

The hardest hit:

Addressing the crisis in alcohol treatment services

May 2018

Alcohol Concern



Introduction

Substance use treatment services in England are, it appears, facing a crisis. Recent reports by both the Advisory Council on the Misuse of Drugs and the Recovery Partnership have pointed to a range of problems, which threaten to push services 'beyond the tipping point'. These include swingeing cuts in funding, rapid re-tendering cycles, loss of qualified staff and lack of political support.¹

In an era of general and ongoing squeezing of public sector finances, there is the real danger that alcohol treatment services could come to be viewed as non-essential: that their critical role in helping to address the array of wider social problems associated with alcohol misuse could be overlooked. The evidence is clear: well-resourced and skilfully delivered alcohol treatment can play a decisive role in reducing alcohol harms.² According to Public Health England (PHE) estimates, every £1 invested in effective alcohol treatment brings a social return of £3.³ Viewing treatment services as inessential, therefore, risks both creating a false economy and damaging the lives of countless individuals, families and communities.

Alcohol is the most widely misused drug, and the effects of dependency are as devastating as for any illicit substance. The need for treatment is enormous, but the proportion of people who are actually accessing services remain small. PHE estimates that around 595,000 people in England alone are in need of specialist alcohol treatment. Around 200,000 children live in a household with a dependent carer.⁴ However, in 2016-7 just 80,454 people received treatment for alcohol

(with a further 28,242 receiving treatment for alcohol alongside another non-opiate substance). This represents only about 20% of those in need. More worryingly, and unlike the figure for drug treatment, this number has fallen by 12% in the last three years.⁵ This suggests there may be acute problems facing alcohol treatment, in addition to those faced by the substance misuse sector at large.

This report sets out the findings from a national survey of stakeholders involved in, and using, alcohol treatment services in England. It identifies a range of challenges: some common to substance use treatment more broadly, but others particular to alcohol. It highlights the urgent need for action to ensure that treatment services do not enter a vicious cycle of disinvestment, staff depletion, and reduced capacity. This report aims to focus attention on this issue and offer useful recommendations to save alcohol treatment services and improve the lives of hundreds of thousands of people.

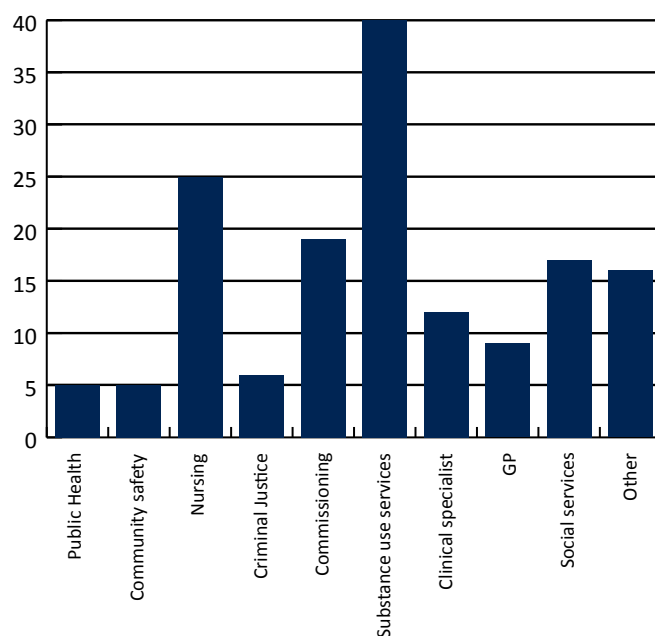
Methods

Between June and July 2017, stakeholders were invited to complete an online survey. The invitation was sent via the mailing list of the Alcohol Concern Consultancy and Training Unit, and recipients were invited to notify interested colleagues. 154 completed responses were received, representing individuals from an array of professional backgrounds as well as service users. In addition to closed question answers, over 1,200 open comments were submitted.

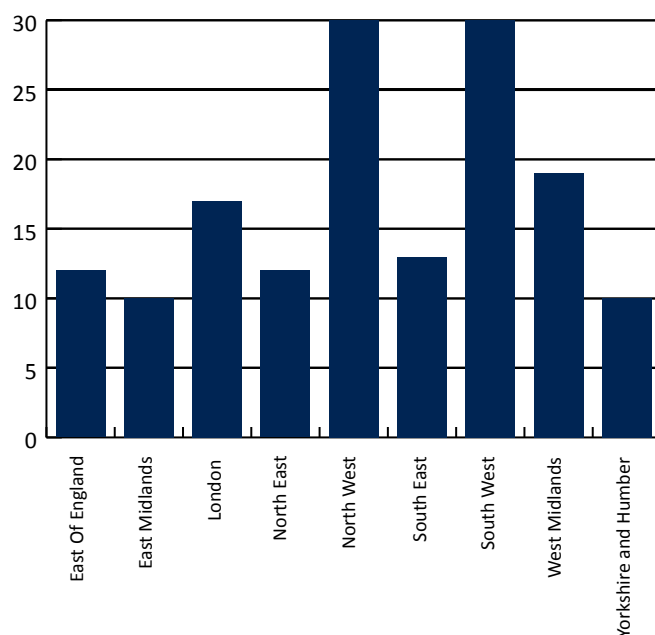
A further 40 telephone interviews were carried out by Mike Ward, a Senior Consultant at Alcohol Concern. Interviewees were sampled to represent a range of stakeholders.

Survey and interview results were analysed and thematically coded by staff at Alcohol Research UK and Alcohol Concern. Survey design and analysis was aided by the generous support of an external steering group (see Annex 1).

Survey respondents by profession



Survey respondents by region



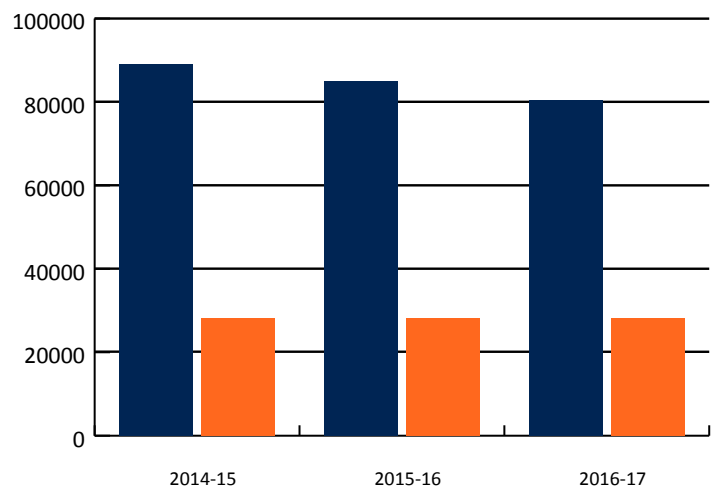
The report focused only on services in England, and only on those that are commissioned by local authorities through the Public Health Grant. This represents only a partial picture of the treatment landscape. The results inevitably reflect the views of those who opted to respond. In interpreting the results, we have sought not to draw conclusions that go beyond those contained in the survey and interview data. However, the breadth of the responses, and the alignment of our findings with those of previous comparable studies, suggests that what we present is a robust picture of experiences in alcohol treatment services today.

Background

In 2016 there were 7,327 deaths directly due to alcohol in England. These include deaths due to conditions such as alcoholic liver disease or alcohol-induced pancreatitis, which are usually associated with heavy drinking.⁶ Over the last forty years, UK liver disease rates have increased by around 250% - during which time they have fallen across much of the developed world.⁷

At a conservative estimate, about 1.4% of the population are dependent on alcohol and in need of specialist support.⁸ However, around 80% of dependent drinkers are not in contact with services.⁹

**Adults In Treatment
2014 - 2017**

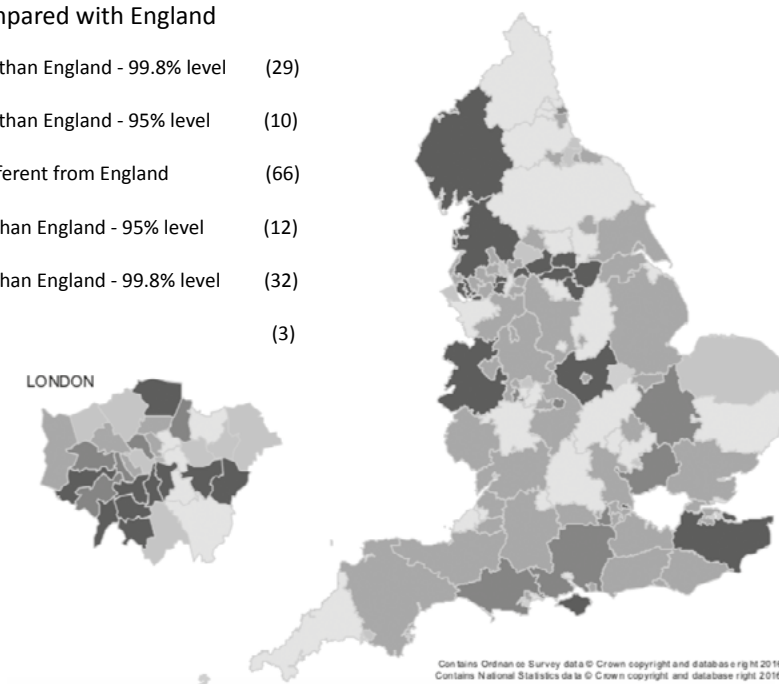


Furthermore, this varies geographically with many of the most deprived areas facing the highest levels of need, most acute gaps in provision, and poorest treatment outcomes.

Successful (6-month) treatment outcomes by upper tier local authority

Significance level compared with England

- Significantly higher than England - 99.8% level (29)
- Significantly higher than England - 95% level (10)
- Not significantly different from England (66)
- Significantly lower than England - 95% level (12)
- Significantly lower than England - 99.8% level (32)
- No Data (3)

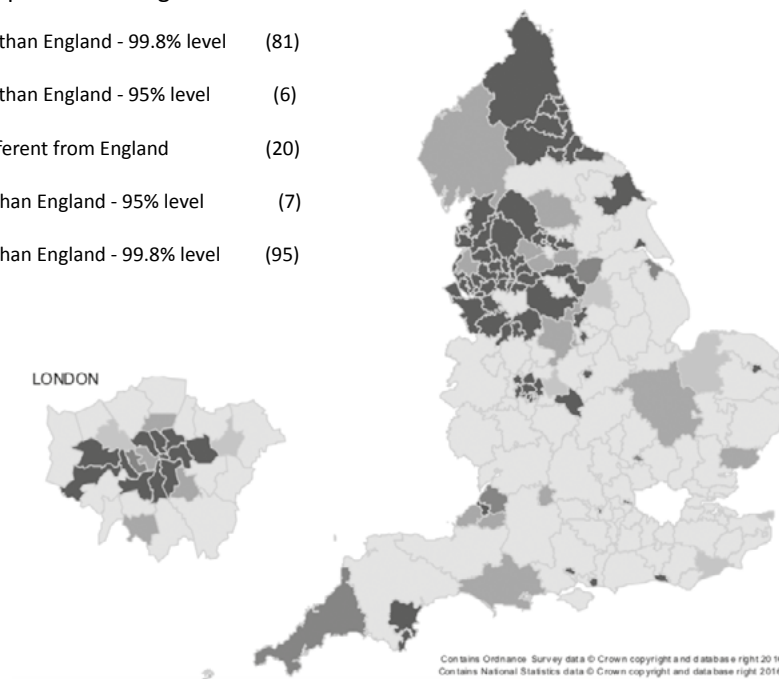


Alcohol-specific hospital admission by CCG area

Source: Public Health England¹⁰

Significance level compared with England

- Significantly higher than England - 99.8% level (81)
- Significantly higher than England - 95% level (6)
- Not significantly different from England (20)
- Significantly lower than England - 95% level (7)
- Significantly lower than England - 99.8% level (95)



Since 2013, commissioning for alcohol treatment in England has been overseen by local authority Public Health teams, with support from Public Health England. Funding is provided through a ring-fenced local authority public health grant, although drug and alcohol services are not protected within this larger fund.

However, from 2020, the public health ring-fence will be removed, and services will be funded through local business rate retention. This poses an additional risk to those areas of high need in which business rate income may be among the lowest. There are already enormous health inequalities in alcohol harm. Without the introduction of radical policies to address this, the shift to business rate funding seems likely to make these inequalities even more devastating. In 2007, the Centre for Social Justice proposed the introduction of a 'treatment tax' on alcohol to fund services.¹¹ In the current climate, it is time to consider this radical policy to prevent the emergence of a postcode lottery in which the poorest, more so than ever, are the hardest hit.

In 2016 total expenditure on alcohol, despite slight increases in the previous years, remained less than half that spent on drugs – a discrepancy reflected in the description by a number of our respondents of alcohol treatment as a 'Cinderella' service.¹² Furthermore, King's Fund analysis suggests that not only have recent increases stalled, but that they were concentrated in alcohol prevention programmes, and masked an estimated 14% reduction in expenditure on treatment from 2016-17.¹³

Unfortunately, assessing the precise scale of cuts is made more difficult because local authority data returns lack detail and are not always accurate: a problem also noted by the Advisory Council on the Misuse of Drugs.¹⁴ Again, given the very wide variations at the local level – and the impact of this on wider social inequalities – it is essential that more effective systems are put in place to monitor actual expenditure, and to map it against local need.

Given the relationship between harmful alcohol use and a range of wider social problems, and the cost-savings known to accrue from treatment, reducing provision is a false economy.¹⁵ Addressing this can both improve lives *and* reduce the real and the

social costs that are currently created when people fall through the net.

Since the publication of the *Alcohol Harm Reduction Strategy* for England in 2004, successive Government publications have set out the need for effective alcohol treatment. The Government's Alcohol Strategy (2012) stated:

It is vital that we provide effective treatment and recovery...Increasing effective treatment for dependent drinkers will offer the most immediate opportunity to reduce alcohol related admissions and to reduce NHS costs.¹⁶

The 2017 *Drug Strategy* also recognises the importance of alcohol treatment and calls for 'joined-up action on alcohol and drugs'.¹⁷ However, effective and well-integrated services require more than just encouragement: they need investment, effective commissioning systems and a well-trained, motivated workforce. Alcohol treatment also needs the focus and integration with wider prevention that can only come from a National Alcohol Strategy, which would consider the full range of approaches to alcohol harm reduction and would locate treatment in that context.

In setting out some of the key challenges, this report will help develop the focus needed to improve services which play a vital role across society.

Recommendation 1:

The Government develops and implements a National Alcohol Strategy that affirms the critical role alcohol treatment plays in reducing social harms and that outlines how treatment services fit within a broader suite of interventions to reduce alcohol harm.

Recommendation 2:

The Government urgently introduce new financial arrangements to plug the gap in treatment funding and reduce health inequalities arising from local funding structures. In doing so, they should consider the introduction of 'treatment tax': a small increase in alcohol duties earmarked to ensure that all local areas can meet their treatment needs.

Findings

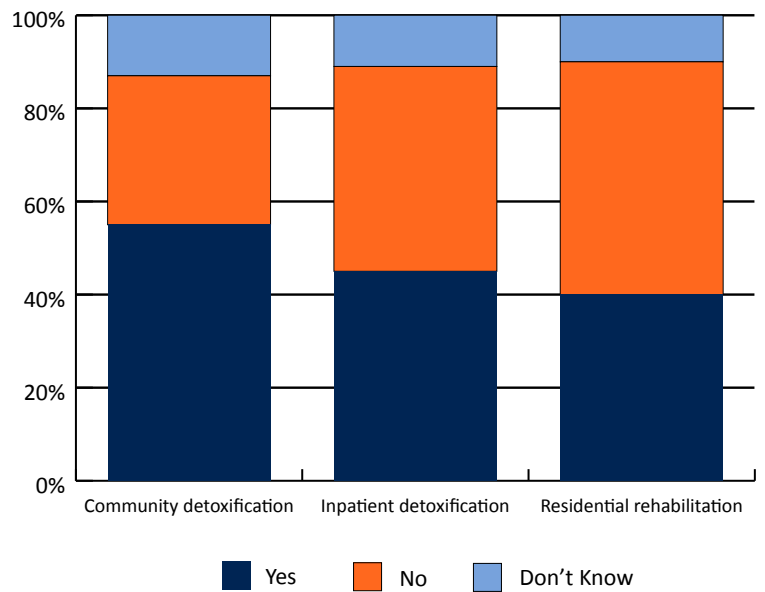
Funding and capacity of services

Lack of funding was, by far, the threat to service provision most commonly cited by our survey respondents. Only 12% of respondents felt resources were sufficient in their area, and comments revealed widespread frustration at the impact of lost funding on staff numbers, treatment capacity and workforce morale. Cuts of between 10% and 58% were reported, with knock-on effects for a range of critical services. Respondents talked of an ‘assault on funding’ (clinical specialist), ‘phenomenal’ workloads (service user), and ‘paring back to a skeleton service’ (treatment provider).

Impact on service availability

Reduced funding was seen as having an especially acute impact on particular types of service. Only 55% felt there was sufficient availability of community detoxification. The situation was worse for inpatient detoxification (45%) and residential rehabilitation (40%). In comments, respondents repeatedly said there was simply no money, especially for rehab services.

In your area, is there sufficient access to:



There were also concerns about the availability of community services, especially to individuals living in rural areas. Where service provision is consolidated into a single centre, it often creates difficulties for people who either lack transport or, because of complex needs, may miss appointments.

Difficulty in accessing services is, in some cases, severe and can have significant impacts:

I attended an appointment with a client who needed support and asked for help. The appointment was cancelled when we arrived, as the person doing the assessment had sought alternative employment. No apology [was given] ... I travelled 70+ miles to take the client to the appointment to ensure he attended. The client who consumes 45 units per day was devastated and immediately went and bought more alcohol. (Children's services provider)

Impact on community outreach

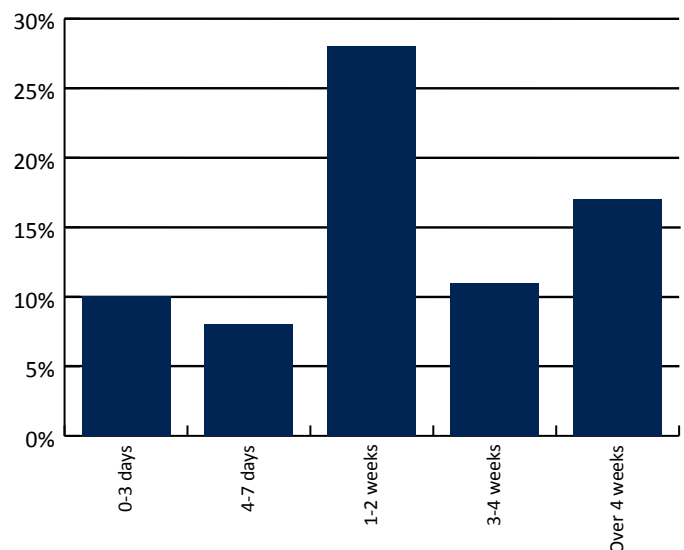
Community outreach plays a crucial role in supporting individuals with some of the most complex needs. However, it is expensive and potentially time-consuming. While 61% of respondents reported that there was outreach work in their area, a third went on to say the provision was limited or inadequate. This was clearly an area of work which, despite its importance (and the fact that it can contribute to significant savings in the long run), was becoming increasingly difficult to provide as cuts continued to bite.

Impact on delivery

59% of our respondents felt that aspects of services in their area had worsened in the last three years, with particular threats to community detox and residential rehabilitation facilities.

There was a mixed picture for waiting times. While 18% reported waiting times of less than a week, the majority were longer, with 17% over four weeks.

How long is the typical wait time in your area?



For some of the more complex clients, especially, delays between referral and accessing treatment were viewed as critical – often leading to lost opportunities to help people who had been identified as needing support.

Reductions in capacity have also led to a move away from one-to-one interventions to group work. Although group-based interventions can be powerful and effective, they should be driven by appropriateness to client needs, rather than by economic necessity. If access to one-to-one support is lost where needed, then this will impact negatively on clients for whom it is a necessary element of their treatment.

Recommendation 3:

The Government ensures that substance use treatment is a prescribed local public health activity and that systems are established to address potential inequalities in capacity following the transfer to business rate funding.

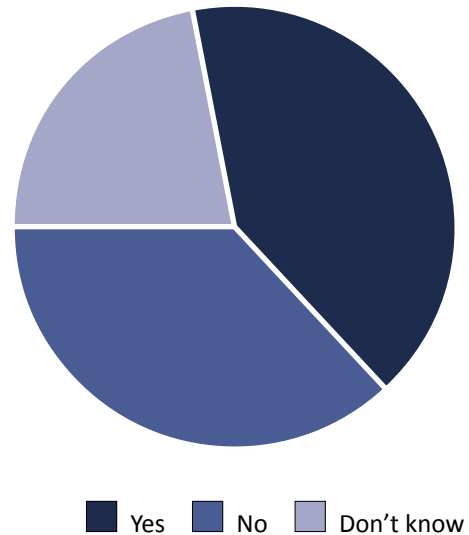
Recommendation 4:

The Ministry of Housing, Communities and Local Government work with Public Health England to establish effective systems for transparently monitoring the scale of ongoing investment.

Commissioning processes

Our findings presented a mixed picture regarding the quality of local commissioning for alcohol services.

Is the commissioning of alcohol services working well in your area?

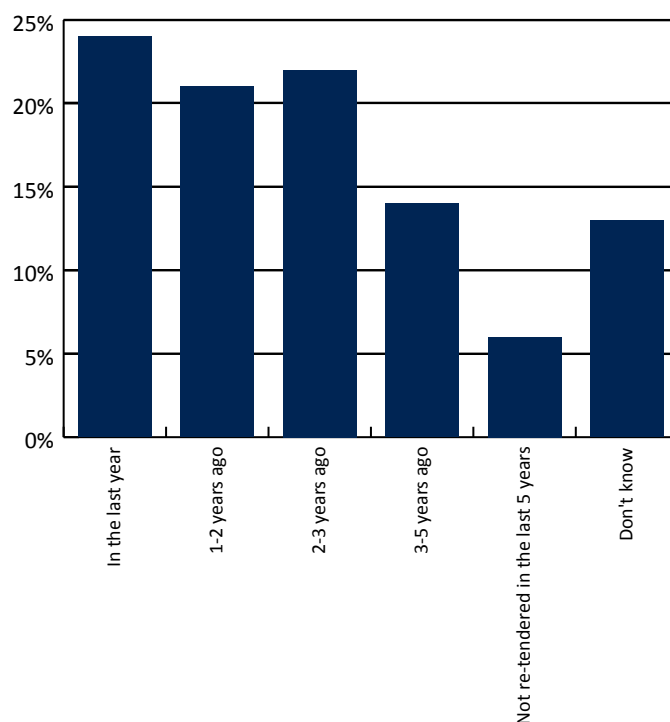


Only 41% of respondents said they felt commissioning was working well in their area, despite commissioners forming a significant proportion of our sample.¹⁸ Two key problems were identified: the speed of re-tendering cycles and the level of commissioning expertise.

Re-tendering cycles

We estimate that 44 out of 152 alcohol treatment services – about one third of the total – were recommissioned in 2017 alone.¹⁹ Previous analyses have shown even higher recommissioning rates of up to 57% in recent years.²⁰ 67% of respondents to our survey had seen their local treatment systems re-tendered in the last three years, and 26% had seen them re-tendered in the last year. 63% of respondents had seen a new local provider as a result of the tender.

When were alcohol treatment services in your area last tendered?



In their report on commissioning, the ACMD found that 62% of surveyed commissioners reported that re-commissioning was having a negative impact up to six months after new contracts had started, with almost a quarter still reporting negative impacts after two years.²¹ The experiences of our respondents were similar, with many reporting that short contract periods were disruptive and damaging to service delivery.

The commissioning process destabilises services. Staff become very uncertain. They are at risk of losing staff. (Treatment provider)

We need to stand still and reflect – a moratorium on this cyclical procurement. Look at the evidence base and ask whether what we have done has improved the quality of treatment. (Commissioner)

Government rightly calls for evidence-based interventions, yet no evidence exists that regular competitive tendering is delivering better, or even more cost-effective, services. As one interviewee observed: 'No correlation exists between cheaper services and better outcomes.'²²

Of course, any Government may choose to prioritise the reduction of costs over the improvement of outcomes. However, that does not appear to be a stated policy objective of this Government. While current commissioning systems have created an array of problems, we recognise that the solution will not be as simple as calling for longer cycles or returning to previous ways of doing things. Nevertheless, the consensus among our survey respondents and interviewees is that the current system is not working as it should and needs to be reviewed.

Recommendation 5:

An independent review of the commissioning of alcohol services is undertaken to ensure it delivers the safest, most effective and best value services.

Commissioning expertise

Moving responsibility for commissioning alcohol treatment into local authority Public Health was viewed as a positive development by some of our respondents. Local authorities have oversight for community safety, domestic abuse, licensing, anti-social behaviour, housing, and social care – all areas that impact upon problematic alcohol use. Clearly there are benefits from integrating this with oversight of alcohol interventions.²³

A review of commissioning in 2014 highlighted a widespread recognition of the need to better integrate alcohol treatment with other services, such as housing and criminal justice.²⁴ This was partly driven by a desire for efficiency, but also a recognition that alcohol problems can drive or exacerbate other social problems, and vice versa.

The move towards placing responsibility for alcohol misuse into public health teams has, however, created some unintended consequences. Combined with a reduction in commissioning capacity, many of our respondents reported that it had led to a dilution of expertise, with commissioners specialising in general public health rather than substance use treatment.²⁵

If we are not careful we can see alcohol diluted in the wider public health agenda. It is the perfect storm of the public health agenda alongside the local authority austerity agenda. (Commissioner)

The specialist commissioners are disappearing, and they are becoming more generic across the country. (Housing charity worker)

We are now more public health professionals rather than alcohol specialists. (Commissioner)

Portfolios are being widened. The big issue is expertise – you need some knowledge and experience to develop and commission services. (Service provider)

As services across the board face cuts, it is inevitable that the size of local commissioning teams will shrink. While this may be an unfortunate consequence of austerity, it should not result in a draining of expertise away from treatment commissioning altogether. Treatment services play a vital role in any community, and it is as important that they are commissioned well as that they have adequate funding. Steps are being made to support commissioners with improved data services.²⁶ However, the clear message from our research is that more needs to be done to promote the specialist skills needed to carry out the full roles of quality commissioning.

Recommendation 6:

Local authorities must ensure that those staff members who are responsible for commissioning substance use services have the required level of in-depth skills, expertise and knowledge to commission these services well.

Merger of drug and alcohol services

The merging of drug and alcohol services has become standard practice in many areas. Indeed, only one participant area reported that the two services were still delivered separately. There are good reasons for merging drug and alcohol services: as a number of participants noted, there is a degree of crossover in terms of treatment as well as use. Merging services not only allows for efficiencies, it highlights the fact that alcohol is a drug of dependence as much as an illicit substance.

Nevertheless, merging services was viewed by many respondents as creating a number of critical, unintended consequences. In particular, many felt that the co-location of drug and alcohol services could deter alcohol users, especially older drinkers, from attending.

I think it has been negative for older people who are reluctant to change, to engage in drug service waiting rooms. The waiting rooms can be intimidating. (Nurse)

A number of respondents used the phrase 'Cinderella service' to describe alcohol treatment in relation to drug services. For some, the merger represented an opportunity to increase the proportion of funding that went into alcohol services, thereby addressing a long-standing skew in funding which meant the large majority of money went towards substances which, in overall numbers, were used by far fewer people. However, others expressed concern that the merger would only exacerbate alcohol's 'Cinderella' status: diluting the particular skills and approaches appropriate to alcohol treatment, while making the service less attractive to those clients who felt, for whatever reason, that they did not belong in an environment that was geared towards supporting people dependent on illicit drugs.

The impact of merging services on the experiences of alcohol-only clients has not been tested robustly. However, it is plausible

that it has contributed to the marked fall in the number of 'alcohol-only' clients accessing treatment in the last few years. If so, then this is a serious issue which needs to be reviewed, and for commissioning policy needs to be developed in ways that ensure the trend is reversed.

Recommendation 7:

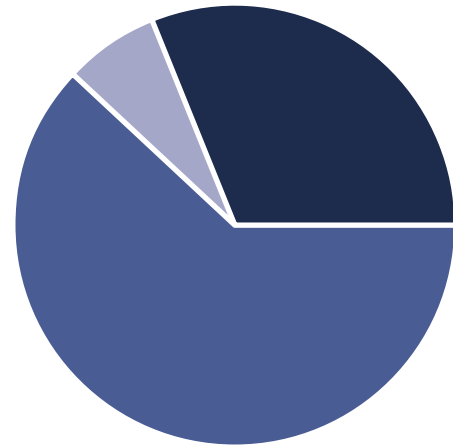
Public Health England should carry out a review into the reasons behind the recent decline in alcohol-only treatment access, consider whether the merger of services is a significant factor, and take appropriate action if it is.

Drinkers with complex needs

The problem of how to support dependent drinkers who also experience mental health problems is one that has dogged treatment provision for years. Despite guidance and support from NICE, PHE and other key agencies, recent evidence confirms that people with some of the most severe needs continue to fall through the gaps.²⁷

This problem emerged clearly in our research. Only one third of participants felt there was sufficient provision for people with co-occurring alcohol and mental health issues in their area.

Are there appropriate care pathways for people with both a mental health and an alcohol problem?



■ Yes ■ No ■ Don't know

Despite years of effort to develop better guidance, some of the most vulnerable people continue to be cast adrift.

[The Community Mental Health Trust] allegedly have a zero-tolerance approach to alcohol abusers. (Service provider)

Clients are consistently told they need to resolve the drinking before being able to access mental health services. (Service provider)

Clients still get passed from one service to another. (Nurse)

However, the problem is larger than just the failure of mental health and treatment services to effectively coordinate their activity – critical as this is.²⁸ Inadequacies in community outreach, especially the kind of 'assertive outreach' that targets the most

vulnerable, also means people with complex needs are often left abandoned. Participants pointed to problems in housing provision, which meant that homelessness was not tackled – something which, in many cases, creates an enormous barrier to recovery. Some also reported that GPs struggled to deal with complex or chaotic clients effectively: one service user commented that GPs 'looked down their nose' at very problematic drinkers.

Our survey responses also highlighted a clear training gap in regard to workers (such as probation or ambulance services) who encounter 'high impact, high need' drinkers, but do not have the specialist skills to deal with them. 84% of our respondents felt better training was needed for 'non-specialist' workers, in order to promote a more joined-up approach to dealing with this particular group.

Recommendation 8:

Local authorities must ensure that staff from non-specialist services are well trained in how to work with heavy drinking and alcohol dependent clients.

Recommendation 9:

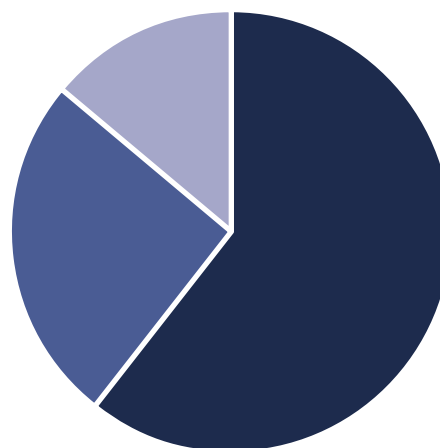
Better guidance must be developed to support the effective implementation of solutions to problems around the relationship between alcohol misuse and mental health.

Outreach services

Referral issues were highlighted as a particular problem when trying to support people who have complex needs. In many cases, the gap between referral and engagement with alcohol treatment was the critical stage at which complex clients were lost. It is not enough to simply identify an individual as needing treatment and pointing that person to a service; the challenge is to positively engage those individuals, reach out to them, and actively support them right through the alcohol treatment process.

61% of our respondents reported that there were outreach services of some kind in their community. However, of those who did report outreach was available, 39% said the provision was inadequate or had recently been reduced.

Is there outreach to engage and work with dependent drinkers in home or community settings?



■ Yes ■ No ■ Don't know

The most complex and chaotic drinkers are small in number in any given community, but they often create a disproportionate cost to that community. Because they fall through the gaps, they will often frequently attend A&E departments, be picked up by ambulances, or be arrested.

I tried to get support for a chronic alcoholic and was told he was known to the alcohol service but did not engage last time and due to this there seemed to be a reluctance to offer support again. (Social worker)

People have to attend fixed appointments and induction groups before being able to access treatment – this is unrealistic for people who are less motivated or have complex needs. (Clinician)

The alcohol field needs to turn current addictions model upside down and concentrate on the people who do not engage with services. (Commissioner)

As initiatives such as Blue Light and Making Every Adult Matter have shown, patient wraparound support for these individuals not only improves their lives but also the wellbeing of the wider community – and with savings that far outweigh the costs.²⁹ Our research, however, suggests there is still a very long way to go before commissioners and service providers grasp the value of concerted action with this group.

Recommendation 10:

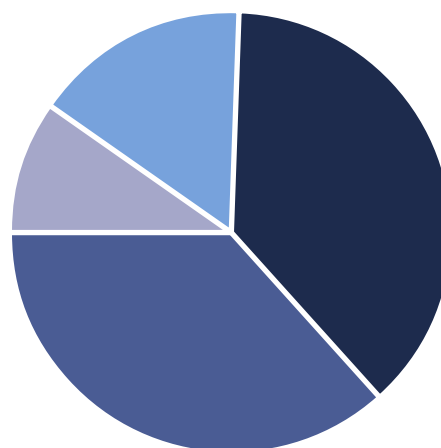
Commissioners must design and commission ‘assertive outreach’ services and other approaches that bridge the gap between identification and treatment, particularly among high need, high impact drinkers.

Integration between treatment services and health care

It is vitally important that there is a good relationship between alcohol treatment services on the one hand and primary and secondary health care on the other. Both GPs and hospitals are key to the identification of drinkers in need of treatment and their referral on to appropriate services. While some problems in GP's referrals were identified, the role of alcohol liaison teams in hospitals, which provide specialist support in hospital settings, was viewed very positively.

However, while most survey respondents said that alcohol liaison teams, or individual nurses, were available in their local hospitals, only 38% felt the provision was adequate. Among those who had good provision, the service was widely praised, but many respondents reported that staffing numbers were being cut and that there was a decline in the capacity of these teams, hampering their ability to provide the effective interventions for which they are recognised.

How would you describe the availability of specialist alcohol liaison nursing in your area?



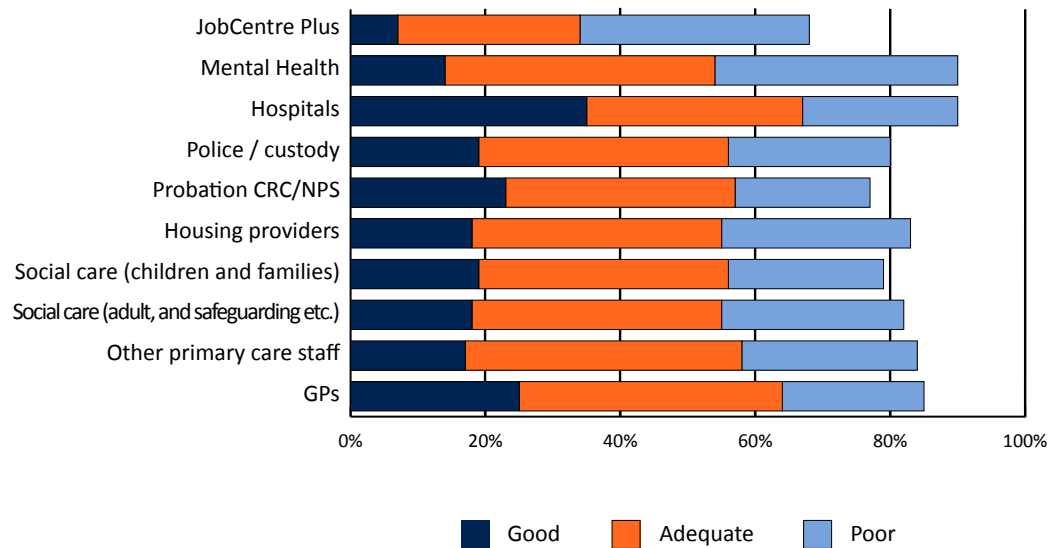
- It is available
- It is available but insufficient to meet the need
- It is not available
- Don't know

Relationship between alcohol services and other non-specialist services

Alcohol and wider substance use services play a crucial role in linking between other areas of social need. Very often, problems in housing, health care, criminal justice, families and employment are linked to substance use. This is one reason why services play a vital role: in tackling alcohol use, providers can help alleviate the many social problems associated with dependency or alcohol-related violence. However, effective service provision also requires strong and effective relationships with non-specialist services. As the Blue Light project has demonstrated in numerous local areas, when the full range of services come together, it can dramatically improve the lives of dependent drinkers and reduce demand for other statutory services.³⁰

However, our research suggests there is much more to be done to establish strong and effective relationships between different services. Asked about the quality of relationships between alcohol treatment and other services, only hospitals and GPs were rated as 'good' or 'adequate' by more than half of our respondents.

How would you describe the quality of engagement between local specialist alcohol services and other services?



In particular, there is clearly considerable work to be done improving relationships with Jobcentre Plus. In light of the increasingly well-recognised link between recovery and work, and the trial roll-out of Individual Placement Support in addiction services and through Job Centres (a national trial of Individual placement and support trial for drugs or alcohol dependency (IPS-AD), was announced in November 2017), this is an area where improvements must be made.³¹

Recommendation 11:

The Department for Work and Pensions, Department of Health and Social Care, and Public Health England should support better engagement between Job Centres and local treatment services, including promoting learning from the IPS-AD trial.

Older drinkers

While a number of respondents identified services for young people as inadequate, a larger number pointed to the need for much better provision for the growing cohort of older people with drinking problems.

The general ageing of the population, as well as recent trends in consumption patterns, is increasing the number of older drinkers. Indeed, recent research points to a cohort of relatively heavy drinkers, both men and women, who are now entering middle and old age.³² This new cohort of, sometimes dependent, older drinkers create a range of new challenges for services.

Older drinkers: the system does not recognise the health problems they experience – the symptoms are being missed and misinterpreted. The acute system is not linking the symptoms to the alcohol use.
(Commissioner)

The challenges in supporting this expanding client group range from the types of treatment available to accessibility to age restrictions. One recent study of residential rehabilitation services found that not only did older drinkers often struggle to fit in, but that three-quarters of providers actually excluded people over the age of 66.³³ This is likely to be illegal under age discrimination legislation but is not yet being challenged by the Government. Furthermore, older drinkers attending rehab often find that the activities and culture are alienating, designed with a much younger cohort in mind.

A number of our respondents also suggested that the merger of drug and alcohol services was a particular deterrent to older drinkers. Again, this was because they may feel either alienated from, or intimidated by, settings in which they are treated alongside younger people with illicit drug issues.

Workforce challenges

While the impact of funding cuts on staff was noted by most respondents in the context of general declines in capacity, a number of specific challenges emerged. Not only was there less money for staff per se, but there appears to be an increasing problem of the loss of specialist staff. This decline in specialist skills has been described elsewhere as ‘one of the most significant barriers to recovery outcomes’.³⁴

Addiction psychiatry, in particular, is seen as facing an acute threat. There appears to be both a loss of addiction psychiatrists in services and a collapse in the number of students opting to take addiction as a psychiatry specialism. Where addiction is chosen as a specialism in the context of psychiatry more generally, new graduates appear to be opting to work in the relatively better funded field of mental health.

There is a lack of trained doctors and prescribing nurses. There is recognition that training placements for psychiatrists are not available in Third Sector organisations. If the training pipeline for addiction psychiatrists is running dry – who will replace them? People will go into other disciplines. (Prisoner support)

10 years ago, there were seven addiction trainers in psychiatry...there are now only three. There are less people pursuing it as a career and people doing other areas of psychiatry are not getting exposure to addiction. There is a small number of places where the voluntary sector has taken addiction psychiatry placements. (Clinician)

Participants reported that declines in funding, and an associated weakening of career prospects, was making career experience in substance misuse less attractive to potential employees. Many respondents also reported that nursing staff were becoming more difficult to hire and that there was an increasing reliance on agency staff to fill important roles. This, undoubtedly, varies depending on provider and contract. The picture is not one of a universal staffing crisis. However, it does appear that a combination of difficulty in recruitment, loss of specialist staff, and rapid churn in the general workforce risks

draining the essential skills away from alcohol treatment services, leaving those in need of support without the skilled guidance that they need.

This loss of expertise was viewed as affecting both delivery and planning. In addition to the previously described concerns over the specialist knowledge of commissioners, when asked only 45% of respondents said they felt specialist expertise was being used to plan services.

Peer mentors and volunteer staff

The recent trend towards using peer mentors in the delivery of alcohol treatment services was widely welcomed. The role of ‘experts by experience’ in designing, delivering and supporting research for services is well recognised.³⁵ Indeed, one criticism levelled at commissioning in some areas is that it continues to pay insufficient attention to the knowledge and experience of service users and ex-service users. Only 32% of respondents felt the knowledge of service users and carers was being sufficiently used in local service planning.

However, there is also a concern that peer mentors are often employed without sufficient training and for economic reasons rather than to improve provision.

[Peer mentors] are great but they are often used because they are cheaper rather than because they are experienced. (Treatment provider)

A lot of the workers are ex-service users. That has its positives, but the time between them leaving treatment and becoming a peer mentor is not long enough. One had only 30 days of recovery before becoming a mentor. (Housing services)

There is no fixed time period after recovery before which individuals should be allowed to support their peers. However, careful thought is needed to ensure peer mentors have the necessary experience, skills and support to do the job effectively and indeed to protect themselves from unnecessary strain, unhelpful triggers or the risk of relapse.

Training

The increased use of peer mentors also raises the important issue of training. With the decline in more traditional training in addiction psychiatry and similar specialisms discussed above, there are fewer skilled staff entering services through established routes. This increases the need for greatly enhanced training on-the-job: more training opportunities and an even greater training focus within the system. However, 17% of our respondents reported that training had worsened in the last three years and only 13% said it had improved. Furthermore, only 29% felt there were sufficient training and qualification frameworks in place.

If we were in a context in which pre-employment training pathways were functioning well, providing a stream of trained professionals for services, these would be concerning figures. Given the reality of declining specialist skills and increased use of peer mentors and volunteers, this is deeply troubling. Although training and accreditation programmes for peer mentors are being developed, this support needs to be mainstreamed as effectively as possible. This will improve service provision and help people in recovery to develop career pathways and prospects that will enhance their recovery journey.

Better national coordination would help ensure good practice and allow commissioners to specify and monitor the skill mix provided by a commissioned service. Recent work being carried out by SMMGP and the Federation of Drug and Alcohol Professionals to develop a drug and alcohol practitioner apprenticeship scheme could prove an important development. The establishment of nationally accredited training for the workforce has the potential to improve skills, increase motivation and promote retention – all of which are critical to effective service delivery.³⁶

The Drug and Alcohol National Occupational Standards (DANOS) provide a framework that can be used to build this response.

These should be updated to reflect recent development, such as work on assertive outreach, and built into a professional accreditation or qualification that can provide a structure to alcohol interventions.

Recommendation 12:

A national review of the balance of staffing in the alcohol field should be undertaken to identify what expertise is required at each point in the system, including commissioning, and how that expertise can be retained.

Recommendation 13:

A national system of qualification and accreditation for workers in the alcohol field should be developed to allow the specification and monitoring of the expertise in the field, and to build attractive career pathways for staff.

Recommendation 14:

Public Health England and the Department of Health and Social Care should support the development of published clinical guidelines for alcohol treatment services, similar to the 'Orange Book' used in drug treatment.

Conclusion

As this report has demonstrated, the challenges facing alcohol treatment services are numerous and, in many cases, acute. They are, undoubtedly, a consequence of funding cuts which have gone beyond what a functioning system can sustain if the goal is the meaningful reduction of harm to individuals, families and communities. Alcohol services cannot survive at their current level of funding. Simply put they require more investment. Given the prevalence of alcohol problems across society, disinvestment in alcohol treatment services is a false economy. Given what we know about health inequalities, failing to support regions with the highest need is a dereliction of duty. Both national and local Government need to recognise the seriousness of this issue and act now; to prevent a ripple effect of negative consequences for people in need of treatment, their families, communities, and taxpayers.

Government – both national and local – needs to recognise the vital role that alcohol treatment plays in addressing the tragic consequences dependency can have on individuals, their families and the wider community. This means both investing smartly and ensuring that services are commissioned with skill, expertise and commitment; that the workforce has the necessary expertise and support to carry out its difficult task; and that training and career pathways are sufficient to maintain talent.

This is not a matter of investment *per se*, it is a matter of investing smartly, developing infrastructure, applying the best knowledge and experience, and focusing on what works. If effective treatment services are not maintained the wider social effects are enormous: with expensive knock-on effects for an array of other services, not to mention the human suffering that will entail. Alcohol treatment services need strategic leadership at national and local level, better investment, support for the sector, and the promotion of best practice. We need to act before it is too late.

Recommendations

Recommendation 1:

The Government develops and implements a National Alcohol Strategy that affirms the critical role alcohol treatment plays in reducing social harms and that outlines how treatment services fit within a broader suite of interventions to reduce alcohol harm.

Recommendation 2:

The Government urgently introduce new financial arrangements to plug the gap in treatment funding and reduce health inequalities arising from local funding structures. In doing so, they should consider the introduction of ‘treatment tax’: a small increase in alcohol duties earmarked to ensure that all local areas can meet their treatment needs.

Recommendation 3:

The Government ensures that substance use treatment is a prescribed local public health activity and that systems are established to address potential inequalities in capacity following the transfer to business rate funding.

Recommendation 4:

The Ministry of Housing, Communities and Local Government work with Public Health England to establish effective systems for transparently monitoring the scale of ongoing investment.

Recommendation 5:

An independent review of the commissioning of alcohol services is undertaken to ensure it delivers the safest, most effective and best value services.

Recommendation 6:

Local authorities must ensure that those staff members who are responsible for commissioning substance use services have the required level of in-depth skills, expertise and knowledge to commission these services well.

Recommendation 7:

Public Health England should carry out a review into the reasons behind the recent decline in alcohol-only treatment access and consider whether the merger of services is a significant factor and take appropriate action if it is.

Recommendation 8:

Local authorities must ensure that staff from non-specialist services are well trained in how to work with heavy drinking and alcohol dependent clients

Recommendation 9:

Better guidance must be developed to support the effective implementation of solutions to problems around the relationship between alcohol misuse and mental health.

Recommendation 10:

Commissioners must design and commission ‘assertive outreach’ services and other approaches that bridge the gap between identification and treatment, particularly among high need, high impact drinkers.

Recommendation 11:

The Department for Work and Pensions, Department of Health and Social Care, and Public Health England should support better engagement between Job Centres and local treatment services, including promoting learning from the IPS-AD trial.

Recommendation 12:

A national review of the balance of staffing in the alcohol field should be undertaken to identify what expertise is required at each point in the system, including commissioning, and how that expertise can be retained.

Recommendation 13:

A national system of qualification and accreditation for workers in the alcohol field should be developed to allow the specification and monitoring of the expertise in the field, and to build attractive career pathways for staff.

Recommendation 14:

Public Health England and the Department of Health and Social Care should support the development of published clinical guidelines for alcohol treatment services, similar to the ‘Orange Book’ used in drug treatment.

Annex 1: Steering group

A small group of experts was convened to be a virtual steering group for this report. They were sent papers for comment at the outset and received progress reports for comment. The research work was undertaken by Mike Ward and overseen by James Nicholls.

- Professor Sarah Galvani – Manchester Metropolitan University
- Annette Fleming - Aquarius
- Andrew Misell – Alcohol Concern Wales
- Dr Emily Finch – South London and Maudsley NHS Trust
- Hazel Jordan – Public Health England (Observer)
- Professor Alison Ritter – National Drug and Alcohol Research Centre, University of New South Wales
- Dr Will Haydock – Public Health Dorset

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