from specialist services, and then waiting for detoxes.*
- *We have clients who have been referred by GPs to shared care normally seen within the week but then a delay in triage at the service, some have then waited 2 to 3 weeks to be allocated a key worker.*
- *These can fluctuate from having no waiting list to having one in place and referrers are not always informed of this.*

Others simply identified inadequate local resourcing:

- *Services have waiting lists due to reduction in funding and lack of resources.*
- *There is a waiting list for the residential detox and rehab unit.*
- *There are people waiting whose lives are at risk and they are being offered nothing.*
- *There are too many needing help, and not enough qualified staff.*
- *Some services are unable to offer a service due to staffing issues.*

One comment stood out from all the others:

"Someone presenting today would probably wait about 3 years before being

considered for a detox and rehab care.”

It was interesting to note that when the responses were broken down by role, specialist staff were more likely to feel that there were waiting times than anyone else. This does suggest that waits are a real and current phenomenon.

4.5 Time limits

The researchers had hypothesised that during re-tendering, commissioners might have attempted to impose time limits on the length of treatment available. 25% of respondents said services had time limits; however, 47% said this was not the case.

Are there time limits on services that affect the pathway in your area (for example max length of time in treatment)?

Yes	25.41% (62)
No	47.13% (115)
Don't know	27.46% (67)

Where limits were identified these were of 6, 12 or 26 weeks duration and varied with modality. Comments simply reflected the varied local practice.

4.6 Community interventions

The views on the availability of community based treatment modalities are reflected in the data below:

In your area is there sufficient access to the following in specialist treatment services:

	Yes	No	Don't know
One to ones?	62.70% (153)	26.23% (64)	11.07% (27)
Groupwork?	67.21% (164)	21.31% (52)	11.48% (28)
Structured day care?	34.84% (85)	45.90% (112)	19.26% (47)
Relapse prevention?	58.61% (143)	26.64% (65)	14.75% (36)
Motivational interventions?	61.07% (149)	21.72% (53)	17.21% (42)
Harm reduction with drinkers?	58.20% (142)	25.82% (63)	15.98% (39)

The comments reflected the lack of structured day care or local problems with one or other of these modalities.

A useful cautionary note, which reflected the views of others was: *“While I put yes for all the above, I put this because we have very good provision in our area. But if we are to properly serve the needs of all problematic alcohol users in our area there would not be sufficient access.”*

4.7 Detoxification and other prescribing

The survey asked about access to four specific medical interventions. Again a negative response had been expected to most of these questions but to varying degrees the majority of respondents felt that detoxification and other prescribing were available in their area.

In your area is there sufficient access to:

	Yes	No	Don't know
Community detoxification?	57.79% (141)	29.51% (72)	12.70% (31)
Inpatient detoxification?	50.82% (124)	38.11% (93)	11.07% (27)
Medications like Antabuse, Acamprosate, Nalmefene?	55.33% (135)	16.39% (40)	28.28% (69)
Pabrinex (vitamin therapy)?	43.85% (107)	15.16% (37)	40.98% (100)

The comments in this section were largely focused on residential services which were addressed in chapter 2 above. However, a more negative picture emerged in the interviews:

- *There are two detox beds for the area. These beds are in a psychiatric unit. They don't receive any intervention.⁵⁰*
- *There are problems for those who need a detox and are waiting 6 months to get one because they are deemed too sick for the community and are waiting for a specialised bed. In this time they die or deteriorate.⁵¹*

Interview and workshop comments on the use of Antabuse and other medications also contradicted the survey:

- *It is used a little bit, it is not my part of the sector, not sure how much it is promoted in the sector. You do hear talk of supported medication from clients.*⁵²
- *I actually think that its use has gone down.*⁵³
- *Antabuse is a vital part of recovery; its use is variable due to cultures in services, different localities and different medics.*⁵⁴
- *I don't think it is being used widely at all in our area. GPs can start using it but then stop and try and refer them into services.*⁵⁵
- *The specialist doctors here won't prescribe Antabuse/acamprosate. This prescribing is not in the contract.*⁵⁶
- *Doctors are quite scared of Antabuse. They want workers to say that it is OK.*⁵⁷

4.8 Aftercare

48% of respondents felt that there was sufficient aftercare in their area. 31% felt it was insufficient locally. However, the importance of aftercare was widely recognised.

Is there sufficient aftercare in your area?

Yes	48.36% (118)
No	31.15% (76)
Don't know	20.49% (50)

One respondent commented, helpfully, on the terminology

"We do not use the term aftercare as it suggests that the building of lifeskills etc. should wait till after treatment - our new service is building recovery capital services from treatment commencement."

However, most comments reflected either the local approach or the lack of necessary support.

4.9 Joined up care

While 45% of services felt that care was sufficiently joined up, 32% disagreed.

Is care sufficiently joined up along the care pathway?

Yes	45.08% (110)
No	32.38% (79)
Don't know	22.54% (55)

In general the comments presented a more nuanced viewpoint, with most people recognising inadequacies in the pathway:

- *There are excellent pathways from local general hospital to community OK pathway from primary care; poor from psychiatric hospitals / services.*
- *We are currently reviewing this.*
- *They can be hit and miss.*
- *Yes but there are breaks due to shortages of staff.*
- *It's a lot better than it was and it's improving all the time.*

5. The impact of the recovery agenda, peer support & mutual aid

5.1 Overview

Various survey questions considered aspects of the recovery agenda, peer support and mutual aid. In general respondents were positive about progress in this area.

5.2 The recovery agenda

The views on the recovery agenda were generally positive. Only a handful of respondents felt it had had a negative impact. The more crucial question was whether it had had actually had an impact on the alcohol field as compared to the drugs field.

The recovery agenda has had:

A positive impact on local alcohol services	50.41% (123)
A negative impact on local alcohol services	4.51% (11)
Little or no impact on local alcohol services	31.15% (76)
Don't know	13.93% (34)

This question elicited an interesting and varied range of comments. A mixed sample of positive and negative comments is presented below, albeit the positive comments clearly out-number the negative:

- *I think there has always been an agenda about 'recovery' with alcohol treatment services rather than a 'maintenance' focus.*

- *The Recovery Agenda has led to an increase in the number of SMART groups available, a better recognition of the role of mutual aid and promotion of mutual aid.*
- *The emphasis and value is cornered by 'treatment/recovery' services and the abstinence model, leaving Motivational Interviewing, Brief and Extended Brief Interventions and Harm Reduction underfunded and undervalued. The recovery agenda implies that services exist to help people recover from the 'disease' of 'alcoholism'. This has a negative impact on early intervention services and leads to clients thinking they can't justify accessing services unless they have the 'disease'.*
- *More people visibly in recovery and able to offer peer support.*
- *Encourages individuals to take ownership of their recovery and is motivational to others to see how other service users have made positive changes in their life.*
- *It is early days in conceptualising what this really means locally but the impact appears positive insofar as more alcohol users are now accessing the developing portfolio of recovery supports offered across the substance misuse system. Service integration appears to have assisted this.*
- *It is misguided and meaningless to drinking clients.*

5.3 Mutual aid

A clear majority of respondents felt that mutual aid is sufficiently used, albeit 22% disagreed.

Is there sufficient use of mutual aid groups like AA/SMART in your area?

Yes	61.07% (149)
No	21.72% (53)
Don't know	17.21% (42)

None of the comments opposed the use of these approaches. SMART groups were more likely to be unavailable or under-used than AA. In general the negative comments were simply the need for more use of this approach or the development of SMART groups. Only one respondent said they did not know what SMART was.

5.4 Peer support

65% felt that peer support was being used as an approach locally but well over half of these respondents felt that far more could be done locally. Less than 10% felt it was

not being commissioned locally.

Is peer support being commissioned as part of alcohol services?

Yes it is well used	27.32% (50)
Yes it is used but not sufficiently	37.70% (69)
No	9.29% (17)
Don't know	25.68% (47)

The comments reflect the survey results very closely. One more negative comment was:

“Often inexperienced service users are put in positions they should not be or are used as cheap labour.”

However more positive comments included:

- *Early stages of peer support and this continues to improve and grow.*
- *Currently being developed by the existing treatment provider.*
- *We are looking to increase the number of peers involved in service delivery through the re-commissioning.*
- *Peer support takes place both within commissioned treatment services and within the independent service previously mentioned.*
- *Yes but needs some further development, particularly around taking on peer mentors from prisons when they are released as this is a valuable resource we shouldn't lose.*
- *It has not been officially commissioned, but we run a number of successful peer support services to enable graduates to progress in their recovery journey.*

5.5 Abstinence and controlled drinking

48% of respondents felt that there was an adequate balance between abstinence and controlled drinking. 15% felt this was not the case.

Is there an appropriate balance between abstinence and controlled drinking in your area?

Yes	47.54% (116)
No	14.75% (36)
Don't know	37.70% (92)

Three pairs of survey comments, each pairing left within a few hours of each other, highlight the variation in views on this topic:

- *Some services will only work with abstinence.*
- *Controlled drinking is king.*

- *The investment is heavily favoured towards controlled drinking - probably by a ratio of more than 20:1.*
- *Abstinence is pushed, not once is controlled drinking mentioned whereas in years before this was an option.*

- *Some groups of patients are receiving bad advice for example controlled drinking when they are cirrhotic and need to stop.*
- *Lion's share is abstinence, such that talking about controlled drinking sometimes feels a bit taboo.*

The rest of the comments varied between people feeling the balance is appropriate or feeling that the balance is too far one way or the other.

6. Commissioning process

6.1 Overview

The surveys explored a number of aspects of the commissioning process. These included: how well the process was understood, whether the information on which commissioning is based was adequate and the involvement of key stakeholders.

6.2 Is the commissioning process well understood?

Only 24% of respondents felt that the commissioning process was well understood locally. 54% felt this was not the case: this represented over two thirds of those who expressed an opinion.

Is the commissioning process for alcohol services sufficiently well understood locally?

Yes	24.32% (54)
No	53.60% (119)
Don't know	22.07% (49)

The comments confirmed this balance of views:

- *It is OK for staff who work in the alcohol teams but other services are confused about our limitations/budget restrictions.*
- *Within London every borough's services are different and can become quite confusing.*
- *Local authority has responsibility for commissioning alcohol services, but clinical commissioning groups have responsibility for reducing admissions to hospital with alcoholic liver disease...Need concerted efforts on primary prevention.*
- *I don't think it's clearly understood, actually it's quite difficult to understand as it's quite fragmented.*
- *As commissioners we understand it very well and try to make things clear for partners and the public, but it's a complicated process and I am sure that not all aspects are understood.*
- *The commissioning process for alcohol services is barbaric. We have been providing multi-award winning abstinence based treatment since 1987 and we have twice lost out at commissioning to remain as service provider. The tender process is not aimed at small organisations that do not have the resources to bid against the larger organisations.*

6.3 Is there sufficient information about the local impact and prevalence of alcohol?

A quarter of respondents felt that there was insufficient information to enable the commissioning of alcohol services but close to half of respondents felt that there was sufficient information.

Is there sufficient information about the local impact and prevalence of alcohol to enable the commissioning of alcohol services?

Yes	48.09% (88)
No	24.59% (45)
Don't know	27.32% (50)

The comments were almost entirely about specific perceived gaps in the information, for example health data. Data from hospitals and primary care was the most commonly perceived gap.

- *Poorer information on young people’s use. Gaps exist for impact within family settings.*
- *There is some information available if you know where to look, but whether this enables adequate commissioning of alcohol services is another matter.*
- *You can never have enough information. It would be of value to work with the local acute hospital more closely around their admission patterns.*
- *Methods used to collect this data are notoriously unreliable and give rise to conclusions that are tainted by other agendas.*
- *Hidden areas of harm around perhaps the Asian community.*
- *I believe there are a lot of hidden drinkers whom the services are not aware of.*
- *Not enough time/resource to analyse this fully and properly as we have almost no data analysis available to us locally.*

6.4 Are service users sufficiently involved in the planning of services in your area?

Views on the adequacy of service user involvement were evenly split, with a very small majority feeling there was insufficient involvement.

Are service users sufficiently involved in the planning of services in your area?

Yes	33.88% (62)
No	36.07% (66)
Don’t know	30.05% (55)

The question elicited a very large number of comments. These appeared more positive than the numerical responses, with examples of good practice. However, some still highlighted gaps. One interesting comment asked about the evidence base for the effectiveness of service user involvement:

“The question should be “Can Service Users improve the planning of alcohol services?” rather than assuming they can. What evidence is there for service users improving services significantly to warrant their involvement?”

Other comments included:

- *Service users were engaged in the retendering process and sat on the procurement panel.*
- *Massive improvements have been made in the last couple of years to involve service users but there is still a long way to go to improve the uptake of service user involvement in general, let alone in the planning of services.*
- *There is an existing structure which is very useful in integrating the service user's perspective but it is inconsistent in its application on a county wide basis.*
- *A clear strategy from commissioners on this topic could help - so they could be measured against and held accountable.*
- *There is a dedicated service user involvement worker.*
- *Via consultations prior to tender process.*
- *When they were consulted all their views about choice we totally ignored.*

6.5 Are other stakeholders (for example non-specialist services) sufficiently involved in the planning of services?

A majority of those expressing an opinion felt that other non-specialist stakeholders were sufficiently involved in service planning; however, this still represented a minority of respondents, with 45% not knowing.

Are other stakeholders (e.g. non-specialist services) sufficiently involved in the planning of services in your area?

Yes	33.88% (62)
No	21.31% (39)
Don't know	44.81% (82)

The comments tended to be negative in tone with many identifying gaps in the consultation process. People who are satisfied with the process are probably less likely to comment:

- *There does not appear to be any engagement with voluntary or community groups who are ideally positioned to signpost clients.*
- *The planning feels very secret.*

- Yes - but stakeholder interests are complex.
- We host a regular drug and alcohol steering group with stakeholders from all areas. In addition, our local service provider has good links with all these stakeholders.
- JobCentre Plus, Probation etc. sit on the Task Group. There could be more stakeholder involvement of course.
- They are invited but don't always respond.
- Housing and hostels not included.
- Usually this is only decided by specialist services.
- We are never asked now to be part of planning services or be involved in steering groups etc. This used to take place but it has changed.

6.6 Is the data collection required of alcohol services appropriate?

The expectation was that data collection requirements would be viewed negatively in this survey. This was not the case. Only 17% felt data collection was inappropriate although the “don’t knows” are the largest group.

Is the data collection required of alcohol services appropriate?

Yes	38.80% (71)
No	17.49% (32)
Don't know	43.72% (80)

The comments were few in number but tended to be more negative:

- *Data collection is good but reporting is complex and takes too much time to monitor.*
- *Well broadly but it would be better to monitor other outcomes i.e. improved social networks which we know are important in terms of recovery.*
- *Too much emphasis on positive completions as the only goal rather than improved health and wellbeing.*
- *Would like information regarding the use of brief interventions from non-commissioned services.*
- *There is no data collection on the numbers of people refused a service as they don't meet the threshold for the system. There is no data collected on the numbers of carers identified, assessed and offered a service.*

- *Data has become a terrible industry with a significant expanse of service calendars wholly dedicated to the collection of poorly informed quantitative metrics, and precious little understanding of qualitative and outcomes data. We are currently working to try and provide alternative approaches.*
- *Worth a full review to assess absent data. Too closely aligned with drugs treatment data.*

6.6 Are there good outcome measures for alcohol services?

As with data collection, the ‘don’t knows’ make up the largest group. However, 39% felt that performance indicators were appropriate compared to 20% who felt that this was not the case.

Are there good outcome measures for alcohol services?

Yes	39.34% (72)
No	19.67% (36)
Don't know	40.98% (75)

Again the few comments were more negative in tone than the survey response:

- *Outcomes do not account for reduction of daily amount, only days abstinent.*
- *The outcome measures may be good but I'm not sure the measurable outcomes are always good. Lots of room for improvement.*
- *I think this can be improved.*
- *Not sure. The services took a real dip in outcomes due to all the changes that services have gone through.*
- *Measured all round? – yes. Valued? - I think not.*

An interviewee commented: *“The targets are about getting people through not engaging with people.”*⁵⁸

7. The role of non-specialist services

7.1 Overview

Engaging non-alcohol specialists into the alcohol agenda via the roll out of IBA is one of the seven *high impact changes* advocated by the Department of Health in their 2009 guidance on commissioning interventions to reduce alcohol-related harm.⁵⁹ Even if this were not the case, a referral pathway will always be required from frontline to specialist services.

The message that emerges from this research is that, in general, efforts have been made to roll out IBA and improve these pathways; but much remains to be done. Only 11% felt that people at risk of alcohol related harm received an appropriate response from frontline services.

Do people at risk of alcohol related harm receive an appropriate response from non-specialist services, for example. GPs, hospitals and social workers?

Yes	11.48% (28)
Yes but only to a limited extent	47.54% (116)
No	30.74% (75)
Don't know	10.25% (25)

The basic response to this question was – patchy: *“It is very hit and miss, it depends on the worker or doctor.”* This question elicited one of the largest number of comments of any question and they are very consistent and best summarised in a single answer:

“There are of course some examples of really good responses from GPs, hospitals and social workers. However, there is considerable need for improvement. GPs where there are alcohol workers based in the surgery usually offer an appropriate response. Many GPs where there is no alcohol worker do not appear to know about some of the health risks and risks of withdrawal and may prescribe detox medication inappropriately. In other cases it appears that they have not asked clients about alcohol issues over many years of a problem. They are often not responsive when a client with an alcohol problem is experiencing acute mental health problems. A high proportion of all professionals treat people with alcohol issues in a stigmatising and judgmental way, making it difficult for them to identify the (sometimes very high level) needs of those clients and their families and making it less likely clients will come forward and disclose the extent of their difficulties.”

It is interesting to note that the main focus of the responses was primary care. Although hospitals, police, probation, social care and others were mentioned, GPs remain the main focus of concern.

One respondent commented on data sharing:

“They may get professional help from health care but they are still at risk in their homes or on the road and other agencies i.e. the Fire Service can help reduce that risk but are not allowed to access data / information that would help the targeting and reduction of risk to the individual.”

A specific barrier is stigma and prejudice:

- *Stigma persists.*
- *We also know from service users that hospital staff treat them differently, not in a good way, once they have the 'alcoholic' label.*
- *I have been told by customers that they are treated badly due to their addiction and that they feel very judged...staff are not helpful or supportive.*
- *Services can be judgmental, with an it's 'their own fault' or 'just stop' mentality ... More awareness and training is needed in this area.*

Three respondents identified specific poor practice:

- *People with alcohol addictions are left to reduce alcohol of their own accord and not with full support, so are less likely to achieve their goals. The local social services would rather people self-detoxed instead of using rehab.*
- *I know that sometimes patients are prescribed Librium by GPs without any support or a structured care plan. A&E alcohol recognition is good, but the aftercare is patchy.*
- *Some GPs try to help but are not always prescribing safely, i.e. prescribing large quantities of chlordiazepoxide to alcohol dependent patients.*

7.2 The use of alcohol Identification and Brief Advice (IBA)

A specific question was asked about the roll out of IBA. These very closely reflected the question about the response from frontline services generally. 68% of respondents said that efforts were being made to rollout IBA and only 9.5% said no effort was being made. However, 66% felt that more could be done to roll out IBA.

Is IBA used in non-specialist services such as GPs, hospitals, housing or social care?

Yes it is well used	11.48% (28)
Yes but only to a limited extent	56.56% (138)
No	9.43% (23)
Don't know	22.54% (55)

The comments were generally examples of who had been trained locally or where the gaps remained. Despite extensive investment, only 11% say it is well used.

Commissioner comment:

IBA – we did a pilot of this. We got money from the Department of Health to do this. We trained hundreds of people and some of it is still ongoing. I have not noticed a measurable effect from that. It may still be an underdeveloped area.⁶⁰

Interviewees commented on the problems and challenges of rolling out IBA:

- I think it is unrealistic to expect primary care to take this on – they are in chaos. The GPs do not have the time to do this and refer people on.⁶¹*
- We feel that the rest of the pathway needs to be in place to make this work. We need the gap between the two ends closed to push IBA forward.⁶²*
- This has been the main driver for change and overall has been very positive. The drawback to this has been that services have been commissioned separately and there has not been a whole system approach. More investment in this has detracted from other areas of alcohol treatment as there is no new funding.⁶³*

7.3 Do non-specialists need more training in working with problem drinkers?

This question complements the previous one. It received the single most overwhelming response in all three surveys. 88% felt there was a need for more training for non-specialist workers.

Do non-specialists need more training in working with problem drinkers?

Yes	88.28% (128)
No	5% (8)
Don't know	6% (9)

The comments reflected this clear response with a long list of groups who require training from nurses to off-licence staff.

7.4 The specific hospital pathway

The main exception to these comments is the pathway from the hospitals. This is also a specific element of the *high impact changes*. The response to this was very strong, with 52% saying there is a good pathway. This almost certainly reflects the investment in alcohol liaison which is identified elsewhere in this survey. However, just over a quarter of the respondents felt a pathway was missing.

One person said: “*What pathway? What treatment?*” Another asked: “*A lot of work has been done on this – is this a good return on investment?*”

Is there a good pathway from local hospitals into alcohol treatment?

Yes	51.64% (126)
No	27.46% (67)
Don't know	20.90% (51)

7.5 Criminal justice services

The other pathway which has been subject to specific development is the link to the criminal justice system. 77% of respondents felt that there were links with the criminal justice system but 46% felt this was variable. 9% felt it was poor.

Do criminal justice services link into the care pathway in your area?

Yes all criminal justice services link in well	30.74% (75)
Some criminal justices services link well but it is variable	46.31% (113)
No the links are poor	9.02% (22)
Don't know	13.93% (34)

The comments, which were relatively few, are best summarised in this response: “As with anything there is room for improvement but there are links in place with the key Criminal Justice agencies.”

7.6 Are alcohol services sufficiently engaged with other agencies?

Although this question was focused on all the linkages that alcohol services might have with non-specialist agencies, the responses tended to focus on the example given of service users with complex needs and those with mental health problems.

Are alcohol services sufficiently engaged with other agencies, for example around service users with complex needs?

Yes	51.23% (125)
No	33.20% (81)
Don't know	15.57% (38)

A large number of comments were made about the inadequacy of the response to the above groups and these have been summarised in section 2 above.

The rest of the comments reflect the same nuanced views which emerged from the previous question. Some negative and some positive views were expressed, but largely an awareness that while some engagement is happening, more could be done.

The following selection of comments reflects the range of views:

- *High Volume Service User activity was well developed but changes to the commissioning landscape led to neglect of this area.*
- *Some services engage well, others not at all.*
- *Multi agency meetings held.*
- *There is a high level of engagement, the problem occurs when the agencies do not engage.*
- *Greater liaison and discussion to improve pathways is needed.*
- *Changes to the criminal justice agencies have led to deterioration in engagement, particularly with the prison service due to staff shortages.*

8. Specific areas of concern about the service user group served

8.1 Overview

Four specific areas of concern emerged in the research about the groups served which have not been dealt with elsewhere:

- The changing nature of alcohol services' client group
- The care of people with alcohol related brain injury
- The needs of eastern European drinkers
- The physical health needs of service users

8.2 The changing nature of alcohol services' client group

47% felt that the population served by alcohol services had changed over the last three years against 29% who felt it had stayed the same. The comments provided an overwhelming explanation for the answer and that is the increasing number of eastern European service users. This was mentioned more consistently than any other theme. This theme is explored in section 8.3.

Has the population served by alcohol services changed in your area over the last three years?

Yes	46.72% (114)
No	28.69% (70)
Don't know	24.59% (60)

A second theme was the increase in more complex service users, or "more iller" service users as one person put it.

- *Only in that there are more referrals, sicker, younger.*
- *I also believe that we are seeing people with more complex issues coming through the door. This might be because we have more resources and are attracting more clients.*
- *More complicated.*
- *Very slight changes in that we are seeing an increase in street drinkers and homelessness. Also gambling is increasingly noted on our caseload and in*

many cases this links to alcohol misuse.

- We are getting more complex cases through the service now than we used to.
- Increase in those needing intense treatment and care: rapid assessment and detox options.
- More eastern Europeans and sicker clients
- We are seeing more Blue Light Drinkers, but this may be due to services becoming better at recognising need and complex issues and more willing to engage with them and communicate in a multi-agency way.
- More drift to coastal areas more single homeless transient drinkers.
- Increasing complexity - especially physically.
- Slightly more complex needs - higher levels of drinking in the period prior to entering structured treatment.
- We are getting more entrenched alcohol users referred to us who seem in more crisis.
- Only in the sense that they are becoming increasingly sick - we are seeing more very poorly people, often in their 30's and 40's.

Further comment is made on the physical health needs of service users in section 8.4 below. A small number picked out that services were seeing increased numbers of older service users, while another mentioned greater numbers of younger people. Four people mentioned so-called “legal highs”.

Alongside the data on the changing nature of the service user population, questions were asked about underserved groups in the treatment system.

Which groups are underserved in the local treatment system?

Older people (over 65)	57.92% (106)
Young adults (18-25)	43.72% (80)
Minority ethnic communities	43.17% (79)
Socially excluded communities	42.62% (78)
Young people (under 18)	39.34% (72)
Women	38.25% (70)
People with learning disabilities	35.52% (65)
Particular geographic areas	28.96% (53)
Adults with Foetal Alcohol Syndrome / Spectrum Disorder	25.14% (46)
Men	22.40% (41)

Older people were easily the largest group to need better targeting by alcohol services. Although they were nowhere near as big, it is worth noting the need for a better response for both people with learning disabilities and adults with foetal alcohol syndrome. Other groups identified in the comments included:

- *Poly substance misusers.*
- *25-40 year olds.*
- *Hidden harm drinkers.*
- *Binge drinkers and non-dependant but harmful drinkers.*
- *Increasing harmful drinking in more affluent areas.*
- *The travelling community.*
- *Middle aged middle class professionals.*
- *Pregnant women.*
- *The Somali community switching from Khat to alcohol.*⁶⁴

A small number of respondents and interviewees commented on people coming out of the armed forces, particularly with Post-Traumatic Stress Disorder (PTSD). *“No-one is hand holding them as they leave the services.”*⁶⁵

8.3 Eastern European drinkers

The specific survey questions did not seek to identify the needs of eastern European drinkers. However, the comments on the questions about underserved groups, the interviews and particularly the workshops made the point very forcefully that this is a growing group of service users that services are finding hard to manage.

Service provider comment:

*We are seeing an increasing number of eastern Europeans mainly from Poland and Slovakia. The problems are twofold. First is the language problem with some speaking no English. The second is to the housing benefit system.*⁶⁶

*Eastern Europeans are a big problem in the criminal justice system. There are all the issues about recourse to public funds. These people are causing problems and it would be cheaper to get them in to treatment. There are also questions about borough links especially in London.*⁶⁷

8.4 The physical health needs of service users

This was a key focus for the research. 44% felt that the physical health needs were being identified early enough. 33% felt they were not. This does not sit neatly with the perception that service users are becoming sicker, mentioned in section 8.2. The 60 comments suggest that some respondents answered this question on the basis of “are the physical health needs identified as early as possible *in our service*”.

Are the physical health needs of service users being identified early enough?

Yes	44.26% (108)
No	33.20% (81)
Don't know	22.54% (55)

Positive comments included examples of agency good practice:

- *Much attention is paid to the physical health of this client group in all alcohol services.*
- *All clients have a medical examination.*
- *Good health care checks are done on assessment and at referral.*
- *The single entry and assessment point is provided by an NHS provider and therefore physical health needs are addressed.*
- *All clients are offered a physical health assessment within the first 28 days of commencing their programme (whether or not they are in a clinical setting).*

One respondent said: “*The staff have excellent knowledge around physical health difficulties and also facilitate an alcohol awareness programme for service users which looks at the physical effects of problematic use.*”

However, others said:

- *People are not reaching specialist services early enough. There are some very poorly people accessing specialist services who should have been referred in earlier.*
- *I feel some clients are not being referred into the service early enough by GPs. Unsure of the depth of other agency staff's knowledge.*

These latter views were supported in the interviews and workshops:

- *Patients are presenting with worse physical disease.*⁶⁸
- *Physical health - I don't think this is paid attention to – how is this drinking impacting on the whole person? Clients often forget about their physical needs – and workers do need to ask them about this specifically including their eating patterns.*⁶⁹
- *We have a 15 bed high intensity liver unit. Largely occupied by drinkers that will go home and continue to drink. To be honest there should be a nursing home where people who choose to drink can die in rather than a hospital or community. It is a waste of resource. We should be trying to keep people out of hospital more.*⁷⁰
- *Liver services need earlier identification of liver disease.*⁷¹
- *We also observed a massive increase in alcohol clients with severe physical health issues.*⁷²
- *We have much more complex health issues with the drinkers e.g. Korsakoff's.*⁷³

Hepatology comment:

*I am seeing a lot younger people. This month I have had 5 referrals for transplantation for women; the oldest being 34. None have been in meaningful alcohol treatment before. The majority are mothers. Why isn't this being picked up earlier? I looked at liver disease deaths in our area: 70% had no meaningful alcohol treatment.*⁷⁴

It would be possible to argue that the increase in sicker / more complex service users is the result of hospital liaison picking up these individuals. This would put a more positive spin on this data but this interpretation was not put forward by the respondents.

Some identified attitude problems among frontline workers as a barrier:

- *Often people are told to address drinking before physical help is given, although some GPs are better than others. Hospitals can be dismissive of drinkers.*
- *Not spoken about and avoided. You are not allowed to ask direct questions about alcohol. Anything else - fine, but not alcohol.*

Others identified that service users themselves can make it hard to identify physical health problems:

- *I think it is very much dependent on the information the client gives unless medical tests are administered. Questions will be asked but it is not always possible to get information if someone does not want to share it.*
- *Sometimes clients do not disclose the extent of their alcohol use and therefore early diagnosis of physical health impacts is missed.*
- *There is no good system in place. Difficult to get patients to attend the local hospital for further investigations.*
- *Mostly because individuals do not view themselves as having a problem before it affects their daily functioning...*

Two respondents identified a lack of training among specialist staff:

- *As the service has been fragmented and many agencies are involved in the pathway, often the physical health needs are not identified as many of those carrying out the initial assessments do not have the knowledge or training.*
- *The local provider does not employ medical staff so cannot identify such needs as well as a medicalised service would.*

8.5 Care pathways for people with alcohol related brain injury

Nearly 50% of the respondents were unsure about the pathways for people with alcohol related brain injury. Only 21% felt the pathways were adequate.

Are there adequate care pathways for people with alcohol related brain injury such as Korsakoff’s Syndrome?

Yes	20.77% (38)
No	30.05% (55)
Don’t know	49.18% (90)

This section could have been included alongside *dual diagnosis* in chapter 2; however, it was felt that this would overplay the level of response to this question. Nonetheless, a significant number chose to comment:

- *There is a pathway being developed by the service currently.*
- *It happens more by accident than plan and varies from area to area - and is very much dependent on the local consultant picking this up.*

- *Once fully identified... incredibly difficult and prolonged process.*
- *This is a gap within our borough.*
- *They tend to be referred to neurology for diagnosis, but neurology is not joined up with our local alcohol service to my knowledge.*
- *Currently they take up a lot of hospital beds according to nurse specialist with no alternative facility.*
- *Diagnosis appears to be the issue and community and residential services are being reduced.*
- *I have known of only one client being sent about an hour away to have care for something like Korsakoff's.*
- *Care pathways are well established.*
- *This is a small cohort but almost impossible to get suitable adult social care support.*

One respondent identified the need for guidance on the use of the Mental Capacity Act for alcohol dependence and in particular with alcohol related brain injury.⁷⁵ This was a theme that separately emerged in Alcohol Concern's *Blue Light Project*.⁷⁶

9. Carers

9.1 Overview

One of the two focuses of the third survey was carers' needs; however, this was a theme mentioned throughout the process. In the first survey, two people commented on the lack of a family focus in assessment and care planning:

- *We would like to see a more holistic, whole-family assessment as the feeling is that the assessment focus is still too much on the individual sat in the seat.*
- *Poor communication between services and families is extremely detrimental to treatment...Families should actively be involved in care packages if they choose to as they are often a very important part of the bigger picture.*

The third survey asked a series of questions about carers' support. This was also a theme in many of the group consultations. In general, the comments and responses contained strong messages about the lack of an appropriate response for carers.

9.2 Do carers of problem drinkers receive sufficient help?

A clear majority felt that carers received insufficient help and support. Only 27% felt they were being offered sufficient help.

Do carers of problem drinkers receive sufficient help in your area?

Yes	26.90% (39)
No	53.79% (78)
Don't know	19.31% (28)

Comments mainly focused on the lack of resources and the lack of commissioning intentions or identified local services:

- *This is a very difficult group to engage for a variety of reasons - many will not identify themselves as a carer.*
- *Carers receive some fantastic support from the local carers service, however, not all other partners refer, or set up their own carers support groups - this is not always productive and they could be doing carers an injustice due to the fact that most carers services provide much more than individual services that have been set up to primarily support the cared for.*
- *Two separate organisations are doing the same thing.*
- *Even by the standards of the generally neglected carer population, the carers of problem drinkers are particularly neglected and under-resourced.*
- *Need clarity in relation to domestic abuse cases.*
- *Carers are completely forgotten people who are often excluded for 'confidentiality' reasons.*
- *Children are a particular issue - need support to break the cycle.*
- *There is excellent service provision though many carers refuse it.*

9.3 Which carers seek help?

A marked imbalance was identified in the demographic make-up of the carers seen by services. The overwhelming majority of carers seeking help are female partners, the next biggest group is parents. Male partners are rarely seen: both neighbours and children are more frequently seen than male partners. The way the question is

framed means that it is impossible to say that this represents an unmet need but it is certainly an area that merits further exploration.

The group of informal carers you are most likely to meet are:

Wives / female partners of a drinker	48.97% (71)
Husbands / male partners of a drinker	4.14% (6)
Children of a drinker	4.83% (7)
Parents of a drinker	22.76% (33)
Neighbours / friends of a drinker	8.97% (13)
Other	10.34% (15)

9.3 Improving the response to carers

No clear message emerged about the approaches needed to help carers. Support groups had the highest score but interestingly, *more information on the physical and psychological impact of alcohol* received the second highest level of support.

What would help to improve the response available to carers in your area?

One to one interventions	35.17% (51)
Support groups	49.66% (72)
Outreach	35.86% (52)
Respite	32.41% (47)
Out of hours support	38.62% (56)
Harm reduction materials and techniques	33.79% (49)
More information on the physical and psychological impact of alcohol	42.07% (61)
Don't know	6.90% (10)

The comments supported these options or provided examples of local provision.

- *Most of the carers I encounter particularly want to know how they can help more effectively. They would therefore benefit particularly from training in the medical and psychiatric consequences of problem drinking.*
- *Carers are being asked to do more and more: monitor medication, withdrawal symptoms and physical health without training.*

9.4 Is Al-Anon sufficiently promoted?

Al-Anon, the mutual aid group for the family members of drinkers, is the oldest and single most widely available option for this group of needs. However, it is interesting to

see that 50% of respondents did not feel that there was sufficient use of Al-Anon. Given that it is a free resource this is somewhat surprising.

Is Al-Anon sufficiently promoted and used in your area?

Yes	28.97% (42)
No	49.66% (72)
Don't know	21.38% (31)

The comments highlighted that in some cases this is because of the lack of local groups; however, in others a lack of promotion was identified:

- *Again very little signposting.*
- *Somewhat, although it could be promoted better.*
- *We have recently produced a specific mutual aid leaflet to support this.*
- *Could do with more promotion but possibly the group itself is not sufficiently well functioning and could do with some boosting.*
- *Unsure if all staff are aware of their existence.*
- *We promote Al-anon and carers who have used our service have accessed with success. However, and this is not a criticism of Al-anon, experiences of carers who have used our local group have not been positive. One carer recently was reprimanded for "giving others hope" which affected her mental health significantly as it was a big step for her to go there. A large majority of other carers who I know have attended did not find it helpful as they found that the people attending had been attending for years and that they had not moved on in their own lives which is in contradiction to the service model we offer. This is not to say that this will be the experience across the country.*

9.5 Are carers involved in planning the local care pathway for problem drinkers?

It is probably unsurprising that a large majority of respondents felt that carers were not sufficiently involved in planning local care pathways.

Are carers sufficiently involved in planning the local care pathway for problem drinkers?

Yes	13.79% (20)
No	56.55% (82)
Don't know	29.66% (43)

The comments reflected this while giving some examples of good practice.

- *Dedicated carer involvement coordinator post (part time) who contributes to commissioning processes.*
- *They are somewhat involved but not nearly enough.*
- *Where possible. Constraints around consent.*
- *Carer Involvement Coordinator attached to substance misuse peer support organisation.*
- *A group that have been overlooked and now need to be cared for.*
- *Substance misuse services could sometimes be said to fit the client to their pathways rather than the other way round.*
- *New service for alcohol and drugs is currently being designed. Family is a considerable part of the considerations.*
- *Staff involve carers in detox.*
- *Although we have done very little around alcohol pathways - this work is about to commence in the new year and we will involve carers.*
- *The forum exists but there is difficulty in recruiting and insufficient promotion of the opportunity.*
- *They have had the opportunity to be involved in co-production events, and we have encouraged their attendance. Commissioners have also met with Concerned Others.*
- *There is need for improvement.*

9.6 Specific pathways

Questions were asked about two specific pathways for family members: Family therapy and carers' assessments.

Family therapy was only available in 14% of respondents' areas.

Is there sufficient access to family therapy for problem drinkers and their families in your area?

Yes	14.48% (21)
No	57.93% (84)
Don't know	27.59% (40)

The comments below highlight examples of interesting practice. Other comments reiterated the message in the quantitative data.

- *Commissioners can fund access to a residential family group.*
- *Mediation for some families has been identified as a way forward - however this is costly and therefore not always doable. Besides this, the local carers service is now working in partnership with Evolve and has developed new family workshops for families (carers and cared for) - these have had some extremely positive outcomes.*
- *The local rehab provides a Family Support Group but it is not enough and not funded by the local DAAT.*
- *Not sure this is the way forward. Network treatment is best, for example Social behaviour and Network Therapy.*
- *We offer support however it is currently funded by charitable organisations.*
- *The carers' service employs a number of family intervention workers and is looking to develop their staff to be able deliver family therapy.*

Access to a carer's assessment is a statutory right in certain cases. It is, therefore, surprising that only 43% of respondents felt carers could access these.

Are the carers of drinkers able to access carers' assessments?

Yes	42.76% (62)
No	24.14% (35)
Don't know	33.10% (48)

The comments below again highlight interesting practice:

- *We can access a generic carers' assessment but this may not meet the particular needs of carers of those with substance misuse problems, therefore working with the local authority to develop a substance misuse specific assessment - following the implementation of new Care Act requirements.*
- *We provide this as we have been given delegated responsibility from the local authority in exchange for a relatively small grant.*
- *Only if the drinker is in secondary care.*
- *They are able to access one but not many know about it. Some practitioners actually disapprove of it and feel it constrains their practice. I welcome it as these are the people in the front line not me.*
- *They can access assessments but very few are offered or taken up.*

- *Only patients who fall within the secondary care sphere and have a care co-ordinator can access support. Generally community teams would not manage those who have a primary diagnosis of alcohol so their carers cannot access this facility due to current commissioning.*
- *No service users have stated this as far as I know, one volunteer stated she had filled the assessment form in herself with no involvement whereas the cared for's assessment was really good.*
- *We use the term 'Concerned Other' rather than 'carer' because they tend not to fulfil a traditional caring role unless the substance user has additional needs or has deteriorated through substance use to the stage that they need more traditional help. In general, our client group are impacted by substance use, and the actions / behaviours of the user. In many cases the user does not identify the family member/ friend as a carer - there may have been a complete relationship breakdown. The use of the term 'carer' is therefore a misnomer in many cases, but the family member / friend is still struggling to manage/cope with the impact of their loved one's use. A carers' assessment would be largely ineffective if the Concerned Other isn't providing practical support.*

10. Professional training and development

10.1 Overview

Throughout the research, questions were asked about professional training and development. This section focuses on the training needs of staff in specialist alcohol services, including service users. It also considers the question of national accreditation.

A common theme in the interviews and workshops was a perception that staff now had insufficient skills to deal with the complexity of service users being presented.

- *The staff are inadequately trained to deal with the physical disease, mental health and complexity of service users. There are large gaps in knowledge. It's not their fault, they try and do their best. Their knowledge is rudimentary at best.⁷⁷*
- *Less staff, with less skills and less resources.⁷⁸*
- *We are seeing a move away from medical skills. But all workers need to have some kind of certification.⁷⁹*
- *Specialist staff are leaving.⁸⁰*
- *Too many short term contracts are being given and there are too many*

unqualified staff.

- *Non-specialist staff need up-skilling. The generic staff are the secret to IBA and they need some more support. Early intervention saves money and lives.⁸²*
- *Professional training – I'm not sure about this - it is harder to recruit nurses because we have a non-statutory provider.⁸³*
- *Can non-statutory services take student nurses to develop the workforce of the future?⁸⁴*

10.2 Has training and professional development improved or worsened?

Only 19% of respondents felt that professional training and development had worsened recently. 26% felt it had improved and 36% felt it had stayed the same.

Has training and professional development for specialist alcohol workers improved or worsened in your area over the last three years?

Improved	25.99% (46)
Worsened	18.64% (33)
Stayed the same	35.59% (63)
Don't know	19.77% (35)

The comments generally reflect this pattern with a mixture of concerns about budget cuts but also a range of positive practice:

- *With the fragmentation and broadening out of services there has been a loss of specialist knowledge at the top end, i.e. in specialist workers with extended clinical knowledge, expertise and experience. In a sense the organisational memory has been lost and this will have to be rebuilt from the bottom.*
- *Set up an Alcohol Strategy Group to look at training needs and share good practice across the specialist services within our Trust.*
- *It is almost impossible to find training and professional development for alcohol workers that is: within reasonable travelling distance, at a cost within our training budget and achievable while working full time! Also, it is difficult to distinguish between those courses which will have real value and are accredited in some way and others which may turn out to be a waste of time and money.*
- *Nothing like enough time is spent on continuing or even start up training.*

- *The online training offered has made it possible for more people to access the training within all departments, especially the IBA for Alcohol.*
- *Reprocurement exercise resulted in services for alcohol treatment being extended countywide with loss of former resources and expertise.*
- *Community providers are using more volunteers or peer supporters, who are not as well trained, to cut costs.*

10.3 Accreditation

Respondents were asked whether the field had an adequate qualification and accreditation framework. In the context of this survey this question had a strong and consistent response. 55% of the respondents felt there was an insufficient qualification and accreditation framework for staff. Only 16% felt a sufficient framework existed.

Does the alcohol field offer sufficient qualification and accreditation frameworks to staff?

Yes	15.82% (28)
No	55.37% (98)
Don't know	28.81% (51)

The comments reflect a real enthusiasm for the structured development of professional training:

- *Workers in the alcohol field are scattered geographically, come from a number of professional backgrounds, and may work in a range of settings. Those in public health may have little understanding of what goes on in the hospital setting and vice versa. It is therefore important to plan for and facilitate multidisciplinary team working and this should include quality training and accreditation at a range of levels.*
- *There is a lack of workforce development strategy and professional registration for alcohol (and drug) workers.*
- *Limited qualifications available.*
- *I guess it depends who you work for, but our organisation provides sufficient qualifications.*
- *The new course is coming on board run by the Royal College of General Practitioners (RCGP) which is helpful.*
- *There needs to be easy access to training online that is...nationally recognised.*

- *No. It seems that anyone can become a drugs (or alcohol) worker after 6 weeks 'training'.*
- *There should also be accreditation programmes for non-specialists seeking to enhance their knowledge of working with these people.*
- *Given the magnitude and severity of the issues that alcohol use can have it is surprising and disappointing that the work does not seem to attract the same interest, funding and education as other social and health issues.*

10.4 Training needs

The research explored the areas of potential training which needed development. Separate questions were asked about the need for training on different professional “techniques”, for instance assessment and different service user group needs.

Working with treatment resistant service users and the mental health needs of drinkers were priorities for training. This reflects the views emerging in the rest of this process. The third placed need was more training on the physical health needs of drinkers: also a repeated theme within this study.

The other suggested themes were evenly spread with the exception of group work and the use of mutual aid groups which were seen as being of low importance.

What areas of training / professional development require the most attention?

Assessment	43.45% (63)
Advice and information	30.34% (44)
Care planning	40.69% (59)
One to one interventions	39.31% (57)
Motivational interventions	44.14% (64)
Safeguarding children	40.00% (58)
Safeguarding adults	39.31% (57)
Harm reduction	37.24% (54)
Working with treatment resistant clients	73.10% (106)
Group work	19.31% (28)
Physical health needs of drinkers	48.28% (70)
Mental health needs of drinkers	67.59% (98)
Medical interventions	31.03% (45)
The recovery agenda	31.72% (46)
Use of mutual aid groups like AA / SMART	23.45% (34)

The comments offered other potential training themes:

- *Integration of alcohol treatment into generic health care settings.*
- *The use of supervision.*
- *Risk management.*
- *Management of severe withdrawal syndromes. Management of community detoxification programs.*
- *Enhanced psychosocial interventions.*
- *Some attention on case recording (by practitioners).*
- *Training in working with other agencies as the most chaotic clients can't be assessed and treated by one agency in isolation.*
- *Most workers unable to do an assessment without a form in front of them. The art of a decent verbal assessment is being lost.*
- *Maternal medical needs.*
- *Awareness/ promotion of specialist, residential facilities for serious alcohol -dependant clients.*
- *Mindfulness based programmes that aid relapse prevention.*
- *Holistic care.*

The respondents were asked which specific service user groups they might need more training on. The answers reflect those in the previous question and in other parts of this research.

On working with which of these groups is training most required?

Carers	48.97% (71)
Women	31.72% (46)
Young people	37.93% (55)
Older people	45.52% (66)
People from non-White British communities	30.34% (44)
People with mental health problems	62.07% (90)
People with alcohol related dementia	51.03% (74)
People with learning disabilities	40.00% (58)
People who are treatment resistant	68.28% (99)

Other suggested training needs included:

- *People from the gay and lesbian community.*
- *Those who are at their end of life, this is an increasing occurrence and we need to develop the palliative approach with this group.*
- *People with quadri-morbidity - the co-morbidities of drugs, alcohol, mental health problems and physical health problems.*
- *People with Traumatic Brain Injury, personality disorder or other forms of cognitive impairment and who also have a substance misuse problem are often denied access to services because they are deemed untreatable (or just difficult).*
- *People with chronic physical health problems as a result of their alcohol misuse.*
- *Clients in domestically violent relationships.*
- *EU Communities.*

10.5 Are service users involved in training?

The survey asked whether service users are sufficiently involved in training and professional development locally. The message was clearly negative: only 15% felt that this was the case.

Are users sufficiently involved in training and professional development in your area?

Yes	15.17% (22)
No	53.79% (78)
Don't know	31.03% (45)

The comments reflected, however, that there is activity and interest in this area.

- *Recovery Academy in our trust offer courses to users and carers.*
- *Active Service User involvement organisation in place which is separate from treatment services. Service Users can also volunteer/mentor with treatment services.*
- *We are currently trying to put together some training packages.*
- *We have supported service users to take their knowledge out.*
- *I know that services users are involved in training/development but can't say with regards to alcohol services in general.*

- *Active Service User involvement organisations (within and external to treatment services) available*
- *Little credit given to people being in recovery.*
- *Little discussion happening with users.*
- *Users believe what they hear from others and use bias to confirm their beliefs that they are not vulnerable. More efforts need to be made to educate and dispel old ways of thinking.*
- *It is always helpful to involve more service users to explain their experiences.*
- *Not aware they are involved in any training.*
- *Service Users are consulted on all training.*
- *We frequently work in partnership with service users and carers to plan and deliver training and professional development.*

10.6 The development of professional skills

Professional development pathways for users and carers were seen as inadequate by the majority of respondents.

Is there an adequate training and development pathway to help service users and carers develop professional skills?

Yes	23.45% (34)
No	54.48% (79)
Don't know	22.07% (32)

The comments reflected a desire to improve this situation:

- *In our agency, we have developed pathways including bespoke OCN qualifications for people to progress.*
- *As a service we are working on this.*
- *Carers have training and development opportunities within the local carers' service but not sure about any other pathways?*
- *We have peer support for our volunteers and peer mentors can access our core training.*
- *I think that service users and carers should think very carefully before they embark on a course of professional training.*

- *I do not think this has ever been considered.*
- *Carers should have more involvement in the whole process.*
- *More clients would like the opportunity during and once they have recovered to share their experience to better others' recovery journeys and continue the line of support they felt they had.*
- *We are reviewing this.*

11. Clinical governance

11.1 Overview

This final section of research data considers a range of topics related to clinical governance and quality assurance including:

- The use of NICE guidance
- Alcohol death reviews
- Research
- Information sharing.

11.2 Clinical governance arrangements in alcohol services

The general view was that there were good clinical governance arrangements in local services. Only 13% took the opposite view.

Are clinical governance arrangements in alcohol services robust?

Yes	48.09% (88)
No	13.11% (24)
Don't know	38.80% (71)

Comments were few and generally positive, with some exceptions:

- *Safeguarding and clinical governance are both areas that have seen dips in performance post-new provider coming in to deliver the service. This is improving now the service has bedded in.*
- *The provider seems to be quite on top of this but we are currently reviewing these arrangements.*

- *Certainly within the NHS based services, I am less sure about the non-statutory sectors.*
- *Very good service with clear direction and robust management arrangements and support to staff.*
- *Longstanding and effective.*
- *Improved since becoming local authority responsibility as lawyers are cautious.*

11.3 NICE guidance

The majority felt that NICE guidance was embedded in service delivery at the local level.

Is NICE guidance on alcohol treatment and care embedded in local services?

Yes	54.64% (100)
No	13.11% (24)
Don't know	32.24% (59)

Few comments were made on this and despite the positive survey response they tended to be negative:

- *Never seen any guidance available.*
- *Do commissioners know about its existence and how it should be used?*
- *We are currently conducting an exercise to map the NICE quality standards on alcohol dependence and harmful use of alcohol and it is hoped that this will be finished by the end of the year. Although this is not finished, it does appear that NICE guidance is well embedded.*
- *We have cases of non Care Quality Commission (CQC) registered services being approached to try and save money.*
- *It is developing especially in light of recent Nalmefene guidance.*
- *Patchy in areas.*
- *Our provider is expected to do this but we do not check this in detail.*
- *In the clinical sense, not in a more frontline way, it will be used either as an aid when required or ignored if funding may be needed.*
- *We need to audit this more. We are working on a quality schedule which should help.*

- *Mostly - often reminded "it is only guidance".*

11.4 Alcohol death review processes

As with the NICE guidance and the general clinical governance arrangements, there was a view that lessons were being learned from serious incident review processes.

Are efforts being made to learn about the care of problem drinkers through serious incident review processes?

Yes	48.63% (89)
No	12.02% (22)
Don't know	39.34% (72)

However, the comments suggest that these may be either internal processes for services or more drug focused. This could be an area for further work.

- *We have a Domestic Homicide Review process led by community safety, and the alcohol commissioner is not involved, but everything else is hit and miss.*
- *The service provider meets regularly to discuss these and our governance lead is now involved in these discussions.*
- *As above, yes within the NHS.*
- *But the new providers are sharing these reports with commissioners and reflecting on practice so we can expect to see an improvement in more outcomes in the future.*
- *Our Clinical Governance Group led by the Clinical Director review all Serious and Untoward Incidents and feed learning back into service improvement.*
- *We have a drug related deaths panel but I am unclear whether they focus on alcohol too.*
- *None evident.*
- *An interesting question - we have not been involved if this is the case.*
- *We commit as much time to alcohol related deaths meeting quarterly bringing partners together to review.*
- *This happens but the process needs strengthening.*

- *We have done this very robustly in the past but do not do this as routinely as we should pan-system at the moment; this is still being done within clinical settings.*
- *I think this is an area that could be improved and with integrated services might improve.*

11.5 Information sharing

A larger group than in the previous clinical governance questions, i.e. 21% of respondents, felt that information sharing arrangements were not in place in alcohol services. However, more than twice that number felt that arrangements were in place.

Are robust information sharing protocols in place in alcohol services?

Yes	47.54% (87)
No	21.31% (39)
Don't know	31.15% (57)

The survey also asked about whether information sharing worked in practice. Only 15% of respondents felt that there were information sharing arrangements in place with all agencies. 52% felt it was more variable and 13% felt they were not in place at all.

Does information sharing about service users work well between local alcohol services and non-specialist agencies?

Yes with all agencies	14.75% (27)
Yes but only with some agencies	51.91% (95)
No it does not work well	12.57% (23)
Don't know	20.77% (38)

The comments on both questions had a negative feel, highlighting gaps in communication:

- *Being a voluntary organisation we have never received information regarding protocols, guidance, referrals or even support groups available in this area.*
- *Constantly being reviewed.*
- *I don't think there are but I think people are starting to talk about this to avoid duplication of services and have a more efficient way of doing things.*

- *Different computer systems make it hard to share information.*
- *Suspect that not, information shared as part of previous relationships not protocol driven.*
- *Local alcohol service providers pulled out of information sharing agreements prior to re-tendering.*
- *Processes are there but in reality, we often work separately and do not share enough information.*
- *With some agencies yes with others no.*
- *In theory yes, but again we haven't monitored this.*
- *Big breakdown in communication with non-commissioned services.*
- *We are looking to improve information sharing as part of the re-commissioning process.*
- *Very good at sharing information with A&E and Police.*
- *We have developed a good process to address needs of street drinkers which involved information sharing.*

11.6 Research

A small majority felt there was insufficient research into effective interventions.

Is there sufficient research into effective interventions in the alcohol field?

Yes	32.41% (47)
No	38.62% (56)
Don't know	28.97% (42)

The comments provided a list of groups and issues which need more research. Older people and alcohol was mentioned as a need several times.

- *Research on the efficacy of interventions is strong. The weakness is in evaluation of care pathways and real life efficacy and utility in different health care settings.*
- *More needs to be done regarding elderly and alcohol.*
- *More research on effective interventions for women binge drinkers.*
- *The impact on children, young people and women.*

- *Treatment resistant, 'frequent flyers'. How to engage middle class professionals, and the young retired.*
- *Evidence based research on treatment of dual diagnosis.*
- *Too much research. We know what works - NOT DRINKING.*
- *There seems to have been a lot on the value of Cognitive Behavioural Therapy (CBT), Motivational Interviewing and IBAs although some recent findings seem to question their effectiveness. More research to clarify the uncertainty would be very helpful.*
- *More high quality studies are needed into all areas of alcohol treatment.*

One interviewee commented on the need to make better use of technology for example text services, Skype, smart watches, self-breathalyser readings.⁸⁵ However, perhaps surprisingly, this agenda was not pursued by others.

Another interviewee commented on the need to begin to talk about the new anti-social behaviour powers and explore the possibilities that these offer.⁸⁶

12. Discussion

The alcohol treatment system has been through great change in the last three years. Almost 70% of respondents reported that their local services had been recommissioned in that period.

Nothing in this research can prove that such a rate of change is “wrong” or harmful to service users, but it does raise questions about whether this churn is viable in the long-term. The recent PHE *Review of Drug and Alcohol Commissioning*⁸⁷ also commented on the level of recommissioning of services.

The researchers expected a consequent negative view of the state of alcohol services. However, this was not generally the case. This may be *history being written by the winners*: the commissioners and providers of current services have an interest in expressing a positive view. However, other explanations also exist.

Alcohol treatment appears to have benefited from joining with drug services and accessing the resources in the former pooled treatment budget. This has led to an increase in the resources available for alcohol services. The investment in alcohol hospital liaison has similarly increased the resources in the alcohol field. It is also separately clear from research conducted by Alcohol Concern into JSNAs⁸⁸ that alcohol is being given a priority by public health commissioners across the country.

It is interesting to note that the PHE Review also found a similar positive view. Many services working with drug users may perceive a worsening of provision but this is not the case with alcohol services.

In the workshops there were comments which suggest that linkages are breaking down between agencies because of the turnover in provision. Non-specialists may be uncertain about the local provider. In the course of this work it was possible to identify areas where people have had three services in the last four years and local non-specialists are naming a service that is now two providers out of date.

Views emerged about various problems with the tendering process itself. These suggested the need for a review of and guidance on how best to use tendering structures in the alcohol field so that the need for competition is balanced fairly with service users.

The workshops also identified a concern that agencies are being turned into competitors with a detrimental effect on care pathways. Previous providers may continue to run parts of the treatment system and may feel reluctant to share their proprietary material with a competitor.

A relatively positive view also prevailed regarding the internal operation of alcohol services, for instance waiting times, length of intervention, assessment and care planning as well as the range of interventions available. Again alcohol services are benefiting from the resources and targets that drove drug services. This picture is also confirmed by the 2014 PHE review of drug and alcohol commissioning. Public education/social marketing was identified as a gap but no great emphasis was placed on this theme.

The biggest negative among specific treatment modalities was access to residential services. Access to these resources is governed by local priorities and the picture does vary between areas. However, respondents highlighted many local authorities where access to residential services via community care funding was very hard to secure. This is ironic since access to such funding is the one part of the alcohol treatment pathway covered by a legal framework.

The other surprise in this area was the tension between the survey respondents and the interviewees about access to medications such as Antabuse and acamprosate. The survey suggested that these were widely available; the interviews gave a contrary message.

However, the strongest message has been the challenge of meeting the needs of more complex service users. These include:

- the dually diagnosed,
- people who are physically ill due to drinking,
- other more chaotic, treatment resistant service users, and
- Eastern European problem drinkers.

These four themes were repeated in the surveys, workshops and interviews all across the country. The most powerful of these was the failure to meet the needs of the dually diagnosed. National guidance on the management of this group was first published by the Department of Health in 2002.⁸⁹ NICE published further guidance on psychosis with coexisting substance misuse in 2011⁹⁰ However, the view was that the situation has not improved and may be worsening because budgets have been cut in mental health services, and because mental health services are now commissioned by a separate body (Clinical Commissioning Groups) from alcohol services (Public Health).

This represents a real blockage in the pathway of care for problem drinkers (and drug users), a blockage that cannot be easily resolved at the local level.

Concern was also expressed about Alcohol Related Brain Injury / Korsakoff's Syndrome. Fewer people raised this issue than mentioned dual diagnosis but a regular theme emerged about the lack of a clear pathway for this group. Again this is not an issue easily resolved at the local level.

This research cannot prove that the physical health of the service users of alcohol services is worsening. However, this was a widely held view in the research and one which ties in with national concerns about the rising rate of alcohol related liver disease.

This also links with a number of other concerns raised in this report: is professional training on alcohol-related physical harm adequate? Do carers understand the indicators of ill health? Is the re-commissioning of alcohol services and the pressure to reduce costs reducing the knowledge about physical ill-health? As reducing liver disease is a national outcome target, it can be argued that, work on this should be prioritised.

The needs of more chaotic service users embrace many of the themes already set out. They have higher rates of mental and physical health problems and because they are treatment resistant they can be missed in target driven re-commissioning structures. However, the feedback was clear that this is a priority group that requires attention. In

particular, outreach services were seen to require greater expansion.

The lack of focus on chaotic service users suggests two areas of strategic change:

- If Prochaska and Di Clemente's *cycle of change*⁹¹ is considered, it can be argued that the emphasis in the care pathway is placed heavily on the *action / maintenance* stages rather than *pre-contemplation and contemplation*. The comments about chaotic service users and outreach suggest a need to re-balance the cycle.
- Service user priorities may need to be determined more by level of risk than by diagnosis and readiness to change.

Comments on the needs of eastern European drinkers were widespread but also geographically varied. Whether it is an issue will depend on the local population. However, this was the single most frequently mentioned change in the alcohol field and one which is clearly presenting problems to local treatment providers.

A clear message emerged about the needs of carers / concerned others. This is seen as a group that receive too little help and would benefit from further support.

The impact of the recovery agenda on the alcohol field and the wider involvement of service users was explored in several parts of this research, for instance the attendance of service users at many of the workshops. In general the recovery agenda was widely seen as positive and efforts are being made to involve service users in various ways. The most obvious gap was that they are not being sufficiently involved in training for alcohol specialists.

In the last few years much effort has been invested in the training of non-specialist staff: particularly training in alcohol IBA. The importance of this was not challenged but respondents and interviewees were clear that far more work is required in this area. Alcohol IBA offers a real return on investment. However, this return requires frontline services to embed it in their practice. It is the latter that appears to be the shortfall. Commissioners need a means for deciding whether ongoing investment will deliver the predicted return and guidance on how to maximise the take-up of IBA.

Most commonly, concern was expressed about the challenge of engaging GPs and primary care.

Training in the alcohol field was an area that emerged as a priority, albeit not as urgent an issue as some of the other themes above. Respondents were generally in favour of a better system of training and accreditation and some agencies and areas identified good local training.

Nonetheless, the message emerged that a treatment system that faces frequent recommissioning will need a strong system of professional accreditation to ensure the maintenance of standards. In general respondents felt that more training and a system of professional accreditation is required. In particular training was required on the issues of treatment resistant drinkers, the dually diagnosed and physical health.

A more subtle theme to emerge is not simply the need to train staff but also to understand and capture what they do. Although much work has been done to capture competencies, for example via the Drug and Alcohol National Occupational Standards (DANOS), many of the techniques and approaches used by workers have never been captured, analysed or disseminated. This wealth of experience will be lost as workers move on. This is a particular concern in the context of regular agency change.

It is worth recording that the researchers were surprised at the absence of discussion around certain issues:

- The use of technology;
- The impact of the new anti-social behaviour powers which specifically address alcohol; and
- The impact of Foetal Alcohol Syndrome on adult clients of alcohol services.

These absences are simply noted.

What is not in doubt is the enthusiasm of the alcohol field to discuss the issues presented in this report. The number of responses to the surveys and the enthusiasm to be interviewed and involved in workshops were all testaments to the desire to have a voice on the future of alcohol services. A huge pool of expertise is waiting to be drawn on.

Underpinning all of these findings is a single theme which emerged in the interviews and group work: the need for more national guidance. The 2014 PHE review also acknowledged that more national support is needed. It will be hard and, perhaps more importantly, economically inefficient for local commissioners to separately find solutions to the national problems identified above such as the frequency of tendering, the needs of the dually diagnosed, professional training structures and the investment in IBA.

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