Investing in Alcohol Treatment – Reducing Costs and Improving Lives

Alcohol Concern's learning from 10 years of consultancy and training

Alcohol Concern
Making Sense of Alcohol

Alcohol Concern

Alcohol Concern is the national agency on alcohol misuse campaigning for effective alcohol policy and improved services for people whose lives are affected by alcohol-related problems.

Alcohol Concern Training and Consultancy

We work to develop the knowledge and skills of practitioners supporting people with alcohol-related problems and operate a specialist consultancy service for commissioners:

- Providing customised training on alcohol issues for all mainstream workers through a network of alcohol professionals and experts
- Offering a range of solutions to local areas delivering action on alcohol needs assessment and harm reduction targets, including commissioners, service providers and planners

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1. Executive Summary

Alcohol misuse is a costly business. Not just for individuals and their families but also to society, through unemployment, welfare benefits, health care costs and housing support. The cost of problem drinking to society is estimated at £2.7 billion every year for health care costs alone. These costs will increase unless strategic action is taken.

Societal harm from alcohol each year includes approximately one million incidents of violent crime, over 100,000 cases of domestic abuse, and over 600 deaths from drink driving, while costs to society as a whole are estimated at between £17 billion and £22 billion. British teenagers drink more and earlier than their European counterparts, with UK 15-year-olds more likely to have both drunk alcohol and been drunk in the last 12 months than the European average.[1]

Successive Governments have placed much emphasis on tackling drug addiction and drug related crime, but strategies to specifically reduce problem drinking have only been addressed relatively recently through the 2007 revised alcohol strategy. Even this has not directly focused on how to ensure that all problem drinkers, from those drinking harmfully (or at increased risk) to dependent drinkers, get the support they need. Indeed the provision of alcohol treatment services for all problem drinkers is currently insufficient to fully tackle the scale of alcohol misuse, with Primary Care Trusts (PCTs) only spending on average 0.1% of their budgets on support for alcohol misusers.[2]

Alcohol services, in particular those aimed at dependent drinkers, are in short supply. These services support harmful and dependent drinkers to cut down their drinking, become more healthy and where needed find employment and housing. They can also address wider issues such as domestic violence, child protection and mental health issues.

However, the historical lack of high-level support for alcohol services has led to a piecemeal approach to planning and development. In the long term this can be a costly approach: services are often not sufficiently developed to meet demand, or can only meet low priorities. Provision is sometimes in the wrong place or frequently hard to access – and yet rates of alcohol dependency are rising.

With alcohol dependency increasing to 1.6 million people in England[3], unless urgent action is taken to ensure they receive the support they need to tackle their drinking, the cost to society could be as high as £3.7 billion[4], as the problems that dependent drinkers encounter continue to cause a burden to the NHS and criminal justice service.

Supporting dependent drinkers to turn their lives around makes good economic sense. It improves their health, rebuilds families and saves costs. Every one pound spent on supporting problem drinkers saves five pounds. The total saving made in doubling current expenditure on alcohol treatment would yield a £1.7 billion saving.

Alcohol Concern urges national and local decision makers to prioritise support for dependent drinkers, not just for their sake but also for the sake of their families and the communities they live in.

Alcohol Concern is advocating a higher level of political support for this issue, requiring national leadership to ensure that local areas

have the services they need to support harmful and dependent drinkers.

This requires a systematic and well-informed approach to commissioning at local level. Commissioners also need to ensure that the response to alcohol reads across to other local strategic priorities such as crime and disorder or domestic abuse.

Key Recommendations

National decision makers

a) Ministers must show leadership in encouraging local areas to invest in alcohol services. Strategic investment in alcohol services is necessary, cost effective and beneficial to local communities. To continue to ignore the growing problem of increased alcohol misuse and static or shrinking support for those who need it is a recipe for disaster.

b) In order to provide 15% of dependent drinkers with alcohol treatment would require at least doubling the current expenditure on alcohol treatment. While significant this would, according to the established research, lead to estimated saving of £1.7 billion[5] for the public sector.

Local decision makers

a) Alcohol is an issue of such importance that every area, even those with the lowest level of need, requires a clearly thought out, multi-agency, strategic approach to developing services. Alcohol Concern recommends that at least 20% of dependent drinkers in each local area have access to treatment support and that local commissioners use this as a benchmark to aim for.

b) It is Alcohol Concern's view that each local partnership should develop a data collection strategy which identifies what data will be gathered, how it will be shared and the indicators to be monitored. In particular, the development of agreed local performance indicators and baseline data for those measures is vital.

c) A major concern is that Identification and Brief Advice (IBA) services are being introduced without sufficient consideration of their impact on services. Although the aim of IBA is to identify non-dependent drinkers, our work has highlighted that these schemes also identify large numbers of clients who require Tier 2 / Tier 3 services each year. Alcohol treatment systems need to be developed as a whole if Tier 1 work is to avoid generating clients which will then clog up already over-stretched specialist services.

d) The single biggest gap in local alcohol treatment systems can be argued to be the lack of an adequate pathway from prison into community treatment. This needs to be addressed urgently.

e) It is important to look at the overall impact of re-tendering alcohol treatment services nationally. Research evidence is required to demonstrate that service re-tendering actually delivers long-term benefits to clients rather than simply reducing costs.

2. Aims of this paper

This paper is aimed primarily at local commissioners and national decision makers.

One of the key challenges for local commissioners is developing a range of alcohol services for those who have problems or who are at risk of developing problems. Key questions to consider are:

- How should demand be assessed and services planned?
- What is the best model for local services?
- Which care pathways should commissioners prioritise?
- How should vulnerable groups be supported?
- How do we measure success?

This paper sets out Alcohol Concern's views on these questions, following 10 years of consultancy and training to regional bodies, PCTs and local authorities. Our primary audience are alcohol treatment commissioners but we also want to offer a vision of treatment to service managers and others involved in service planning and provision.

What makes this paper different is that it draws on Alcohol Concern's extensive experience of working with local services. Since 2001 our Consultancy and Training Unit has been undertaking service reviews, needs assessments and other more specific pieces of research in treatment systems across England. We have a unique vantage point from which to comment on alcohol services.

3. The National Perspective

Alcohol misuse is a costly business. Not just for individuals and their families but also to society, through unemployment, welfare benefits, health care costs and housing support. The cost of problem drinking to society is estimated at £2.7 billion every year for health care costs alone. These costs will increase unless strategic action is taken.

Societal harm from alcohol each year includes approximately one million incidents of violent crime, over 100,000 cases of domestic abuse, and over 600 deaths from drink driving, while costs to society as a whole are estimated at between £17 billion and £22 billion[6]. British teenagers drink more and earlier than their European counterparts, with UK 15-year-olds more likely to have both drunk alcohol and been drunk in the last 12 months than the European average.[7]

Every dependent drinker[8] is estimated to cost the NHS £2,300 per year[9] and the number of dependent drinkers is increasing. There was a 24% increase in the number of moderate to severely dependent drinkers between 2000 and 2007, with an estimated 1.6 million people now dependent on alcohol in England[10].

The Diagnostic and Statistical Manual on Mental Health (DSM-IV)[11] defines alcohol addiction as a spectrum, including:

- Experiencing withdrawal symptoms when drinking ceases
- Drinking more than first intended
- An inability to cut down or reduce
- Spending a lot of time either drinking or recovering from drink
- Continuing to drink even if self or others are aware of its consequences

Successive Governments have placed much emphasis on tackling drug addiction and drug related crime, but strategies to specifically reduce problem drinking have only been addressed relatively recently through the 2007 revised alcohol strategy. Even this has not directly focused on how to ensure that all problem drinkers, from those drinking harmfully (or at increased risk) to dependent drinkers, get the support they need. Indeed the provision of alcohol treatment services for all problem drinkers is currently insufficient to fully tackle the scale of alcohol misuse, with Primary Care Trusts (PCTs) only spending on average 0.1% of their budgets on support for alcohol misusers[12].

This has meant that the number of moderate to severely dependent drinkers having access to treatment services has remained relatively low. A study conducted in 2005 concluded that for every 18 dependent drinkers, only one actually received treatment[13]. New provisional figures collected by the National Treatment Agency suggest that in 2008/9 one in 13 problem drinkers accessed treatment support, however this may include those who are not dependent and so may be an underestimate[14]. The last government's Health Secretary, Alan Johnson MP admitted in 2009 that the level of provision to dependent drinkers was "patchy", however providing support to dependent drinkers is not only known to reduce dependency but also to reduce health and social care costs as well as crime[15]. In fact for every £1 spent on treating dependent drinkers, £5 is saved on health, welfare and crime costs[16].

In the USA, a "good" level of access to treatment provision is considered to be 20% of the dependent population[17]. The Department of Health under the Labour government

suggested that treatment access levels should be 15% of the local dependent population[18].

Calculating the proportion of dependent drinkers who access treatment is difficult as systems are not in place to measure this. It is estimated that 100,098 problem drinkers accessed treatment in 2009/10[19]; however some of these may not be dependent drinkers. Based on the prevalence of dependent drinking in England, our best estimate of the proportion of dependent drinkers accessing treatment is therefore 6%, but this may in fact be lower.

The National Audit Office found that average PCT expenditure on alcohol services was £600,000 (0.1% of annual budgets) in 2008. This compares with on average £2.7 million spent by each PCT on treating drug addicts, providing 58% of problem drug users with access to treatment services. Those with an illicit drug dependency are subsequently ten times more likely to have access to treatment than alcohol dependents (see Table 1).

Supporting dependent drinkers to turn their lives around makes good economic sense, in terms of improving their health, rebuilding families and saving costs. Alcohol Concern urges national and local decision makers to prioritise support for dependent drinkers, not just for their sake but also for the sake of their families and the communities they live in.

In order to provide 15% of dependent drinkers with alcohol treatment would require at least doubling the current expenditure on alcohol treatment. While significant, this would, according to the established research, lead to estimated saving of £1.7 billion for the public sector[26].

Substance	Prevalence of dependence	Numbers in treatment	Percentage in treatment	Expenditure on treatment
Drugs	332,000[20]	191,695[21]	58%	£436 million[22]
Alcohol	1.6 million[23]	100,098[24]	6%	£217 million[25]

Table 1 – Comparison of Drug and Alcohol Treatment expenditure and percentage in treatment

4. How should demand be assessed and services planned?

Alcohol services should be built on an assessment of need. However, needs assessment in the alcohol field must be approached with care. Too often needs assessments have become a purely statistical process that attempt to gather all the local statistics on alcohol. This information is useful but is not enough: health profiling alone is not needs assessment.

Needs assessment should guide future action. Understanding the statistics has never been enough to guide alcohol interventions.

- The scale of alcohol related harm so dwarfs the interventions provided that very often developing services is more about providing an adequate minimum rather than meeting the identified need or adjusting the provision to the specific local manifestation of the problem. For example the Department of Health's Alcohol Needs Assessment Research Project states that drawing between 10-20% of problem drinkers into services is the figure to achieve;
- The huge range of needs related to alcohol means that an essential part of the process is prioritisation; this requires knowing not just what is needed but what can possibly be addressed and what local people feel about the different priorities.

As a result, in guiding an area on how to move forward Alcohol Concern uses a range of evidence:

- National statistics – e.g. what does national data tell us about the likely prevalence of alcohol misuse among women, homeless people, those with a dual diagnosis or older people?
- Local statistics – e.g. what does local data tell us about the extent of alcohol misuse among various population groups?
- National Guidance – e.g. what does the law or national guidance require to be done?
- Comparisons with other areas – e.g. how are other comparable areas tackling the problem among various population groups?
- Local opinion – e.g. what do local stakeholders feel needs to be done?

For example, knowing that there are 150 homeless or marginally housed drinkers in a particular city is not a guide to future action. This information needs to be looked at in the context of other questions. What is already being done locally? What could or should be done locally? What is local opinion on the seriousness of this problem both in isolation and in comparison to other alcohol related harm? Should we prioritise resources on tackling this or target other issues such as education for young people in schools? Such questions cannot be reduced to a numerical analysis.

A number of areas such as Birmingham, Bournemouth and Poole and Knowsley have gone through such processes. These involve consultation with service users, service providers, commissioners and community representatives. Alcohol Concern sees it as vital to secure a wide range of input.

It is our experience that accessing adequate data on alcohol-related harms is a problem in the majority of partnerships. The available information varies across the country. Addressing this demands a strategic approach. Each area must decide what data is required, what it will illuminate and what use will be made of it. It is Alcohol Concern's view that each partnership should develop a data

collection strategy which identifies what data will be gathered, how it will be shared and the indicators to be monitored. In particular, the development of agreed local performance indicators and baseline data for those measures is vital.

However, action on alcohol should not be delayed by the need to develop data systems. Generally, there is enough data to justify action on alcohol in any area. Using the data on the Alcohol Learning Centre and the data provided by the North West Public Health Observatory can provide simple analysis of the scale of need.

An alternative approach to understanding the local context is to learn lessons about the adequacy of care for problem drinkers from local critical incidents. A number of acts of violence or self-harm will be subject to inquiry processes e.g. Child Death Inquiries, Internal Serious Untoward Incident (or Critical Incident) Inquiries in mental health services (covering homicides, suicides, violent acts and serious self harm), Independent mental health homicide inquiries, inquiries into homicides related to domestic violence.

Many critical incidents may involve significant levels of alcohol misuse as a contributory or causative factor and the reports may highlight specific failings in the local response to problem drinking. Birmingham Drug and Alcohol Action Team (DAAT) has a drug related death group which meets to review such incidents. It is interesting to note that at a recent meeting, the majority of the deaths reviewed had alcohol as a significant element. Consideration could be given to developing “alcohol death reviews” to mirror the attention the National Treatment Agency (NTA) is giving to drug death reviews.

5. What is the best model for local services?

The starting point for any model treatment system is the Department of Health's *Models of Care for Alcohol Misuse* (*MoCAM*). This document has the force of a National Service Framework in the health service and provides a standard to judge the adequacy of the range of local services.[27]

MoCAM provides a stepped care model which divides services into four Tiers:

- Tier 1 Non-specialist services which see substance misusers e.g. social services and primary care;
- Tier 2 Open access, low threshold, substance misuse services;
- Tier 3 Structured community-based substance misuse services;
- Tier 4 In-patient and residential substance misuse services.

However, it is clear that four years after its publication, most areas of the country are still some way from establishing alcohol services which match *MoCAM*.

The effectiveness of alcohol services has been studied on both sides of the Atlantic and there is clear evidence that the types of therapies used by alcohol services do have positive outcomes for clients. The UK Alcohol Treatment Trial and Project Match both showed that although one treatment is no more effective than any another, the range of treatments available do elicit change, albeit not for every client. In 2006 the Department of Health published the *Review of the effectiveness of treatment for alcohol problems*.[28] This provides an extensive evidence base on the effectiveness of alcohol services including Identification and Brief Advice (IBA) and the National Institute of Health and Clinical Evidence (NICE) have now recommended a suite of interventions to prevent alcohol misuse[29].

MoCAM expects that those providing Tier 1 alcohol interventions should identify, offer brief interventions to, and refer increasing risk, high risk and dependent drinkers. The roll out of Identification and Brief Advice training is now widespread thanks to the priority the Department of Health has given to this area of work. Locally Enhanced and Directed Enhanced Schemes focus on IBA and alcohol in primary care and these should be considered if they are not already in place.

However, it is Alcohol Concern's belief that the roll out of IBA is only effective if it can be placed within a programme which:

- ensures buy in and support at a senior level so that staff are required and supported to attend;
- encourages the use of IBA in the workplace through the provision of a clear structure for its use;
- monitors and reports the use of IBA in the workplace.

Effective services may also require funding to incentivise GPs particularly but also to employ specialist staff to train, support and sometimes undertake IBA work.

A key part of IBA is hospital-based work. Nationally it has emerged that what are called "alcohol health workers" or "hospital liaison posts" embrace a number of very different roles. In brief these cover:

- Identification and Brief Advice in Accident and Emergency or on the wards;
- Training and support to hospital staff;
- Clinical work to arrange detoxification regimes and ongoing management of dependent clients who have been referred onto the wards for other reasons.

All these roles are legitimate and very difficult to turn into just one role. For example in Hertfordshire voluntary sector workers undertake just the first role and in Doncaster a nurse undertakes only the latter two roles.

Commissioners need to be very clear about which needs they are trying to meet in setting up hospital posts. It should also be noted that while the policy emphasis is very much on IBA in A&E, it is much easier to see an immediate benefit in reducing bed days through better detoxification and management of dependent drinkers. As a result these posts are often pulled into that type of work.

Alcohol Concern's major concern is that IBA is being introduced without sufficient consideration to the impact on services. Although the aim of IBA is to identify non-dependent drinkers, our work in Westminster has highlighted that these schemes also identify large numbers of clients who require Tier 2 / Tier 3 services each year. Alcohol treatment systems need to be developed as a whole if Tier 1 work is to avoid generating clients which will then clog up already over-stretched specialist services.

The key question is what should a good configuration of services look like? Geographical areas are so different that it is not possible to give a definitive answer to this question. Large geographical areas such as shire counties will need a different configuration of services to smaller urban boroughs. However, some principles can be set out.

One model Alcohol Concern would advocate for urban areas is provided by Bolton. Alcohol Concern worked with Bolton PCT and Bolton Council to reconfigure the alcohol treatment system.

Two key principles were agreed for the system. It should be:

- as simple as possible to enter, and
- swift to respond.

The entry into specialist services is via a single point of entry and a triage assessment at ADS (Alcohol and Drug Services – a voluntary sector agency operating across the north of England). They will then determine the best interventions for each person. The only exception to this pathway is made for pregnant women, in which case a referral can be made directly to the CAT (Community Alcohol Team).

If in doubt the first point of referral is always ADS not the Community Alcohol Team. ADS will offer a triage assessment within three working days of contact. ADS can also offer a four-week programme of individual motivational interventions.

If a more intensive response is required a referral will be made to the CAT who will offer a comprehensive assessment, followed by detoxification, individual or group interventions as well as access to inpatient care and residential rehabilitation. Clients who complete these interventions will receive access to aftercare groups provided by ADS.

Timescales for interventions were agreed. The expectation is that:

- ADS will offer a triage assessment within three working days of the request.
- The CAT will offer a comprehensive assessment within two weeks of the request from ADS.
- The CAT will offer a community detoxification within one week of a comprehensive assessment if the client requires it.

It is positive to note that Bolton is one of very few areas in the country to have reduced its alcohol hospital admissions (by 2.4%). Although it is of course impossible to prove a causal link, local workers have suggested that the new structure has contributed to the reduction.

In larger areas these structures may have to be adjusted. Birmingham has developed a telephone single point of contact. Shire counties may need a scattering of access point clinics operating once or twice a week in different venues. In other structures Tier 3 services may be integrated into community agencies such as homelessness services, GP practices or social work settings.

While community detoxification is the preferred route, a small number of dependent drinkers will require inpatient detoxification because of specific risk factors such as a complicating psychiatric condition. Inpatient places in a dedicated local unit will be the best practice.

Residential rehabilitation services are not necessarily an exclusive local service. It is acceptable for a particular authority not to have a residential service within its boundary. The key question is whether local people can access the national range of services. Social services departments have a legal duty to offer clients who require it a full individual assessment of need. This will then determine whether they meet the Fair Access to Care Services eligibility criteria. Both service providers and service users should be made aware of their right to seek an assessment and the arrangements for accessing community care funds.

In the Bolton model aftercare is provided by ADS, this is not the only model. Some areas have specialist aftercare services (e.g. the Alcohol and Drug Community Aftercare Project in Dorset) and others will use peer-led, self-help, models such as the SMART recovery framework highlighted by Alcohol Concern[30], as well as Alcoholics Anonymous.

6. Which care pathways should commissioners prioritise?

The previous section identified the major pathway which needs to be addressed by commissioners: the path from those providing Tier 1 interventions into specialist services and on to aftercare. Other pathways will also be required.

It can be argued that the single biggest gap in local alcohol treatment systems is the lack of an adequate pathway from **prison** into community treatment. The most striking evidence of need comes from data provided by HMP Birmingham: of 8,318 admissions, 1,171 required a detoxification.[31] Addressing problem drinkers moving from the prison system into the community will both increase the identification of problem drinkers and also target crime reduction. Interventions in the prison system itself also need to be improved.

Evidence suggests that at least a quarter of **problem drug users** will also develop alcohol problems. Drug workers should be able to identify and assess problem drug users with patterns of hazardous, harmful or dependent drinking, offer them advice, brief interventions and refer on if required. Drug agencies should have policies in place to cover this, leaflets and materials available for clients and staff trained to deliver interventions. Drug services should have the skills to work with alcohol and should not be referring on to specialist services unless there is a clear need which they do not have the skills to meet.

Carer's services are often poorly developed and may actually be reducing. We have noted that the development of tighter contracts can lead to a reduction in the attention given to this group with the focus being placed on drinkers themselves. The absence of any support for these services in *MoCAM* is another barrier. Nonetheless, at the very least services must be developed which address the needs of the children of drinkers. Around one million children live with a parent with an alcohol problem. Their protection must be central to all service provision.

Other possible pathways for exploration are Regional Burns Units and Acquired Brain Injury services. These have been identified as gaps in Birmingham and Sheffield respectively. Both these types of services will see people with serious physical problems related to alcohol use. Links are therefore needed with all tiers of alcohol treatment.

7. How should vulnerable groups be supported?

National statistics indicate that 40-60% of clients who enter alcohol treatment services will drop out within as little as a couple of sessions.[32] The Alcohol Needs Assessment Research Project (2005) also shows that two-thirds of those referred never enter services[33]. Those most likely to disengage will be the most at risk and vulnerable clients among the substance misusing population. These vulnerable groups will include: those with criminal justice histories, personality disorder, and / or mental illness. Yet Alcohol Concern has seen care pathways which read: ""client disengages – end" i.e. services see their responsibility as ending when a client drops out of contact.

Clients who are difficult to engage in treatment or who disengage from treatment are an important group of clients. They may be frequent flyers in the hospital system or prolific offenders. As a result their needs should not be ignored. Commissioners should develop a protocol or care pathway for services to follow in meeting the needs of this group.

A particular weak point in alcohol services is the use of a robust care coordination model. The counselling model still predominates in alcohol services. The focus is on helping clients to change rather than managing risky behaviours. Difficult to engage clients would benefit from the more structured approach offered by care coordination as a step on the way towards change focused interventions. They will also benefit from assertive engagement and aftercare.

Work should be carried out to create a system which mirrors the Care Programme Approach used in mental health services. It is ironic that this system is already in place in mental health services but not alcohol services. The evidence is very clear that alcohol clients pose far greater risks than mentally ill people. Rates of violence, in particular, are far higher among problem drinkers than those with mental disorders alone.

Services for the alcohol misusing perpetrators of **domestic abuse** are seen as a need in virtually every area. However, in some areas there is also a gap in services for alcohol misusing victims of domestic abuse. This latter group may find it hard to access refuges if they are still drinking.

A significant proportion of problem drinkers will also have a **mental health problem**. This combination is associated with high levels of suicide, self-harm and violence to others and makes clients difficult to engage in services or treat effectively. Alcohol services will need to have both training in this area and specific protocols with local mental health services about the referral and management of this client group. These protocols will need to be written within the framework of the Department of Health's *Dual Diagnosis Good Practice Guide* which was published in 2002.

Pathways for **alcohol related dementias** are rarely in place, although it does not appear that this is placing a particular burden on services. On the other hand it is very unclear how many cases are emerging and what is happening to this client group.

8. Measuring success

If the impact of the steps taken to tackle alcohol misuse is to be monitored over the years the development of agreed local performance indicators and baseline data for those measures is going to be vital. As a stakeholder in Warwickshire said: “we need an inspirational target to reduce alcohol consumption.”

Public Service Agreement targets such as National Indicator 39, which targets a reduction in alcohol related hospital admissions, provide a framework for performance monitoring. North West Public Health Observatory and National Alcohol Treatment Monitoring System data provide useful monitoring data. However, it will also be useful to measure the specific outcomes of alcohol interventions. This could set a target for the proportion of increasing risk, high risk and dependent drinkers who are accessing services. It could target the proportion of family members engaged in care or the number of clients who disengage and are re-engaged.

Alcohol Concern has a long history of working to develop outcome tools for the alcohol field. Six years ago it published the Alcohol Spider tool, in the last year it has published the Outcome Star which helps workers measure and record client progress against a number of qualitative measures such as *“Use of time”, “Money”* or *“Emotional health”*.

9. Re-tendering services

The hardest aspect of service development is deciding whether to tender or re-tender services. Alcohol Concern is neither for nor against re-tendering. The priority is the best possible array of services for problem drinkers and their families. However, re-tendering is a powerful process and commissioners should consider the following in making their decision:

- Can current services be re-designed rather than re-tendered? This will certainly be less disruptive for clients.
- Will services be disrupted in the period around the tendering?
- Will the re-tender really achieve its goal? In many cases existing staff will move to the new services and may bring with them the problems which caused the commissioners to re-tender.
- Is the specification detailed enough? Commissioners will receive what they specify.
- What will happen to existing services which lose their contract? Commissioners can withdraw funding but they cannot compel services to close. Alcohol Concern is aware of areas where de-commissioned services continue to operate on other funding and confuse the care pathway for clients.
- How will bids be evaluated? The evaluation process is central to re-tendering and commissioners should be careful to include the right criteria e.g. asking for local knowledge will be a significant advantage for a local organisation competing against national bodies.

Crucially, it is important to look at the overall impact of retendering services nationally. Research evidence is required to demonstrate that these changes do actually deliver long-term benefits to clients rather than simply reducing costs.

10. Conclusion and Key Recommendations

Alcohol services, in particular those aimed at dependent drinkers, are in short supply. These services support harmful and dependent drinkers to cut down their drinking, become more healthy and where needed find employment and housing. They can also address wider issues such as domestic violence, child protection and mental health issues.

With alcohol dependency rising to 1.6 million people in England[34], unless urgent action is taken to ensure they receive the support they need to tackle their drinking, the cost to society could be as high as £3.7 billion[35], as the problems that dependent drinkers encounter continue to cause a burden to the NHS and criminal justice service.

Alcohol Concern is advocating a systematic and well-informed approach to commissioning. The historical lack of high-level support for alcohol services led to a piecemeal approach to planning and development. In the long term this can be a costly approach: services are developed which meet low priorities, provision is in the wrong place or hard to access. Commissioners also need to ensure that the response to alcohol reads across to other local strategic priorities such as crime and disorder or domestic abuse.

Alcohol is an issue of such importance that every area, even those with the lowest level of need, requires a clearly thought out, multi-agency, strategic approach to developing services.

Key Recommendations

National decision makers

a) Ministers must show leadership in encouraging local areas to invest in alcohol services. Strategic investment in alcohol services is necessary, cost effective and beneficial to local communities. To continue to ignore the growing problem of increased alcohol misuse and static or shrinking support for those who need it is a recipe for disaster.

b) In order to provide 15% of dependent drinkers with alcohol treatment would require at least doubling the current expenditure on alcohol treatment. While significant, this would according to the established research lead to estimated saving of £1.7 billion[36] for the public sector.

Local decision makers

a) Alcohol is an issue of such importance that every area, even those with the lowest level of need, requires a clearly thought out, multi-agency, strategic approach to developing services. Alcohol Concern recommends that at least 20% of dependent drinkers in each local area have access to treatment support and that local commissioners use this as a benchmark to aim for.

b) It is Alcohol Concern's view that each local partnership should develop a data collection strategy which identifies what data will be gathered, how it will be shared and the indicators to be monitored. In particular, the development of agreed local performance indicators and baseline data for those measures is vital.

c) A major concern is that Identification and Brief Advice (IBA) services are being introduced without sufficient consideration to the impact on services. Although the aim of IBA is to identify non-dependent drinkers, our work has highlighted that these schemes also identify large numbers of clients who require Tier 2 / Tier 3 services each year. Alcohol treatment systems need to be developed as a whole if Tier 1 work is to avoid generating clients which will then clog up already over-stretched specialist services.

d) The lack of an adequate pathway from prison into community treatment is arguably the single biggest gap in local alcohol treatment systems. This needs to be addressed urgently.

e) It is important to look at the overall impact of re-tendering alcohol treatment services nationally. Research evidence is required to demonstrate that service re-tendering actually delivers long-term benefits to clients rather than simply reducing costs.

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UK total annual cost of alcohol misuse, £25bn

Problem

- Alcohol costs the NHS £3bn
- £6.4bn is lost to the economy through alcohol-related sickness, absence and death
- In some areas one-third of child protection cases involve alcohol
- Nationally one million children are affected by a parent's alcohol-related problem
- Almost half of all violence is alcohol related

Solution

Alcohol Concern is the national agency on alcohol misuse campaigning for effective alcohol policy and improved services for people whose lives are affected by alcohol-related problems.

Since 2000 we have successfully delivered training and consultancy to clients that include PCTs, Social Services, Youth Services, Housing Associations, Police and Schools to help meet alcohol targets and reduce the financial costs of alcohol misuse.

Contact Alcohol Concern to find out how you can be part of the solution.

Alcohol Concern, 64 Leman Street, London E1 8EU
Tel: 020 7264 0510
Email: consultancy@alcoholconcern.org.uk
Website: www.alcoholconcern.org.uk

Registered Charity No. 291705 Company No. 1908221

Training

We deliver the following training:

- Alcohol Awareness Training
- Alcohol and Young People
- Alcohol and the Workplace
- The Family Training Programme for Alcohol Misuse

Alcohol Concern
Making Sense of Alcohol

Alcohol Concern, 64 Leman Street, London E1 8EU
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Alcohol Concern
Consultancy and Training