NEVER THE BRIDE

Trevor McCarthy argues that the Government's new alcohol strategy still leaves alcohol treatment as drug's poor cousin, but suggests Public Health England could be the driver to reprioritise substance misuse treatment.

Alcohol services looking for hints of improvement in the new alcohol strategy are probably still looking. Chapter 5: *Supporting individuals to change* includes precisely nothing about specialist treatment. The only reference to anything resembling specialist treatment comes in one small paragraph; " … Funding through the Public Health Grant will allow local authorities to commission Identification and Brief Advice, which is proven to be effective in reducing the drinking of people at risk of ill health, and specialised treatment for those with greater needs. Alcohol liaison nurses within A&E have been shown to reduce re-presentations and may in future be co-funded by Clinical Commissioning Groups alongside Local Authorities."

For the alcohol strategy to work, it needs to take a whole population approach to alcohol – and for that, you need to engage the whole population. Politically this has not been popular. The fingers of Special Advisers (SPADS) are all over the alcohol strategy.

The ideology underpinning the alcohol strategy is all about blaming drinkers for their alcohol problems. The individualised approach to people who may cause problems to others denies the contribution of marketing, availability and licensing laws, for example.

In fact government alcohol and drugs policy does not really focus on the direct needs of people with problems at all. Alcohol and drug treatment is almost always justified by the amount of money it will save the NHS, the criminal justice system or local authorities. Treatment may also be justified on the basis of reducing anti-social behaviour. Treating drinkers and drug users is a means to desirable ends. Benefit to the individuals receiving treatment is rarely if ever the policy rationale. It is not about people with problems having a right to treatment.

Most drugs for alcohol treatment like Acamprosate are not in patent so pharmaceutical companies lack incentive to push them. Naltrexone manufacturers do not even seek a licence in the UK for treating alcohol problems even though it is recommended by NICE.

So in the virtual absence of direction from the strategy; what should alcohol treatment comprise? Before Labour's 2004 alcohol strategy there was no evident requirement for local areas to provide alcohol treatment, yet everywhere had some. There would usually be an advice centre and a community alcohol team: a mix of voluntary sector and NHS services. The first comprehensive analysis published in 2005 found those local arrangements delivered insufficient capacity.

Contrary to popular myth, civil servants spotted the acronym before the Alcohol Harm Reduction Strategy for England (AHRSE) was published. Like its 2007 successor, *Safe, Sensible, Social* and the current document, AHRSE was biased toward prevention; a whole population, public health approach.

The drugs strategy has been based on the analysis that most drug-related harm is perpetrated by dependent, illicit drug users: hence a focus on getting dependent users into treatment.

Alcohol is not illegal and alcohol strategy is different. The harm experienced by dependent drinkers, and others directly affected, is significant. However, the Prime Minister's Strategy Unit 2003 interim analytical report found most alcohol related harm is associated with drinkers who are not dependent. Consequently, treating dependent drinkers was not the priority.

Drug targets have been to get two thirds of dependent drug users into treatment; an aim that has been fully funded, centrally. For alcohol the aspiration has been 15% of dependent drinkers in treatment at any one time. This calculation was based on one Canadian paper published over twenty years ago. And the treatment is not funded either centrally or fully. Spot the difference?

Models of care for alcohol misusers (MoCAM) and accompanying publications, including the *Review of effectiveness of treatment for alcohol* problems published in 2006 gave guidance on commissioning treatment systems and evidence based interventions. But with next to no money backing up the publications, rhetoric was the main implementation strategy.

In most areas of England drug commissioning teams took on alcohol, with the familiar results that accrue from ridiculous levels of re-commissioning for no discernible benefit. The main result of this churn – displacing provider agencies and disrupting existing partnerships – is never accounted for. It is not clear that alcohol outcomes or delivery of best practice, evidenced based interventions have improved. However, the NDTMS data collection system has kicked in for alcohol and data was a key element driving improved drug treatment.

The commissioning processes which spawned large regional and national voluntary sector providers are also affecting alcohol treatment, narrowing

the multi-disciplinary aspect of local systems.

When I joined the alcohol field the Community Alcohol Team (CAT) included psychiatry, psychology, psychiatric and general nursing, occupational therapy and social work. GPs were supported by the CAT in prescribing for community detoxification. Services were delivered in home and community venues, augmented by an Alcohol Advice Centre and a specialist hostel supporting controlled drinking as well as abstinence.

Now alcohol psychologists are rare. Occupational therapists are long gone. Psychiatrist-led services are replaced by GP-led services. There is no evidence that removing psychiatry from the mix has improved or would improve systems. Commissioners have acted to strip out some professional expertise and experience on the basis of unsubstantiated tenders from those large voluntary sector providers who are making an argument for their own organisational advantage

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Commissioners fail to specify what multi-disciplinary services should comprise. Some tenders from the voluntary sector-led consortia maintain there is no need for (expensive) psychiatric input. Once expensive elements are eliminated there is no guarantee they will ever return. Where Commissioners believe GPs with Special Interest are equivalent to psychiatrists they literally buy into narrowing alcohol provision.

The expansion of GP engagement in local drug treatment systems was surprisingly straightforward. Many GPs responded and have been intrinsic to the development of effective and penetrative, normalising drug treatment. The GP medical role is a good fit for treatment systems and congruent with their work in other specialisms. Drug treatment prescribing: medically assisted withdrawal or maintenance has well established evidence based protocols. Accompanying talking therapies are not delivered by GPs. Drug users go to specialist drug services where they are assessed; the subsequent GP role is straightforward, well boundaried (and paid). Crucially, GPs are supported by well resourced community drug services.

Alcohol is different. Drug users are a relatively small segment of the

population whereas people drinking above recommended levels make up a large proportion of GP lists. National Service Frameworks (NSFs) were NHS priorities with Primary Care typically in the gatekeeper role. NSFs included mental health; coronary heart disease; older people and diabetes. With the national cancer plan, dual diagnosis guidance and the suicide prevention strategy, GPs were in the front line delivering multiple overlapping strategies. All should have routinely included alcohol as part of holistic Primary Care assessments. That didn't happen.

Identification and Brief Advice (IBA) is mentioned in the new alcohol policy. The rationale of the DH alcohol team was that GPs are put off by technical terms like "assessment" and "intervention". Assessment and intervention implies time and GPs are (and say they are) time-poor. A vast amount of work previously delivered in hospitals has been devolved to Primary Care; a trend that continues. In a literature search of the alcohol research evidence base IBA will turn up no results. Tools and techniques claimed for IBA are assessment, brief interventions and treatment in the literature. Here's everything you need to know about IBA. NICE don't mention it. At all. Not once. Because NICE is all about the evidence – not about spin. IBA was a cuddly alternative to Assessment and Intervention. And of course it fundamentally misses the point.

It is normal for front line professionals to avoid routinely asking about alcohol – even when alcohol problems are implicated in their service users' and patients' problems. People in front line roles find it difficult to ask about alcohol. MoCAM insisted alcohol is everyone's responsibility; NICE confirmed that. So that is a major problem for the alcohol strategy.

IRONICALLY, THE REVILED HEALTH AND SOCIAL CARE BILL MAY INADVERTENTLY ESTABLISH AN ENVIRONMENT WHERE ALCOHOL TREATMENT AND INTERVENTIONS ARE PROPERLY COMMISSIONED

Yet the shared-care model has begun to resolve wide spread reluctance to raise addiction issues. Still not all GPs engage though, and there are many more people with alcohol than drug problems.

Integrated, well resourced, responsive drug treatment systems, make referral easy and offer GPs (and other professionals – notably Probation) a clear role. The result: more people in treatment and increased engagement with wider partnerships of professionals. Some money sweetened the deal for GPs but appealing to their better professional nature was crucial. It wasn't about time. It was about having a role in a responsive system that supports professionals and users.

So, why not make alcohol work easier? Establish well resourced multi-disciplinary systems with clear referral routes. When front line professionals have begun routinely screening and assessing service users and patients they need somewhere to send the drinkers they find and experts to inform their interventions. This is what works in drug treatment.

Ironically, the reviled by many Health and Social Care Act may inadvertently establish an environment where alcohol treatment and interventions are properly commissioned.

There are two potential drivers. Aligning NHS and social care outcomes makes sense for alcohol investment. Perhaps even more important will be the active involvement of Directors of Public Health who were marginalised during the centralised expansion of drug treatment.

Alcohol is a top three issue for Directors of Public Health (after smoking and obesity). DPHs respond to data and evidence. Having them centrally involved in commissioning alcohol treatment offers a real prospect that alcohol will become a priority. NICE alcohol guidance will inform commissioning and *Screening and Intervention Programme for Sensible drinking (SIPS)* found that Primary Care should screen everyone for alcohol: targeted screening – which most GPs preferred – missed 40% of at risk drinkers.

Despite the Health and Social Care Act's unwanted and unwarranted de-nationalisation of the NHS it may offer hope for alcohol. The commissioning Health and Well Being Boards and Public Health England might just act on the evidence and guidance, putting resources into alcohol screening and assessment and expanding treatment as recommended by NICE and implied in MoCAM

Public Health are ideally placed to implement policy because policy is to drive down alcohol problems at risky levels of drinking below dependence criteria. And they understand the logic of knock-on effects. The NICE public health guidance on alcohol (Tier 1 & 2 guidance for the most part) states that the capacity of specialist treatment should be increased to meet the anticipated increased demand from successfully identifying more people with alcohol problems by introducing widespread if not universal screening

I'll drink to that.

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