A Measure of Change

An evaluation of the impact of the public health transfer to local authorities on alcohol

Interim Report

Alcohol Concern
The charity making sense of alcohol

Contents

Acknowledgements

Alcohol Concern would like to thank members of the expert group for their advice and guidance in developing the survey questionnaire. We would also like to thank Alcohol Research UK for funding this research.

This report was written and researched by Alcohol Concern
Date of preparation: April 2014

Published by Alcohol Concern, Suite B5, West Wing,
New City Cloisters, 196 Old St, London EC1V 9FR

020 7566 9800
contact@alcoholconcern.org.uk
alcoholconcern.org.uk

Alcohol Concern is a registered charity no. 291705

Key findings

1	Local authorities report that spending on alcohol services and activity has mostly stayed the same (57%) or increased (36%) in the last financial year. Only two of the 28 local authorities that participated (7%) reported a decrease.
2	A majority of local authorities expect funding for alcohol services and activity to stay the same (39%) or increase (43%) over the next three years. Five (18%) local authorities expect it to decrease.
3	Local authority areas experiencing high levels of alcohol-related harm are the least likely to expect increased funding for alcohol; only 20% expect increases compared to 63% experiencing medium and 40% experiencing lower levels of harm.
4	Local authorities expect the proportion of the substance misuse budget that is spent on alcohol to either increase (52%) or to stay the same (44%). Only one local authority expects it to decrease.
5	Feedback from treatment providers is less optimistic than that from local authorities. Almost a third (30%) of treatment providers have seen funding decrease in the last financial year. Most of these were in areas experiencing medium levels of alcohol-related harm.
6	Nearly two-thirds (61%) of treatment providers expect funding to decrease in the next three years.
7	Treatment providers in high- and medium-harm areas were far more likely to expect a decrease than those in lower-harm areas.
8	Most local authorities (85%) have alcohol as a named priority in the Joint Health and Wellbeing Strategy.
9	Treatment providers report a significant discrepancy between the priority given to alcohol and the funding received to deliver alcohol services. Many treatment providers recognise that alcohol is now given greater priority in relation to drugs than in the past, but this may not be reflected in current levels of funding.
10	Two-thirds of clinical commissioning groups (CCGs) are not currently directly funding any alcohol services or activity.

Introduction

Background

Alcohol misuse is having a significant impact on communities throughout England, severely affecting the health of local populations.

There were approximately 1.2 million alcohol-related hospital admissions in England in 2011/12[1]. In addition, alcohol misuse has a much wider impact than on health alone: in half of all violent incident perpetrators are believed to be under the influence of alcohol[2] and a fifth of all young callers to Childline are worried about drinking by a parent or other significant person[3]. In financial terms, the cost to society is no less great: in England alcohol misuse accounts for approximately £21 billion a year[4]. Local communities are paying the price for excessive alcohol misuse, and it is essential that they develop effective local actions to combat the problems, alongside much needed national levers such as minimum pricing.

The Health and Social Care Act 2012 radically reformed the way in which health care in England is commissioned and managed. One of the key legislative changes in this Act was the transfer of public health to local authorities. Another was the introduction of Clinical Commissioning Groups (CCGs) – putting clinicians in charge of shaping health services. Many of the changes in the Health and Social Care Act, including the two mentioned above, came into being on 1st April 2013. From this date, the commissioning and funding of alcohol services have been the responsibility of the 152 upper-tier London boroughs and unitary local authorities in England. Funding for alcohol services comes from the ring-fenced public health grant that each local authority receives to provide a wide range of public health interventions and services. The National Treatment Agency for Substance Misuse has been abolished, with its functions transferred to Public Health England, now the national lead for public health.

The 152 upper-tier local authorities are required to have a Health and Wellbeing Board that sets out local health needs and priorities through Joint Strategic Needs Assessments (JSNAs). Joint Health and Wellbeing Strategies (JHWSs) are the documents that set out how local authorities will meet the needs identified in JSNAs. Local authority and CCG commissioning plans are expected to be informed by both the JSNA and JHWS, which are continuous processes. Health and Wellbeing Boards (HWBs) will decide when to update and refresh the JSNA and JHWS and must encourage integrated working between health and social care commissioners. As a minimum, HWBs must comprise the following members:

- One local elected representative
- A representative of local Healthwatch
- A representative of each local CCG

Introduction

- The Director of Public Health for the local authority
- The local authority Director for Adult Social Services
- The local authority Director of Children's Services

The return of public health to local authorities provides a significant opportunity to reduce alcohol harm by bringing together many of the different levers into one arena. These levers include such measures as gathering data on local levels of alcohol-related harm; conducting a thorough needs assessment; developing local strategy and alcohol pathways; using licensing legislation to ensure the responsible marketing, promotion and selling of alcohol; running social marketing campaigns; and providing Identification and Brief Advice (IBA), hospital-based services, specialist treatment, peer support options and wider support including employment, training and housing.

However, there are significant structural challenges resulting from such a major reorganisation and local authorities are also currently tasked with implementing substantial budget cuts. One year on from the transfer of public health to local authorities, Alcohol Concern has sought to investigate the impact of the changes on tackling alcohol harm locally. 'A Measure of Change', an 18 month research project funded by Alcohol Research UK, was initiated in June 2013. This interim report publishes the first wave of findings; a final report will be published in November 2014.

Aim

The aim of this project is to assess whether recent organisational changes to the NHS and public health have had an impact on alcohol services and activity – specifically, by addressing the following questions:

1. Has **funding** for alcohol increased or decreased since the changes to the health system?

2. Is alcohol a **greater priority** than before the changes to the health system?

Methodology

Questionnaires

Two waves of survey questionnaires will be used to explore the research questions. One questionnaire in each wave has been developed for alcohol treatment providers; the other is directed at local authorities and clinical commissioning groups (CCGs). Both questionnaires are to be disseminated twice during the course of the project. The first was sent out during the financial year 2013/14, and the findings are presented in this interim report. The second questionnaire dissemination will take place in the next financial year, 2014/15, with the results being presented and discussed, along with comparisons with the first-wave analysis, in the final project report due to be published in November 2014. The purpose of the two waves of questionnaires is to map change between the first and second years after the transfer of public health. It is anticipated that change is most likely in the second year, as it was expected that many local authorities would maintain existing arrangements in the first.

The questionnaires were devised with the help of an expert group, comprising:

- A Director of Public Health
- A Clinical Commissioning Group board member
- An elected Councillor who is an alcohol lead and member of a Health and Wellbeing Board
- A Chief Executive of an alcohol treatment provider
- A representative of Public Health England

Once developed the questionnaires were piloted with a small group of Directors of Public Health, CCGs and treatment providers. Findings from this pilot exercise highlighted certain difficulties – most notably that the depth and complexity of financial information asked for was too time-consuming for respondents to complete. The questionnaires were therefore amended accordingly before being sent to the sample of local authorities, CCGs and alcohol treatment providers in England. The questionnaires contained mostly closed questions with one opportunity for free text response, and asked respondents about the funding and prioritisation of alcohol in their area.

Methodology

Sample

There are 152 upper-tier local authorities who now have responsibility for commissioning alcohol prevention and treatment services. For this research a sample of 30 local authority areas were selected to take part, representing approximately 20% of the total – sufficient to provide an insight into developments and trends across England. The first-wave questionnaire was sent to these 30 local authorities along with CCGs and alcohol treatment providers operating in the same 30 areas. The second-wave questionnaire will be sent to exactly the same local authorities, CCGs and treatment providers.

To select the local authority areas, a system was used of notionally ranking alcohol harms based on data from a range of Local Alcohol Profiles for England (LAPE) indictors:

1. Hospital admissions per 100,000 population
2. Alcohol-specific mortality, males, all ages per 100,000 population
3. Alcohol-specific mortality, females, all ages per 100,000 population

Data from every authority for the rate of alcohol-related hospital admissions, and both male and female alcohol-specific mortality, were averaged to create a notional 'average' harm, enabling the authorities to be ranked in comparison with each other. A notional '*league table*' ranked the authority areas from the highest rates of harm to the lowest, across these averaged three indicators. Authorities were divided into three categories: high harm (local authorities experiencing high levels of alcohol-related harm); medium harm (local authorities experiencing medium levels of alcohol-related harm); and lower harm (local authorities experiencing the lowest levels of alcohol-related harm).

The sample of 30 authorities selected to take part in the research was made up of ten from each of the high, medium and lower categories. The final sample was selected purposively to achieve a regional and rural/urban spread. Once the 30 areas had been chosen, questionnaires were sent to Directors of Public Health in each authority, and to CCGs and alcohol treatment providers operating in the relevant local authority area. In total, questionnaires were sent to 30 Directors of Public Health, 53 CCGs and 55 alcohol treatment providers.

The original list of alcohol treatment providers was developed by reviewing the websites of the 30 local authorities to find the providers operating in the area. Where this information was not available, the local authority was contacted to ask for an up-to-date list of those alcohol treatment providers operating in their area. The total number of treatment providers in the study was revised down to 45 after it was established that ten of the original 55 either no longer existed, did not operate in the relevant local authority, or were solely private treatment providers and therefore ineligible for the study.

Response rate

The total response rate for the first-wave questionnaire was 78% – 100 responses received out of a total of 128 questionnaires sent. The response rate amongst local authorities was 93%; amongst alcohol treatment providers, 76%; and amongst CCGs, 72%. The figure for CCG responses takes into account those which completed the questionnaire as well as those which reported that they did not fund alcohol activity, and did not complete the questionnaire in full. CCGs had the lowest response rate of the three groups sent the questionnaire; this appears to be because not many of them directly fund alcohol activity and so did not see the questionnaire as relevant, despite being asked to partially complete it even so. To simplify the process subsequent to an initial poor response from the CCGs, each organisation was asked by email and phone call simply to state if they did not fund alcohol activity, without having to complete the questionnaire. This helped to increase the CCG response rate.

Table 1: *Response rate by type of respondent and alcohol-related harm category*

	Total % (Completed/Sent)	High category % (Completed/Sent)	Medium category % (Completed/Sent)	Lower category % (Completed/Sent)
Local authority response rate	93% (28/30)	100% (10/10)	80% (8/10)	100% (10/10)
CCG response rate	72% (38/53)	82% (9/11)	79% (15/19)	61% (14/23)
Treatment provider response rate	76% (34/45)	77% (10/13)	79% (11/14)	72% (13/18)
Total response	**78%** (100/128)	**85%** (29/34)	**79%** (34/43)	**73%** (37/51)

Table 2: *Regional spread of respondents*

	Local authority	CCG	Treatment provider
East of England	3	3	4
East Midlands	2	7	4
London	3	2	5
North East	3	3	0
North West	4	3	5
South East	5	7	3
South West	2	3	4
West Midlands	3	6	5
Yorkshire & the Humber	3	4	4
Total	**28**	**38**	**34**

Response rate

Table 2 shows regional spread of respondents according to former Government office regions. How this relates to the new Public Health centres and regions can be seen in the table below.

Table 3: *Regional spread of respondents by Public Health England centre/region*

	Local authority	CCG	Treatment provider
North of England	**9**	**8**	**7**
North East	3	3	
Cumbria and Lancashire	2	2	2
Yorkshire and the Humber	2	2	2
Greater Manchester	1		2
Cheshire and Merseyside	1	1	1
Midlands and East of England	**9**	**18**	**15**
East Midlands	4	9	6
West Midlands	3	6	5
Anglia and Essex	2	3	4
South Midlands and Hertfordshire			
South of England	**7**	**10**	**7**
Devon, Cornwall and Somerset	1	2	2
Avon, Gloucestershire and Wiltshire	1	1	2
Wessex	1	1	1
Thames Valley	2	1	
Kent, Surrey and Sussex	2	5	2
London	**3**	**2**	**5**
Total	**28**	**38**	**34**

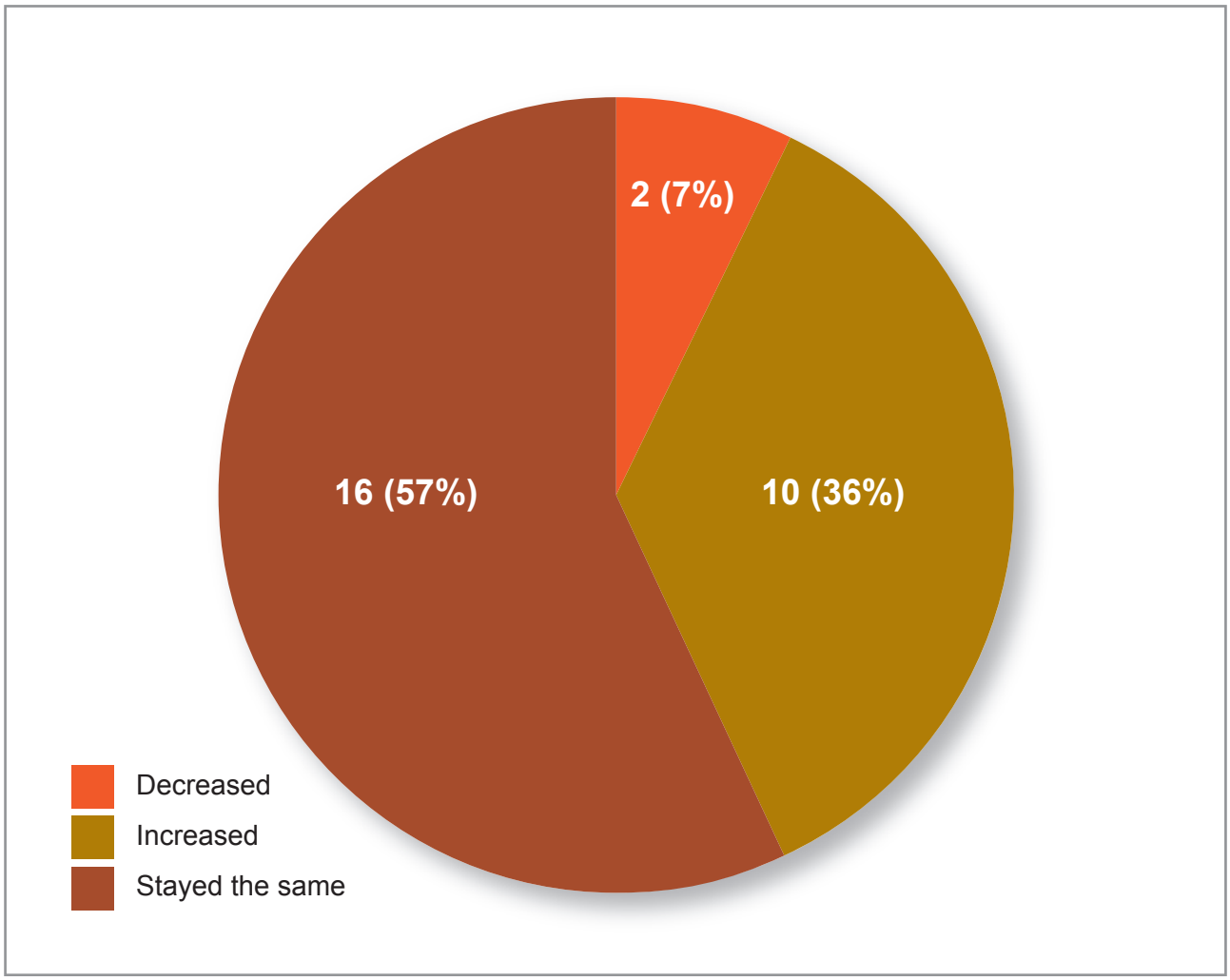
Results

The results of an analysis of the first-wave questionnaire are presented below by type of respondent: local authority, CCG and treatment provider, followed by a discussion of the key findings.

Local authorities response

Over half (16; 57%) of the local authorities that responded to the questionnaire reported that the amount they had spent on alcohol services and activity over the last year had stayed the same, with two (7%) saying it had decreased and ten (36%) reporting an increase.

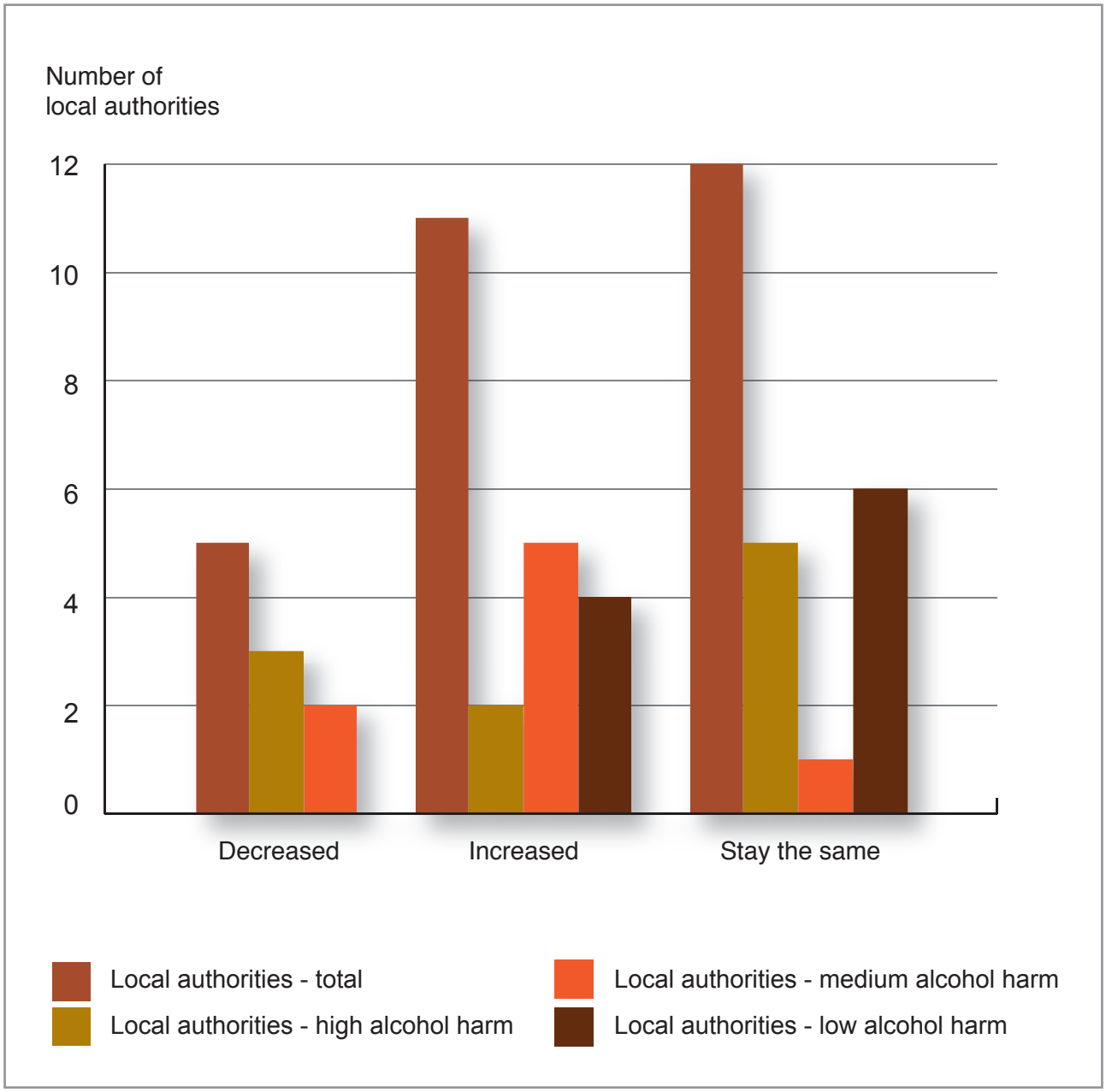
Chart 1: *Since the last financial year, has the total amount spent on alcohol services and activity decreased, increased or stayed the same? (Local authority response)*



Results

In addition to the question about funding for alcohol in the last financial year, local authorities were asked how they thought funding for alcohol services would change over the next three years. Responses show that those local authorities experiencing a high level of alcohol-related harm were less likely than others to expect an increase in funding for alcohol services and activity, with only two expecting an increase compared to five in the medium category and four in the lower category. Overall, 12 (43%) local authorities were expecting funding to remain the same over the next three years, 11 (39%) expecting an increase, and five (18%) expecting a decrease.

Chart 2: *Do you think the actual amount spent on alcohol services and activity over the next three years will decrease, increase or stay the same? (Local authority response)*



Results

The following statement from one of the respondents in the high-harm category highlights the uncertainty that some local authorities are experiencing about the funding of alcohol services in the future.

> *We do not know what the funding landscape will be in the future. We hope to protect the alcohol spend in the local authority.*
>
> (Local authority in high-harm category)

Some local authorities are more pessimistic about the future. The following statement suggests that it is not possible to adequately fund both treatment and prevention services.

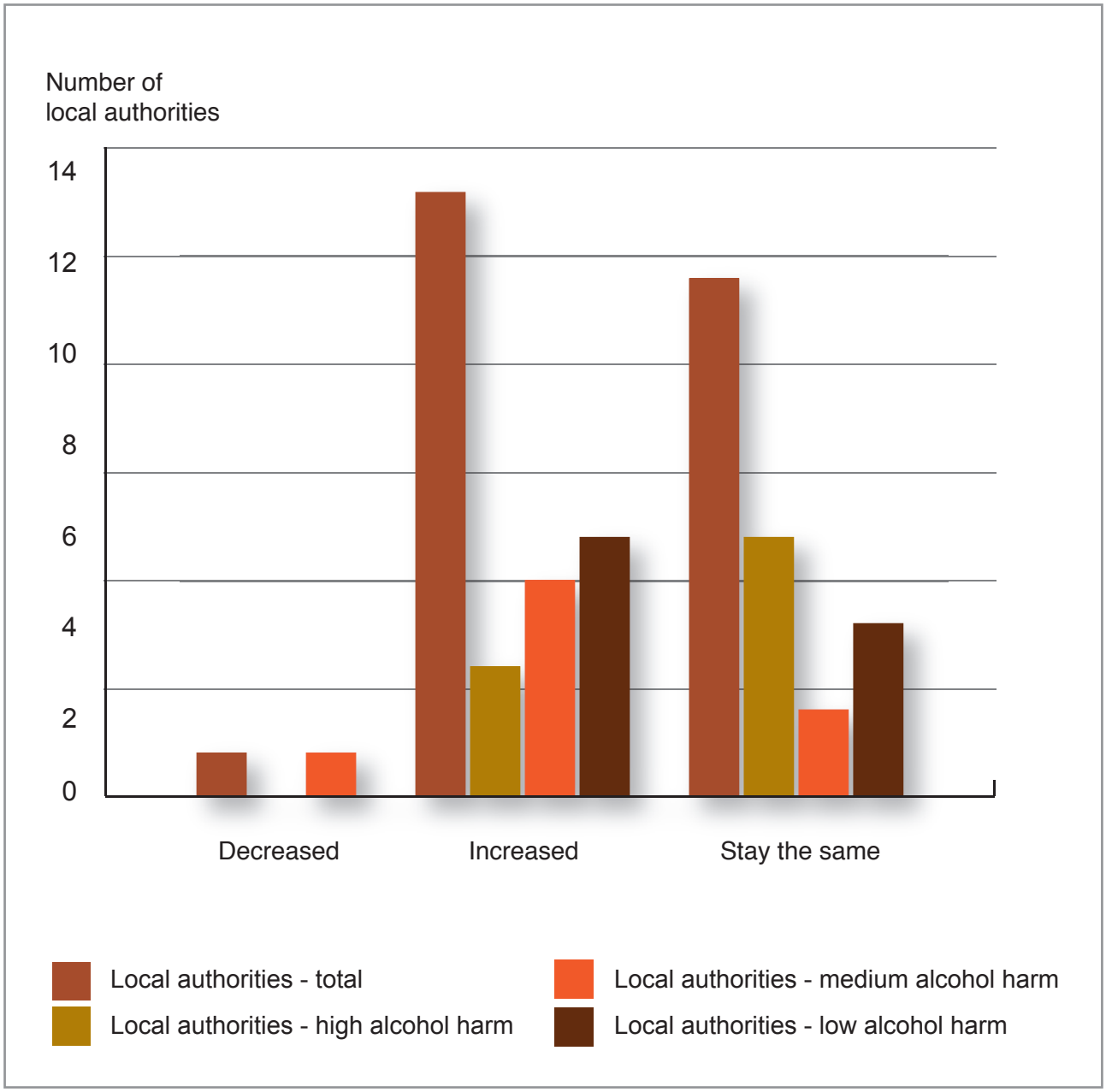
> *Local government funding is under huge pressures. There is an expectation that as commissioner of services, we must begin to share our financial pressures with our suppliers – i.e. we will require them to undertake more for the same or provide the same for less. As we are likely to increase preventative work overall the likelihood is of zero growth in funding for alcohol services.*
>
> (Local authority in lower-harm category)

The following statement reflects the tension faced by local authorities of the lack of money available along with the increased awareness of alcohol harms.

> *Concerns for the future are further local authority savings. On the other hand, across departments in the local authority is increasing awareness of alcohol as a significant contributor to a range of social harms, and concern that the historical disparity between drug and alcohol misuse funding needs more balance.*
>
> (Local authority in medium-harm category)

The quote above suggests that, in some areas at least, there is recognition that funding for alcohol vis-a-vis drugs has in the past been under-addressed. Local authorities were asked in the questionnaire whether they expected the proportion of the total substance misuse budget spent on alcohol to decrease, increase or stay the same. Those experiencing medium levels of alcohol-related harm were more likely than those in high and lower areas to expect an increase. Those in high areas mostly (67%) expected it to stay the same. Overall approximately half (52%) expected it to increase.

Chart 3: *Do you think the proportion of the total substance misuse budget spent on alcohol services and activity over the next three years will decrease, increase or stay the same? (Local authority response)*



Results

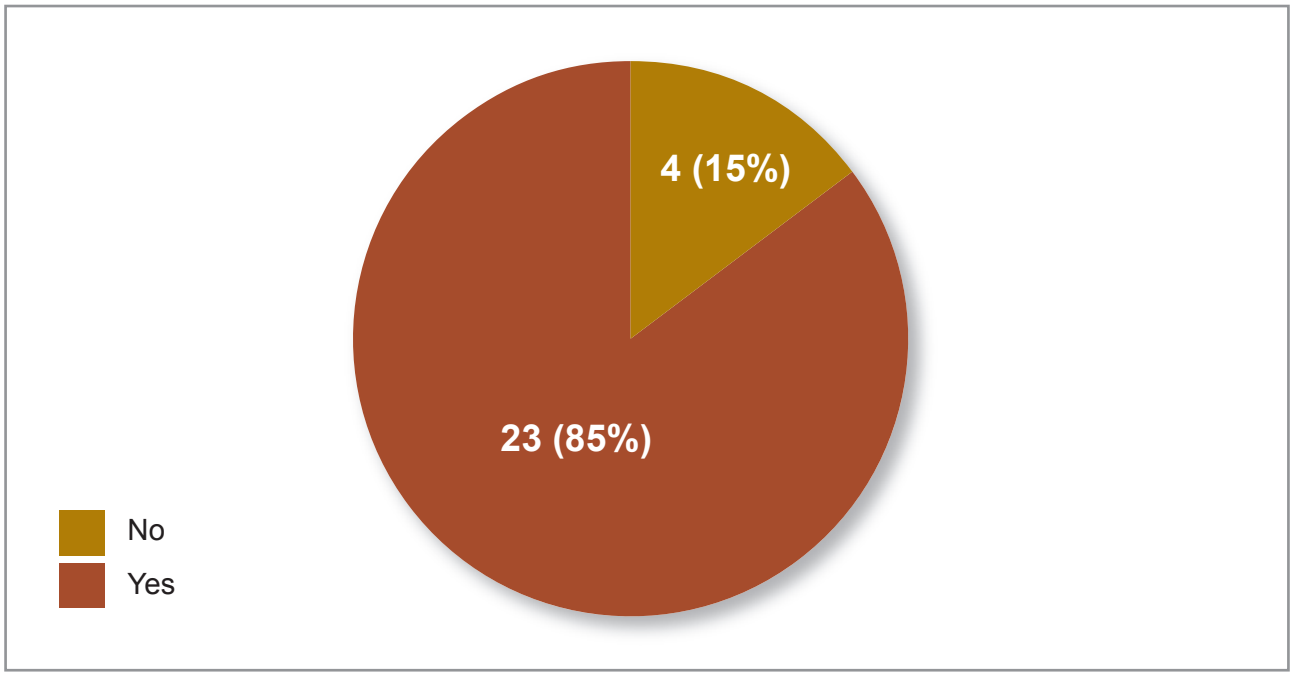
Local authorities were asked what alcohol services and activity they currently fund. The table below shows the responses to this question.

Table 4: *Alcohol services and activity funded by local authority respondents*

	Total LAs funding activity	LAs in high category funding activity	LAs in medium category funding activity	LAs in lower category funding activity
Number who answered question	27	9	8	10
Community/ambulatory detox	24	8	7	9
Inpatient detox	25	8	8	9
Residential rehab	27	9	8	10
Relapse prevention prescribing	24	9	8	7
Psycho-social interventions	27	9	8	10
Open access/drop in services	26	8	8	10
Structured day treatment	22	9	6	7
Brief interventions in A&E	25	9	7	9
Brief interventions in other hospital departments	19	7	6	6
Brief interventions in GP surgeries	19	6	6	7
Brief interventions in pharmacies	8	3	2	3
Brief interventions in custody suites	16	6	6	4
Brief interventions in probation	12	4	4	4
Brief interventions in other setting/s	7	4	1	2
Brief interventions training	20	9	5	6
Hospital-based alcohol liaison person/team	20	6	6	8
Hospital-based repeat attenders	18	6	6	6
Alcohol awareness-raising campaigns	22	9	6	7

Most local authorities (85%; 23/27) reported that alcohol was a named priority in the Joint Health and Wellbeing Strategy. This was lowest amongst local authorities in areas experiencing high alcohol harm (80%; 8/10) compared to those in areas experiencing medium levels of harm (86%; 6/7) and lower levels of harm (90%; 9/10).

Chart 4: *Is alcohol a named priority in the Joint Health and Wellbeing Strategy? (Local authority response)*



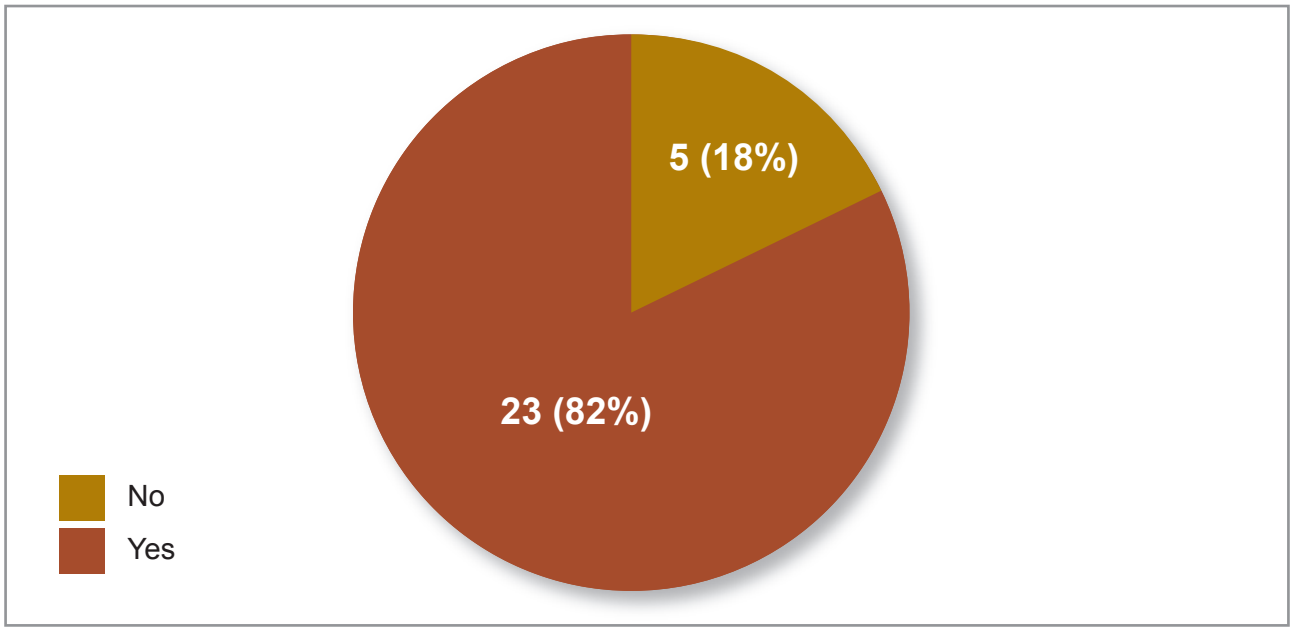
Two local authorities took the opportunity, in the free text space, to explain that although alcohol was not a named priority in the Health and Wellbeing Strategy, it wasn't being ignored.

> *Alcohol is not a named priority area in our Joint Health and Wellbeing Strategy. We have a priority to reduce premature deaths and alcohol is named as a leading cause of these deaths. We also have reducing alcohol-related hospital admissions as a key indicator.*
>
> (Local authority in high-harm category)

> *Although alcohol is not a priority specifically within the Health and Wellbeing Strategy, it is picked up in a number of sections.*
>
> (Local authority in medium-harm category)

Most local authorities (82%; 23/28) reported having a current local alcohol strategy document. Encouragingly, this was highest amongst areas experiencing high alcohol harm (100%; 10/10) compared to those in areas experiencing medium levels (88%; 7/8) and lower levels (60%; 6/10) of alcohol-related harm.

Chart 5: *Is there a current local alcohol strategy document? (Local authority response)*



Of the 23 local authorities that had a local alcohol strategy in place, 22 responded to the question asking them to name which partners contributed to the strategy. The results are presented in Table 5.

Table 5: *Partners contributing to local alcohol strategy*

	Public Health	CCG	Police	Adult social services	Licensing	Children's social services	Local Health-watch	Alcohol treatment provider
High	10	8	10	9	9	8	3	8
Medium	6	4	6	5	6	5	0	5
Lower	6	5	6	4	5	4	2	6
Total	**22**	**17**	**22**	**18**	**20**	**17**	**5**	**19**

As a number of local alcohol strategies will pre-date the transfer of public health to local authorities and the creation of CCGs, it is not possible at this stage to draw any conclusions from the above as to the effect of the transfer on integrated working.

Compared to those local authorities reporting the existence of a local alcohol strategy, a slightly smaller proportion (78%) reported that a detailed analysis of alcohol needs had been undertaken. Two local authorities in the high category had not undertaken a detailed alcohol needs analysis; likewise one in the medium category and three in the lower category.

CCGs response

Of the 38 CCGs that responded to the questionnaire, approximately one-third (34%) funded some type of alcohol service/activity. The proportion of funding CCGs was greatest in the group experiencing the highest levels of alcohol harm (56%; 5/9), compared to 20% (3/15) in the medium and 36% (5/14) in the lower category. Two-thirds (66%; 25/38) of all responding CCGs reported that they did not fund any alcohol services/activity.

Table 6: *Alcohol services/activity funded by CCG respondents*

Alcohol service/activity	Number of CCGs funding service/activity
Hospital-based alcohol liaison person/team	7
Brief interventions in A&E	5
Alcohol awareness-raising campaigns	4
Hospital-based repeat attenders	3
Brief interventions in GP surgeries	3
Relapse prevention prescribing	3
Residential rehab	2
Pyscho-social interventions	2
Brief interventions in hospital departments other than A&E	2

Of the nine CCGs that responded to the question asking about alcohol funding since the last financial year, five reported that this had stayed the same; three reported an increase and one a decrease. CCGs in the highest areas of alcohol harm were most likely to report an increase. One of the CCGs that reported a decrease explained that this was due to the change in responsibilities.

> *The funding of alcohol services by the CCG has reduced in 2013/14 due to the change in commissioning responsibilities having moved to public health teams within local authorities.*
>
> (CCG in medium-harm category)

Six of the nine CCGs felt that funding for alcohol would stay the same over the next three years, whilst three thought it would increase and none thought it would decrease.

Results

Five CCGs expected the proportion of the total substance misuse budget spent on alcohol services and activity to stay the same over the next three years; two thought it would increase, and none that it would decrease.

Overall, 87% (20/23) of CCGs reported that alcohol was a named priority in the Joint Health and Wellbeing Strategy and the same number reported that there was a current local strategy. Nineteen out of 22 CCGs reported that a detailed analysis of alcohol needs had been undertaken locally.

Treatment providers response

Approximately half of all treatment providers in the survey (48%; 16/33) reported that funding to provide alcohol services had stayed the same in the last financial year, with 30% (10) saying it had decreased and 21% (7) saying it had increased. The outlook over the next three years was more pessimistic, with 61% (20) expecting funding to decrease, 24% (8) expecting an increase and 15% (5) expecting it to stay the same.

Treatment providers operating in areas experiencing medium levels of alcohol harm were most likely to report a decrease in funding in the last year – and also more likely to expect funding to decrease over the next three years – than treatment providers operating in areas experiencing both high and lower levels of alcohol harm. Treatment providers operating in areas experiencing lower levels of harm were more likely to report an increase in funding in the last year and an expected increase over the next three years than those operating in the high and medium areas.

Chart 6: *Since the last financial year has the funding your service receives to provide alcohol services and activity decreased, increased or stayed the same? (Treatment provider response)*

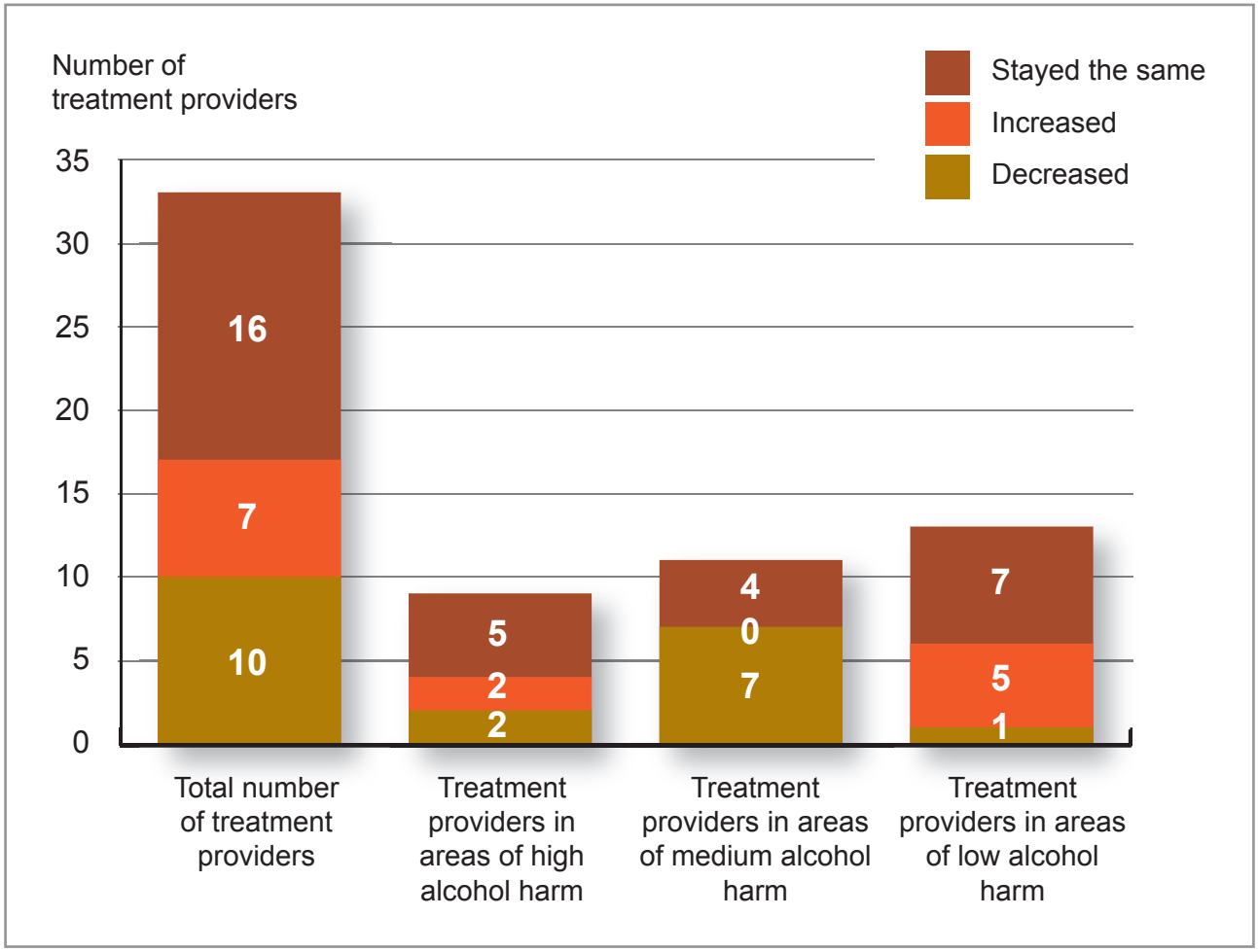
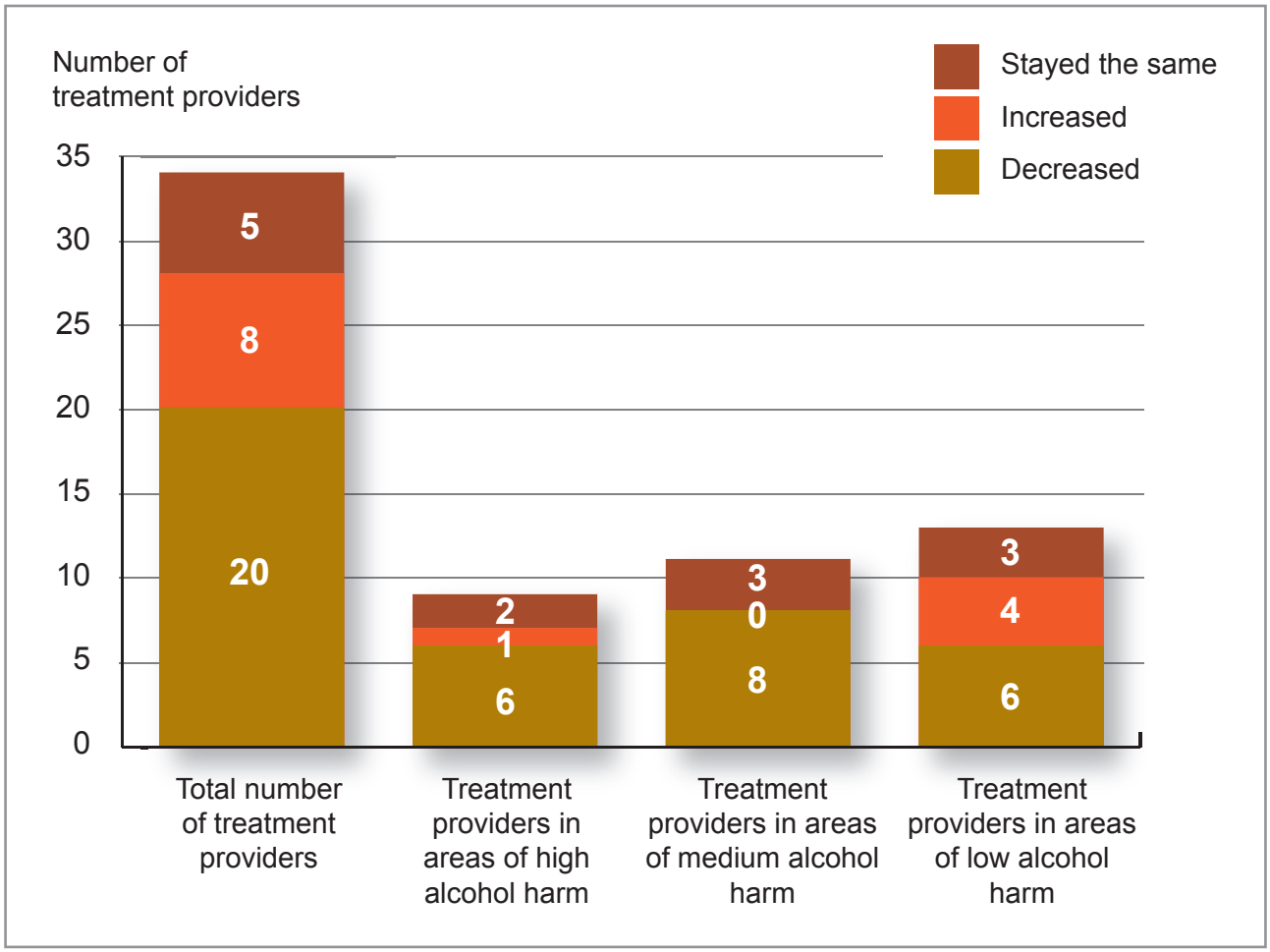


Chart 7: *Do you think the amount your service receives to provide alcohol services and activity over the next three years will decrease, increase or stay the same? (Treatment provider response)*



Most treatment providers (73%) had the opportunity to contribute to the development of local alcohol strategies. Treatment providers in high- and lower-harm areas were more likely than those in medium-harm areas to have had this opportunity, but the differences were not marked and may not be significant.

Treatment providers were asked whether they had experienced change, since the transfer of public health to local authorities, in the nature and provision of alcohol services to reflect a wider population approach to alcohol misuse. Overall, a majority (55%; 18/33) of respondents did not feel that changes had been made to reflect wider population approaches, although there were significant discrepancies between areas, with medium-harm areas far more likely to report no change in approach than high or lower-harm areas.

Overall, treatment providers in medium-harm areas surveyed painted the bleakest picture of their delivery environment, reporting as most likely to have experienced funding cuts and to anticipate future cuts; least likely to have contributed to local strategies; and least likely to have seen wider population approaches from services.

Results

Treatment providers deliver a range of alcohol services. The table below shows the numbers providing each service and which of these are funded on a payment-by-results (PBR) basis. *Note:* The questionnaire was primarily sent to community-based services, rather than to residential/inpatient services.

Table 7: *Alcohol services and activity provided by treatment provider respondents*

Type of service	Number providing service (34 answered question)	Number of which are PBR
Psycho-social interventions	32	4
Brief interventions delivery	28	4
Open access/drop-in services	25	3
Alcohol awareness-raising campaigns	23	1
Community/ambulatory detox	20	3
Relapse prevention prescribing	16	2
Structured day treatment	15	1
Brief interventions training	14	1
Hospital-based alcohol services	13	0
Inpatient detox	12	1
Residential rehab	8	0

The voice of treatment providers

Analysis of the qualitative data reveals that although alcohol seems to have greater priority than in the past, funding has not increased to match this.

Alcohol a greater priority

> *I am confident the Commissioners understand the need in relation to alcohol services, and they are looking to grow alcohol services (recognising the massive discrepancy between drug and alcohol funding historically).*
>
> (Treatment provider in high-harm category)

> *Over the last six months Commissioners are showing more interest in alcohol and alcohol provision. Previously there was more focus on drugs.*
>
> (Treatment provider in medium-harm category)

Less funding

> *We have been notified that all substance misuse services will have the contract sum reduced by 20-25% over the next two years. This despite alcohol being one of the five named priorities in the Health and Wellbeing Strategy. This is going to have a significant impact on the organisation, and on services overall.*
>
> (Treatment provider in high-harm category)

> *... Ironically whilst the Commissioners want to grow services, the funding may be cut.*
>
> (Treatment provider in high-harm category)

> *We have not noticed any change other than that alcohol treatment is receiving greater attention, but funding is still very limited. Drug services seem to receive much greater investment.*
>
> (Treatment provider in lower-harm category)

> *We have seen a marked increased focus on alcohol since the transfer of service to public health. Even though we have seen this refocusing, it has had little impact on what we provide as there is currently no ring-fencing of monies between drugs and alcohol.*
>
> (Treatment provider in lower-harm category)

However, whilst many areas talked of greater priority given to alcohol vis-a-vis drugs than in the past, this was not universal – as the following quotes highlight.

Alcohol a poor relation

> *In our local authority, alcohol is always secondary to drugs. We were hoping that the transfer under public health would have some impact on this, and indeed the city's JSNA has a focus on alcohol, but as yet we have not seen any changes.*
>
> (Treatment provider in medium-harm category)

> *Currently the alcohol problem in the area is substantial, but the treatment budget, in relation to drugs, is tiny.*
>
> (Treatment provider in medium-harm category)

> *With merging of D&A budgets a local concern is that funding for alcohol service, previously separate alcohol funding, may be eroded due to costs of drug prescribing service. This remains to be seen with the enacting of the upcoming new contract arrangements.*
>
> (Treatment provider in lower-harm category)

> *We certainly need more specified funding for alcohol services. Overall, combined service specifications and budgets for drug and alcohol is a risk for alcohol services due to very expensive drug services provisions across the country. Alcohol funding and service provision should be separate from drugs.*
>
> (Treatment provider in lower-harm category)

Even when one treatment provider had received additional funding to provide extra services, there remained anxiety about the future.

> *We are pleased that, at last, alcohol treatment appears to be given as much emphasis as that for drugs. We are being asked to provide a wider range of services and have been funded for this. We really do not have any idea what to expect and this uncertainty continues to be unsettling for our service.*
>
> (Treatment provider in lower-harm category)

Discussion

In the first year after the transfer of public health it appears that most local authorities continued to fund existing contracts previously held by PCTs, as might have been expected. Most local authorities that responded to the first-wave questionnaire, together with CCGs where they have taken on the relevant funding responsibility and treatment providers, report that levels of funding for alcohol remained unchanged from the previous year. However, whilst local authorities and CCGs were more likely to report increases in funding for alcohol than decreases, this contrasted with reporting from treatment providers. One-third of treatment providers reported a funding decrease.

The funding outlook for the next three years is mixed, no doubt reflecting the uncertainty of the overall economic outlook and the current squeeze on local authority budgets. Optimism is broadly polarised between funder and recipient. Local authorities and CCGs funding alcohol services and activity are considerably more optimistic about future levels of funding than treatment providers. The majority of treatment providers expect funding to decrease in the next three years compared with only one local authority and no CCGs that responded to this question. This may reflect the natural confidence of being a giver rather a recipient of funds. It may also reflect changes to commissioning contracts such as consolidation by larger providers and the merging of alcohol and drugs services. It is also possible that local authorities are expecting to fund more alcohol prevention work than in the past at the cost of treatment – a trend we may be able to measure through the next-wave questionnaire.

Local authorities in areas experiencing high levels of alcohol harm are more fearful about future funding for alcohol services and activity than are medium- or lower-harm areas. The reasons for this are unclear, but alcohol harms disproportionately impact the poor. Areas with higher levels of alcohol harm are therefore also more likely to have higher levels of social deprivation, and to experience higher levels of poor health more generally, contributing to competing pressures on public health budgets. In the current difficult economic climate, cuts to local authority budgets have not fallen equitably across the country, with suggestions that some of the poorest boroughs face disproportionate cuts to their funding[5]. This may affect confidence in their ability to maintain current levels of funding in the medium term. It also possible that local authorities experiencing high alcohol harms are particularly sensitive to funding uncertainty due to a heightened awareness of the impact on service provision.

It was hoped that the transfer of responsibility to local authorities would lead to greater responsiveness to local need, and local authorities appear have taken on board the scale of alcohol harms and given the issue due priority. Most local authorities and CCGs include alcohol as a named priority in their JHWSs. Two local authority areas experiencing high levels of alcohol harm do not name alcohol as a priority, but then not all JHWSs set disease or condition level priorities. It is encouraging that all local authority areas experiencing high alcohol harms do have a current local alcohol strategy, but of some concern that two have yet not undertaken detailed analysis of alcohol needs. As Public Health England recommends in *Good practice in planning for alcohol and drugs prevention, treatment and recovery*[6], for an alcohol strategy to be effective it should be based upon an analysis of needs in the area.

Discussion

A small majority of local authorities believe that funding for alcohol as a proportion of the total substance misuse budget, will increase over the next three years. Alcohol treatment services have been historically underfunded compared to drugs services: given the greater numbers affected by alcohol misuse, this is an imbalance largely driven by the national-level priority of combating crime associated with drug use. It is essential that alcohol services receive a level of investment not only comparable to drugs services, but also proportionate to addressing the burden of alcohol. Local capacity to respond to local needs may be resulting in greater prioritisation of alcohol within public health since the transfer. However, whilst greater relative focus may be being experienced in some areas, it is certainly not consistent; and it remains unclear whether funding will be made available to match need. Public health budgets are theoretically ring-fenced, although in practice this may not always the case[7] and some providers already report being asked to do more for less.

There is some evidence of multi-agency planning, with public health, the police, licensing, treatment providers, adult and children's social services and CCGs all having contributed to the development of local alcohol strategies. However, as some strategies predate the transfer of public health and the creation of CCGs, it is not possible to draw firm conclusions about the effect of the transfer on integrated working. Most CCGs that responded to the questionnaire are not currently responsible for funding any type of alcohol service and activity. Whilst disappointing, this is unlikely to reflect the complete nature of CCG involvement in alcohol. Many CCGs responded that they operate closely with local authorities who are taking the lead in partnership work on alcohol.

It is still relatively early days since the transfer of public health to local authorities. One year on, and there are some encouraging signs that the focus on alcohol as a public health issue is growing. The next survey, to be launched in June 2014, will seek to provide a snapshot, from the new financial year, of the relative priority of alcohol within public health planning and the state of funding for services and activity. In the second year under local control, local authorities are likely to be more familiar with their responsibilities and powers and could be expected to have introduced new approaches that respond to alcohol health challenges. Local authorities may have had the time and freedom to develop new data-collecting processes, accurately assess local need, and join up plans and strategies of intervention. CCGs may also take increased responsibilities. The second-wave survey will enable an important comparative measure of change between years one and two since the transfer, as public health becomes more embedded within local authorities practice.

References

[1] North West Public Health Observatory Local Alcohol Authority Profiles for England (LAPE). www.lape.org.uk/LAProfile.aspx?reg=b (last accessed 24/02/2013)

[2] Crime Statistics, Focus on: Violent Crime and Sexual Offences, 2011/12, Office for National Statistics

[3] University of Stirling (2013) Health First: An evidence-based alcohol strategy for the UK

[4] Department of Health written evidence submitted to House of Commons Health Committee Third Report of Session 2012-13: Government's Alcohol Strategy Ev73 London: House of Commons, 2012

[5] Hasting, A., Bramley, G., Baily, N. & Watkins, D. Serving Deprived Communities in a Recession, Joseph Rowntree Foundation, January 2012

[6] Public Health England, Alcohol and Drugs: JSNA support pack, Good practice in planning for alcohol and drugs prevention, treatment and recovery (2013)

[7] Royal Society of Public Health, The views of public health teams working in local authorities Year 1, February 2014

Published by
Alcohol Concern
Suite B5, West Wing, New City Cloisters
196 Old Street, London EC1V 9FR
Tel: 020 7566 9800
Email: contact@alcoholconcern.org.uk
Website: www.alcoholconcern.org.uk
Registered Charity No. 291705

Alcohol Concern
The charity making sense of alcohol