

Local alcohol treatment and recovery service commissioning practices and their perceived outcomes for service provision:

An in-depth exploration

July 2020

Key findings

- The commissioning of alcohol services is generally seen to be a rigorous and transparent process, but is also time-consuming and anxiety provoking
- Local authorities are under pressure to both meet efficiency savings requirements and to make improvements to their local alcohol service systems
- Common system developments include integration of different service types, redesign of treatment models, enhanced system co-ordination and increased opportunities for peer workers, however, the effect of these developments requires monitoring

Research team

Associate Professor Penny Buykx, University of Sheffield (UK), University of Newcastle (Australia)

Mr Andy Irving, ScHARR, University of Sheffield

Dr Lucy Gavens, Derbyshire County Council & University of Sheffield

Background and aims

Treatment for alcohol dependence, if delivered according to best practice, is effective and cost effective (Raistrick, Heather, & Godfrey, 2006). However, only about one in five people who could benefit from treatment actually receive it (PHE, 2018). In England, there are big differences between local authorities in how many people who are alcohol dependent are treated, and these differences between areas are longstanding (Brennan et al., 2016; Drummond et al., 2005).

Since 2013-14, each local authority in England has been responsible for making sure their own community have access to alcohol and drug services. Local authorities generally do not directly provide the services themselves. Instead they manage the process for 'buying' the services from another organisation. This process is generally known as 'commissioning' or 'procurement'. However, many local authorities have recently faced very heavy funding cuts which may have an impact on what services it is possible to afford.

Local policy-makers are interested in knowing how other areas address alcohol-related issues for their communities in order that they can learn from the experience of others (Gavens et al., 2017). Given both the existing differences between areas in alcohol service provision and current financial constraints, it is timely to investigate the range of approaches local authorities have recently taken to meet their responsibility to provide alcohol services, in order that these experiences can be shared.

The aim of this project was therefore to examine recent experience of alcohol service commissioning processes at a local authority level in five diverse localities.

We explored:

- Differences/similarities between areas in commissioning drivers and processes
- Stakeholder perceptions regarding the strengths and weaknesses of local commissioning processes with a focus on perception of outcomes for alcohol service provision
- Stakeholder perceptions regarding the wider alcohol service commissioning landscape including future risks and opportunities

Methods

Five local authorities from different areas of England were selected as in-depth case studies. They were chosen to include local authorities from different parts of England and with different levels of wealth and alcohol use. We asked people who had been involved in the most recent alcohol service commissioning process in their local authority to take part in an in-depth interview about their views of the process and its outcomes. In total we interviewed 32 people (between four and nine people per site). In addition to the interviews, we also looked at local documents such as reports about alcohol problems in each site, strategy documents and plans for what to include in service provision contracts.

Findings

Common issues

Although each local authority reported a unique set of challenges and considerations to be addressed during recent commissioning, common issues included:

- The need to make substantial savings
- The need to address under-representation of alcohol clients in treatment compared to the level of need in the community and/or compared to the number of people receiving treatment for other substances
- An existing lack of clear and effective 'pathways' into treatment
- The existing system being too complicated / wanting to create a co-ordinated system
- The need to ensure minimum standards of service provision
- A preference to improve engagement with family and hard to reach groups
- A preference to offer more to people in recovery

Commissioners reported consulting with a wide range of stakeholders during the commissioning process about what changes could or should be made to the local alcohol service system. This usually included sharing information about the anticipated size of the budget cuts and seeking input about how this could be managed.

Local approaches

Case study 1: 'Rellington' – Creating a single system

In this ethnically diverse city with high levels of deprivation, a key influence on the 2014/15 commissioning process was the need to streamline from multiple separate alcohol and drug providers into a single integrated system with a lead provider. The new system places greater emphasis on outreach, strengthening the recovery workforce and includes a shortened treatment model developed by the new provider. There have been some further modifications since implementation e.g. to address challenges of mobile working.

Case study 2: 'Frampton' – Improving accessibility via community outreach

Frampton's population is widely dispersed over a large area and the county has high levels of alcohol consumption and harm compared to the national average. Alcohol and drug services were combined in 2015, but there has since been three changes in provider, causing instability. To address perceived under-representation of alcohol clients, the focus of the most recent commissioning (2016/17) was strengthening pathways into treatment. This, along with budget cuts, is to be addressed by the new provider by closing some service buildings and instead co-locating with other community services across more sites.

Case study 3: 'Goughsborough' – Inspiring recovery

Goughsborough is a mixed rural-urban area. It was perceived that alcohol clients were underserved and at the same time substantial savings were required. For the 2014/15 commissioning round, the decision was made to combine alcohol and drug services

within a single 'rebranded' service and to adopt a 'recovery' focus emphasising factors to support this e.g. employment. This has been a challenging cultural shift for some but is generally seen to be the right direction for Goughsborough.

Case study 4: 'Sandley' – A client-centred, co-produced service system

This London borough has a diverse population, with areas of wealth and deprivation side by side. Previous service provision had arisen 'organically' and was disjointed. In 2017, commissioning drivers were to reduce duplication and take a coordinated approach to multiple needs. There was a commitment to the 'co-production' of the service model, although there were some challenges in providing the necessary training and support for this. Unusually, Sandley have committed to a contract of up to nine years.

Case study 5: 'Kelgate' – Making housing support workers recovery workers

This urban, coastal local authority is slightly worse than the national average in terms of alcohol consumption and harms. Alcohol and drug services had already been integrated following budget cuts in a previous commissioning round and so further ways to make savings were required for the 2016 commissioning. Stakeholder engagement focused on further possibilities for service integration with housing emerging as the preferred option. Stakeholders expressed concern that alcohol clients with less severe problems may now be less well served than previously.

Perceptions of commissioning processes

Generally, commissioning processes in all five sites were perceived to be rigorous, transparent and highly scrutinised. However, they were also seen as time-consuming for commissioners and service providers and potentially anxiety provoking for service providers and clients.

Common system developments

Common system developments arising from recent commissioning included:

- Integration of different services types, for example alcohol services being provided with other substance use or housing services
- Reconsidering the location of provision, for example, through greater outreach or co-location (sometimes alongside building closures)
- Redesigning treatment models, generally to streamline and/or to include a greater recovery or peer support component
- Reductions in staff numbers and/or review of staff roles
- Increased opportunities for peer workers
- Consolidation of service delivery to fewer providers with greater responsibility for system co-ordination

Perceptions of commissioning outcomes

Case study participants rarely described the outcomes of their recently commissioned alcohol service system in terms of routine indicators, recognising that before-and-after

comparisons may be complicated by funding cuts, fundamental changes to the service system and other factors. However, several qualitatively described aspects they perceived to have worked well or to have been a challenge in implementing the system and improving alcohol service delivery included:

- 1 Integration: Merging alcohol and drug misuse services was generally seen to deliver efficiency savings, but there were concerns alcohol clients may be reluctant to attend a combined service
- 2 Outreach: This approach was seen to potentially deliver efficiency savings (on fixed sites) and improve service accessibility; however, there had been challenges to implementation in those sites where outreach was a substantial feature of service delivery
- 3 Redesign of treatment models: This generally involved streamlining previous models of intervention, so that they were shorter, involved less intensive use of resources, and/or were more oriented towards recovery outcomes. It was not always clear what evidence source was used to underpin service treatment model redesign
- 4 Lead provider: In some cases, local authorities appointed a lead provider to not only develop a single system and co-ordinate client flow through it, but also to assume some of the responsibilities previously held by commissioners. This presented both advantages and disadvantages to the lead provider
- 5 Contract length: These varied from 3 to 9 years, with shorter contracts perceived to be less attractive due to overly-frequent recommissioning
- 6 Special groups: Service specifications for all sites revealed local priorities to support inclusion of families and hard to reach groups. However, interventions and progress in these areas were rarely mentioned during study interviews

Despite the scale of cuts faced by local authorities, there was often mutual recognition that stakeholders had worked together to develop their vision for a new service system and were committed to continuing to do so.

Wider commissioning landscape

Several commissioners felt it would be helpful if alcohol were more strongly reflected in national strategy documents as this would allow them to make stronger representations for local investment in this area. Joint commissioning (for example with Mental Health Trusts) was seen as a potential opportunity to strengthen provision for clients with more complex needs such as dual diagnosis.

Implications

Recent funding cuts to local authority substance misuse budgets are substantial. Commissioners are responding to these cuts by steering a course through both efficiency savings and system redesign. While some of the system changes implemented address the shortcomings of previous arrangements (for example, simplifying overly complicated systems, focussing on the development of recovery opportunities), many stakeholders are of the view that their community has reached the limit of funding cuts that can be absorbed without significant impacts upon the availability of services and client outcomes.

Integrated systems and lead provider arrangements are being adopted by several local authorities. It will be important to watch how these function and evolve. In particular, it is important to better understand whether perceptions of under-representation of alcohol clients in integrated systems are accurate, and if so whether efforts to strengthen referral pathways (for example, from hospital and primary care) are successful in addressing this.

Where lead providers are taking on commissioner-like responsibilities, they need to have the appropriate skills to manage a system, rather than an individual service. It will be important to better understand what proportion of total contract value is required to cover this role, what expertise and governance measures are required for service providers to adequately fulfil it, and how this could be assessed at bid stage.

The contribution of people with direct experience of service use as system planning stakeholders, peer workers, and in service monitoring is highly valued and increasingly sought. Supporting such participation requires planning and resources. It is also important to better understand the impact of different approaches to involvement on treatment uptake and outcomes.

Local authority alcohol service commissioners and other stakeholders appear to take into account multiple drivers and explore different options in the process of shaping their local service specification. Learning from the practice of other local authorities was a valued part of this process; however, opportunities for commissioners to have such conversations were variable.

Conclusions

Commissioning is a major exercise, placing considerable demands on council and service provider resources. Recent commissioning efforts, while directed towards improving service systems to meet the needs of local communities, were also largely concerned with mitigating the effects of substantial funding cuts.

Although commissioning was an opportunity to address known inefficiencies and duplication in the system, there is thought to be little or no room for further cost savings while maintaining current levels and quality of service provision. Common system developments include service integration, appointing a lead provider with greater oversight responsibility, streamlining treatment models, enhanced recovery options and increased involvement of people with direct experience of service use in system planning and service delivery.

There is some frustration regarding the lack of prioritisation of alcohol problems both nationally and locally given their connectedness to a range of other health, social and economic costs. Partnership working, for example, joint commissioning with Clinical Commissioning Groups is seen as offering potential to improve local systems.

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