

Services for the identification and
treatment of hazardous drinking,
harmful drinking and alcohol
dependence in children, young
people and adults

Commissioning guide

Implementing NICE guidance

August 2011



Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults

This guide for commissioners provides support for the local implementation of NICE guidance through commissioning and is a resource to help commissioners, clinicians and managers to commission evidence based and quality services across England. This guide also aims to support joint commissioning and partnership working between NHS and partner organisations.

- Section 1 is an [executive summary of the commissioning guide](#)
- Section 2 [makes the case for commissioning alcohol services](#)
- Section 3 [specifies service requirements](#)
- Section 4 [makes suggestions for contract specification](#)
- Section 5 [helps you determine local service levels](#)
- Section 6 [explains more about the cost impact of service redesign](#)
- Section 7 is a [glossary of terms used in this guide](#)

This commissioning guide should be read together with the following NICE guidance and quality standard:

- [NICE quality standard. Alcohol dependence and harmful alcohol use](#)
- [NICE clinical guideline 115. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#)
- [NICE clinical guideline 100. Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications](#)
- [NICE public health guidance 24. Alcohol-use disorders: preventing the development of hazardous and harmful drinking](#)

NICE guidance provides evidence based recommendations about clinically effective and cost-effective treatments and interventions to improve health outcomes for individuals and local populations. Making commissioning decisions based on the best available evidence such as NICE guidance and information accredited by [NHS Evidence](#) can help commissioners ensure that they are using their resources effectively.

Commissioners should refer to [NICE quality standards](#) when commissioning services and should include quality statements and measures within the service specification element of the standard contract. Managing performance

against the NICE quality standards could help improve standards of care and outcomes for patients.

This commissioning guide highlights any recommendations supporting cases for disinvestment or decommissioning by identifying treatments and interventions that [do not add value](#), enabling commissioners to release resources or generate savings where appropriate.

Implementation of the guidance noted above is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement this guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in the guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please [send us your ideas for future topic-specific guides or other comments](#).

Read the [NICE disclaimer](#) for information on the use and accuracy of content on the NICE website.

A topic-specific advisory group was established to review and advise on the content of the commissioning guide, details of membership can be found in [section 8](#).

Date of publication: August 2011

1. Executive Summary

This commissioning guide aims to support commissioners in England to implement NICE guidance on alcohol, and to commission high quality services that meet the quality standard on alcohol dependence and harmful alcohol use, by commissioning services for the identification and care of hazardous and harmful drinkers and people with alcohol dependence.

The guide highlights the benefits of commissioning for outcomes ([see section 2.1](#)) – principally reducing consumption, alcohol-related hospital admissions and alcohol-related mortality by improving access to evidence-based interventions that promote recovery.

It is estimated that only a small proportion of the £2.7 billion annual expenditure on alcohol-related harm is spent on identifying and treating alcohol misuse. NICE guidance advocates an invest-to-save approach by prioritising the prevention of alcohol-use disorders. This commissioning guide sets out a whole system approach ([see section 3.4](#)) to commissioning integrated alcohol services across the whole spectrum of care, from preventing harmful drinking through opportunistic screening and brief interventions, to specialist treatment programmes for children, young people and adults, and their families or carers.

The commissioning guide describes the following service components required to deliver a high quality service:

- opportunistic screening and brief interventions for adults who are hazardous and harmful drinkers ([see section 3.1](#))
- diagnosis, assessment and management of harmful drinking and alcohol dependence in adults, in specialist services ([see section 3.2](#))
- services for children and young people who are vulnerable to alcohol-related harm ([see section 3.3](#))
- whole system commissioning of high quality alcohol services ([see section 3.4](#)).

Each section offers examples of service models, including case studies and ideas for using Quality, Innovation, Productivity and Prevention (QIPP) and Commissioning for Quality and Innovation (CQUIN) to drive improvements to alcohol services. There is also an outline service specification ([see section 4](#)) to assist commissioners when tendering or contract managing alcohol services.

The benchmark section ([see section 5](#)) contains further information to help commissioners to assess levels of alcohol dependence and hazardous and harmful drinking in their population. A population benchmark has been provided for the number of people in England aged 16 or above who are hazardous, harmful or dependent drinkers.

The guide contains a [commissioning and benchmarking tool](#) that can be used to calculate the costs of increasing access to opportunistic screening and brief interventions and to specialist alcohol treatment for adults. Providing evidence-based packages of care using the stepped-care model may reduce the unit cost of treatment per person by offering the least intensive, most cost effective intervention that is appropriate. Whole system commissioning may generate savings by reducing alcohol-related harm and alcohol-attributable hospital admissions.

2. Commissioning services for identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults

[NICE public health guidance 24 on preventing harmful drinking](#) recommends that chief executives of NHS and local authorities prioritise the prevention of alcohol-use disorders¹ as an invest-to-save measure. There is evidence that people with alcohol dependence cost the NHS twice as much as other people who drink alcohol. Reducing the need for alcohol-related hospital admissions and reducing mortality can be achieved by commissioning services to identify hazardous and harmful drinkers² and provide effective brief interventions or treatment early, preventing the development of the physical and psychological comorbidities associated with alcohol misuse³.

Reducing the need for alcohol-related hospital admissions and reducing alcohol-related mortality is a priority for commissioners. Alcohol consumption increased steadily between the 1970s and 1990s. Despite a recent plateau in annual consumption levels, evidence for the long-term health consequences of increased alcohol consumption among children, young people and adults is clear from corresponding annual increases in alcohol-related hospital admissions, which doubled between 2002 and 2010, and in alcohol-related mortality from liver disease (see figure 1)⁴.

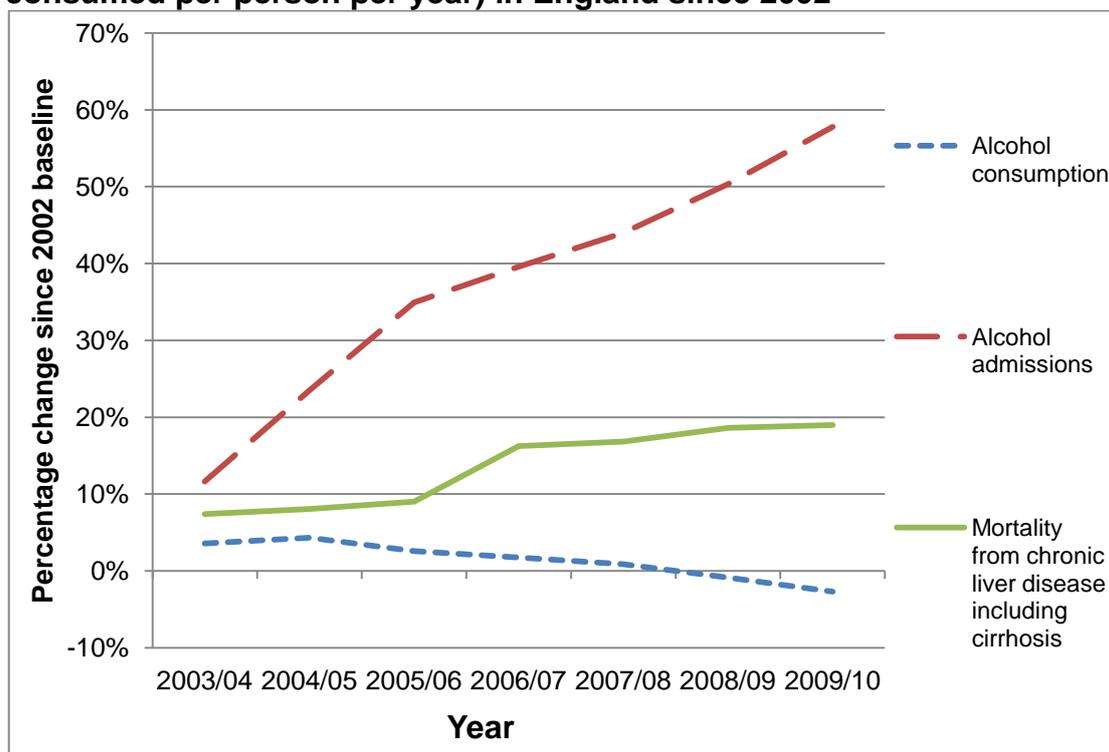
¹ There is a definition of 'alcohol-use disorders' in the glossary in section 8 of this guide.

² There is a definition of 'alcohol misuse' in the glossary in section 8 of this guide.

³ Department of health (2009) [Signs for improvement – commissioning interventions to reduce alcohol-related harm](#). London: Department of Health.

⁴ Department of Health (2009a) [Guidance on the consumption of alcohol by children and young people](#). London: Department of Health; Health and Social Care Information Centre (2010) [Hospital episode statistics](#). London: Health and Social Care Information Centre; Institute of Alcohol Studies (2010) Alcohol consumption in the UK. Available at: <http://www.ias.org.uk/resources/factsheets/consumption-uk.pdf> (downloaded on 07/02/2011); Office for National Statistics (2010) [Mortality statistics Deaths registered in 2009](#) London, office for national statistics

Figure 1 Trends in alcohol-specific hospital admissions, mortality from alcohol-related liver disease and alcohol consumption in adults (litres consumed per person per year) in England since 2002⁵

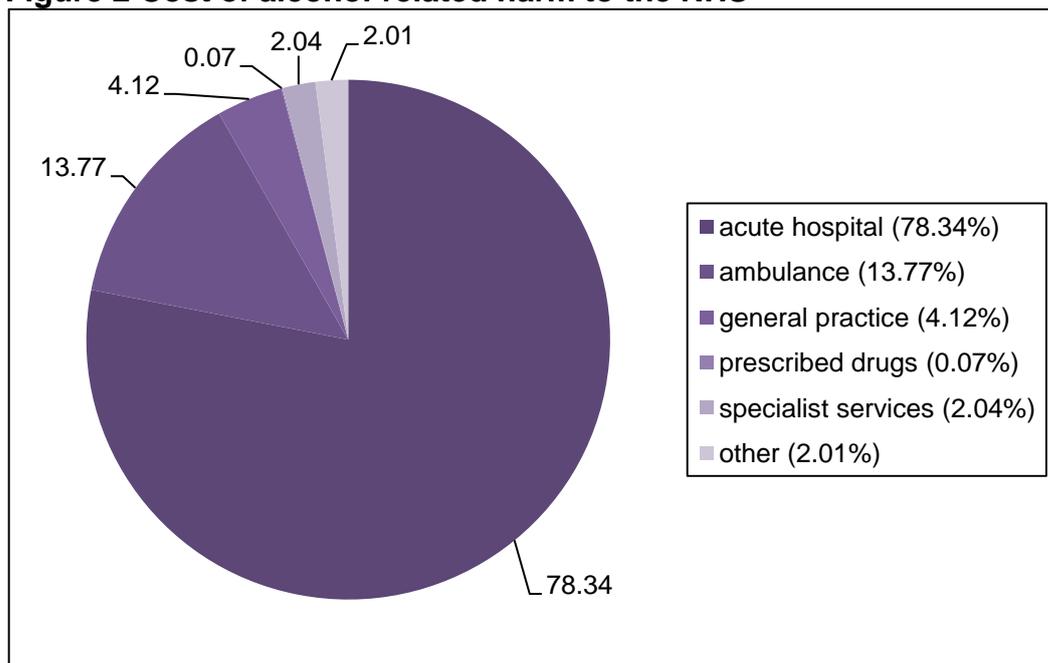


Alcohol-related harm, from mental ill-health and alcohol-related physical complications, is estimated to cost the NHS around £2.7 billion per year; this is equivalent to about £6 million per 100,000 population aged 10 years and above. Despite the growing burden of alcohol misuse on the health service, it is estimated that only 2% of NHS expenditure on alcohol-related harm is currently spent on specialist alcohol services (see figure 2)⁶. A whole system approach may enable commissioners to divert resources between and within primary and acute settings to improve access to opportunistic screening, brief interventions and specialist alcohol treatment in the community.

⁵ Health and Social Care Information Centre (2010) [Hospital episode statistics](#). London: Health and Social Care Information Centre; Institute of Alcohol Studies (2010) Alcohol consumption in the UK. Available from: www.ias.org.uk/resources/factsheets/consumption-uk.pdf [accessed 07/02/2011]; Office for National Statistics (2010) [Mortality statistics: deaths registered in 2009](#). London: Office for National Statistics

⁶ NHS Confederation (2010) [Too much of the hard stuff: what alcohol costs the NHS](#). NHS Confederation; Department of Health (2009) [Signs for improvement – commissioning interventions to reduce alcohol-related harm](#). London: Department of Health.

Figure 2 Cost of alcohol-related harm to the NHS⁶



In addition to the health impact of alcohol-related harm, there are also correlations with crime and anti-social behaviour, loss of productivity in the workplace, and family and social problems. A whole system approach to commissioning alcohol services will draw on the contribution of partners in health, social care, criminal justice, housing and education, among others.

Data from the National Alcohol Treatment Monitoring System (NATMS) in 2009/10 show that only 1 in 10 harmful or dependent drinkers aged 18 years and over is currently receiving specialist alcohol treatment⁷. This may be due to the delay between developing alcohol dependence and seeking treatment, the limited availability of alcohol treatment services in some parts of England and under-identification by health and social care professionals⁸. [NICE clinical guideline 115 on alcohol dependence](#) notes that current practice in the treatment of alcohol dependence varies across the country, with limited access to community-based assisted withdrawal and psychological interventions. A survey by DrugScope found that services for young people are patchy, with variations in funding and relationships with other children's services impacting on equity of provision⁹.

⁷ National Treatment Agency for Substance Misuse (2010) [Statistics from the National Alcohol Treatment Monitoring System \(NATMS\) 1 April 2008 – 31 March 2009](#). NHS National Treatment Agency for substance misuse

⁸ National Institute for Health and Clinical Excellence (2011) [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#). London: National Institute for Health and Clinical Excellence

⁹ DrugScope (2010) [Young people's drug and alcohol treatment at the crossroads: What it's for, where it's at and how to make it even better](#). London: DrugScope

2.1 Commissioning for outcomes

The topic advisory group agreed that an integrated, whole system approach to commissioning high quality alcohol services could deliver the following outcomes:

- **improving outcomes for people**, including better health, wellbeing and relationships, by increasing access to evidence-based interventions underpinned by NICE guidance
- **reducing alcohol-related harm** through delivering interventions that make people aware of the potential risks of alcohol misuse
- **improving quality of life for the community** by reducing alcohol-related crime and anti-social behaviour, and preventing family breakdown
- **reducing the need for alcohol-related hospital admissions** by commissioning services that identify and provide early intervention for hazardous and harmful drinkers, and provide recovery focused treatment for people with alcohol dependence
- **promoting recovery** through integrated treatment that involves family and carers, and includes coordinated care and re-integration support
- **reducing alcohol-related morbidity and mortality** through integrated whole system commissioning of alcohol services¹⁰
- **Improving people's experience** of alcohol treatment and care.

A whole system approach to commissioning high quality alcohol services may also contribute to the following outcomes in the NHS outcomes framework 2011/12:

- **Domain 1 preventing people from dying prematurely:** reducing premature mortality from the major causes of death - under 75 mortality from liver disease
- **Domain 2 enhancing quality of life for people with long-term conditions:** enhancing quality of life for carers and enhancing quality of life for people with mental illness.

¹⁰ There is a definition of 'whole-system commissioning' in the glossary in section 8 of this guide.

2.2 Key clinical and quality issues

Key clinical and quality issues in providing effective alcohol services are:

- Health and social care staff receive alcohol awareness training that promotes respectful, non-judgemental care of people who misuse alcohol (NICE quality statement 1).
- People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment (NICE quality statement 3).
- People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff (NICE quality statement 4).
- Adults accessing specialist alcohol services for alcohol misuse receive a comprehensive assessment that includes the use of validated measures (NICE quality statement 5).
- People needing medically assisted alcohol withdrawal are offered treatment within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities (NICE quality statement 8).
- People receiving treatment for alcohol misuse have regular treatment outcome reviews, which are used to plan subsequent care (NICE quality statement 13).

2.3 National drivers

Table 1 summarises national drivers that are relevant to commissioning alcohol services. Local service redesign may address only one or two of them.

Table 1: National policy on alcohol

Document	Author	Year	Significance
National Strategy for Liver Disease	Department of Health	Forthcoming	<ul style="list-style-type: none"> • Strategy to combat liver disease.
<u>Building recovery in communities (BRiC)</u>	National Treatment Agency for Substance Misuse	Forthcoming	<ul style="list-style-type: none"> • Framework assessing and meeting the wider physical, mental and social needs of people who misuse alcohol and other substances • Will help services promote recovery and further integrate drug

			and alcohol treatment services.
<u>NHS Outcomes Framework 2011/12</u>	Department of Health	2011	<ul style="list-style-type: none"> Improvement area 1.3 is reducing premature mortality from the major causes of death. The measure is under 75 mortality rate from liver disease.
<u>Quality, Innovation, Productivity, Prevention (QIPP)</u>	Department of Health	2011	<ul style="list-style-type: none"> Promotes delivery of quality and productivity in the NHS.
<u>No health without mental health</u> : a cross-government mental health outcomes strategy for people of all ages	HM Government	2011	<ul style="list-style-type: none"> Outcomes-based strategy for the delivery of high quality mental health services. Focus on recovery, harm reduction and people's experience of mental health services.
<u>Clinical directed enhanced services for general medical services contract</u>	British Medical Association and NHS Employers	2011/12	<ul style="list-style-type: none"> Alcohol-related risk reduction scheme for GPs, focusing on case-finding in newly registered patients aged 16 years and over
<u>Drug strategy 2010</u> : reducing demand, restricting supply, building recovery: supporting people to live a drug free life	HM Government	2010	<ul style="list-style-type: none"> Encourages a whole system approach to commissioning recovery focused services. Outlines role of Directors of Public Health, within local authorities, to oversee the commissioning of drug and alcohol treatment by local health and wellbeing boards.
<u>Signs for improvement</u> : commissioning interventions to reduce alcohol-related harm	Department of Health	2009	<ul style="list-style-type: none"> Identifies high-impact changes to reduce alcohol-related harm.
<u>Guidance for the safe consumption of</u>	Sir Liam Donaldson	2009	<ul style="list-style-type: none"> Identifies 5 key priorities to deliver an alcohol-free childhood, including

<u>alcohol in children and young people</u>			services for children and young people who have alcohol-related problems and their parents.
<u>Local routes:</u> guidance for developing alcohol treatment pathways	Department of Health	2009	<ul style="list-style-type: none"> • Good-practice guidance on the development of integrated care pathways for people with alcohol problems.
<u>Models of care for alcohol misusers (MoCAM)</u>	Department of Health and National Treatment Agency for Substance Misuse	2006	<ul style="list-style-type: none"> • Recognises range of health, social and criminal problems associated with alcohol misuse. • Identifies best practice interventions for treatment of alcohol misuse. • Introduces 'stepped care' model.

3. Specifying services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults

Service components

The key service components within whole system commissioning of alcohol services are:

- opportunistic screening and effective brief interventions for adults who are hazardous and harmful drinkers ([see section 3.1](#))
- diagnosis, assessment and management of harmful drinking and alcohol dependence in adults ([see section 3.2](#))
- services for children and young people who are vulnerable to alcohol-related harm ([see section 3.3](#))
- whole system commissioning of high quality alcohol services ([see section 3.4](#)).

3.1 Opportunistic screening and brief interventions for adults who are hazardous and harmful drinkers

Commissioning opportunistic screening and brief interventions for adults, underpinned by NICE guidance and quality standards, is likely to contribute to the overarching outcome of reducing alcohol-related harm and alcohol-related hospital admissions by:

- targeting the delivery of screening and brief interventions to selected populations at an appropriate time and in an appropriate setting
- reducing alcohol consumption in those drinking at hazardous and harmful levels by providing brief advice or extended brief interventions
- improving identification and referral to specialist treatment of people with alcohol dependence and harmful drinkers who have not responded to brief interventions.

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states:

Health and social care staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice (quality statement 2).

Brief interventions for hazardous and harmful drinkers include:

- a session of structured brief advice on alcohol for adults who have been identified via screening as drinking a hazardous or harmful amount
- an extended brief intervention for adults who have not responded to structured brief advice or who may benefit from an extended brief intervention for other reasons. This could take the form of motivational interviewing or motivational-enhancement therapy¹¹.

Before commissioning opportunistic screening, brief advice and extended brief interventions, commissioners should:

- Use their local Joint Strategic Needs Assessment (JSNA) and/or Health and Wellbeing Plans to estimate the local need for alcohol screening and treatment, and to identify vulnerable groups aged 16 years and above who may benefit from targeted screening and brief interventions. Commissioners may wish to use data on alcohol use held by a range of partners including the police, drug and alcohol action team, primary care trust, local acute hospital trusts and public health, and other demographic

¹¹ There are definitions of 'brief interventions', 'extended brief interventions' and 'motivational interventions' in the glossary in section 8 of this guide.

data to understand the local prevalence and patterns of alcohol use.

- Work with clinical experts and partner agencies to identify potential settings where opportunistic screening, brief advice and extended brief intervention services could be implemented. Targeted settings will typically be frequented by groups who may be at an increased risk of alcohol-related harm. These will not always be health or social care settings, and may also include education, housing or criminal justice settings (see table 2 in section 3.1.1 for examples of possible targeted settings).

Commissioners should work with relevant service managers and clinicians to identify and ring-fence resources for ongoing programmes of structured training for relevant staff to deliver screening and brief advice (and extended brief interventions where there is demand)¹². Commissioners may wish to consider commissioning peer-led training or e-learning.

Commissioners should ensure that:

- Staff have sufficient time and resources to carry out opportunistic screening and brief interventions as an integral part of practice.
- The approach to opportunistic screening and brief interventions is appropriate to the needs of the groups who frequent the settings. For example, different approaches to screening and brief advice may be used for a professional person who self-refers to a GP, than for an offender who regularly binges and receives screening and brief advice from a criminal justice professional.
- Their plans for implementing and commissioning opportunistic screening and brief interventions include evaluation, so that the outcome of screening and brief interventions is evaluated to ensure adherence to evidence-based practice and cost effectiveness.

When commissioning brief advice, commissioners should work with relevant service managers and clinicians to ensure that professionals delivering screening and brief advice:

- Use validated screening tools appropriate to the setting, for example the Alcohol Use Disorders Identification Test (AUDIT). Where time is limited they can use an abbreviated version such as AUDIT-Consumption (AUDIT-C). The Fast Alcohol Screening Test (FAST), the Paddington Alcohol Test (PAT) or Single

¹² Refer to the additional resources (section 4.1.1) and service specification (section 5) sections within this guide for further information on training for screening and brief interventions.

Alcohol Screening Questionnaire (SASQ) may be more appropriate for an emergency department setting.

- Use recognised evidence-based resources for brief advice, based on FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy).
- Provide sessions that are between 5 minutes and 15 minutes in length and are offered immediately after screening, or by appointment as soon as possible thereafter.

When commissioning extended brief interventions, commissioners should work with relevant service managers and clinicians to ensure that:

- Professionals use motivational interviewing or motivational enhancement therapy for extended brief interventions.
- Sessions last from 20 to 30 minutes.

When commissioning opportunistic screening and brief interventions, commissioners may wish to consider:

- Combining commissioning and resources for screening and brief advice on alcohol with other relevant lifestyle issues where behaviour change is a key factor, such as smoking or obesity.
- Including blood tests for abnormal liver function in appropriate healthcare settings for patients who are at high risk of alcohol-related harm in order to assess the severity and progress of an alcohol-related problem. Commissioners should ensure that pathways enable people with abnormal liver blood test results to be referred to a specialist experienced in the management of alcohol-related liver disease¹³.
- Ensuring that people who have had a brief intervention are routinely followed up to check on their progress and the outcome of the interventions.

3.1.1 Service models for opportunistic screening and brief interventions for adults who are hazardous and harmful drinkers

Quality, innovation, productivity and prevention

Commissioners may wish to work with their local [Quality, Innovation, Productivity and Prevention](#) (QIPP) lead and develop service models for implementing opportunistic screening and brief advice in targeted settings, as part of a strategy to reduce alcohol-related harm. Example outputs may include:

¹³ Refer to recommendations 1.3.1.1 and 1.3.1.2 in [NICE clinical guideline CG100 on alcohol-related physical complications](#) and recommendation 9 in [NICE public health guidance PH24 on preventing harmful drinking](#) for further information about liver blood tests.

- increasing the number of people screened for alcohol misuse in targeted settings
- increasing the number of brief advice and brief intervention sessions delivered
- increasing the number of referrals for specialist assessment in community-based alcohol treatment services
- percentage uptake of treatment in community-based alcohol treatment services following referral
- reducing alcohol-related hospital admissions and mortality.

Commissioning for quality and innovation

Commissioners may wish to consider working with clinicians when using the [Commissioning for Quality and Innovation \(CQUIN\) payment framework](#) as a lever for service change in acute settings. For example, implementing opportunistic screening and brief advice in emergency departments and other acute clinical settings.

Case studies

Commissioners may wish to refer to examples of existing screening and brief interventions services. Examples are included in table 2.

Table 2 Examples of screening and brief interventions

Setting	Examples of target groups or settings	Case study
Primary care	<ul style="list-style-type: none"> • GPs providing alcohol screening, for example with newly registered patients, higher-risk patient groups and patients on specific chronic disease registers, and during over-40 and over-75 health checks 	<p>See examples of screening and brief interventions in primary care settings from:</p> <ul style="list-style-type: none"> • Bolton • Greenwich • North Tyneside
Community settings	<ul style="list-style-type: none"> • Job centres • Housing services (including for people in insecure accommodation) • Pharmacies • Dental clinics • Youth services 	<p>See examples of screening and brief interventions in pharmacy settings from:</p> <ul style="list-style-type: none"> • Hampshire • Lambeth • Leeds
Mental health services	<ul style="list-style-type: none"> • Improving access to psychological therapy (IAPT) services • Community mental health services • Acute mental health services 	<ul style="list-style-type: none"> • Inclusion Matters in Liverpool aims to integrate IAPT and Models of Care for Substance Misusers (MoCAM) • See example of mainstreaming screening

		and brief advice in Wigan
Criminal justice	<ul style="list-style-type: none"> • Police • Probation 	<p>See examples from:</p> <ul style="list-style-type: none"> • East of England Prison and Hampshire Probation Peer Identification and Brief Advice in Offender Settings • Offender health trainers in prisons
Social care	<ul style="list-style-type: none"> • Children’s social care (children, young people and their parents or carers) • Adults social care • Safeguarding services • Domestic abuse services. 	<p>See example of Bradford and Airedale brief intervention training in a variety of settings, including social care and criminal justice</p>
Acute hospital trust settings	<ul style="list-style-type: none"> • Accident and emergency departments • Fracture clinics • Maternity clinics, as part of antenatal health checks • Gastroenterology clinics • Hepatology clinics • Orthopaedic clinics • Trauma and falls clinics • Genito-urinary medicine clinics 	<p>See examples of screening and brief interventions in emergency settings and other hospital settings from:</p> <ul style="list-style-type: none"> • Knowsley hospital liaison service • Liverpool alcohol services lifestyle team • Manchester alcohol identification and brief advice programmes at Manchester emergency departments • Portsmouth alcohol interventions team • Warrington A&E brief interventions project
Health settings	<ul style="list-style-type: none"> • Routine and opportunistic collection of information on a range of lifestyle health behaviours including alcohol, smoking, diet, physical activity, mental health and wellbeing plus brief opportunistic advice 	<p>See example of lifestyle health behaviour screening in the West Midlands – Every Contact Counts</p>
Workplace	<ul style="list-style-type: none"> • Screening by occupational health staff 	

Please note – these case studies are offered to share examples of practice and NICE makes no judgement on the compliance of these services with its guidance.

Additional resources

Commissioners may also find the resources in table 3 useful when commissioning opportunistic screening and brief interventions.

Table 3 Additional resources for commissioning opportunistic screening and brief interventions

Document	Source	Year	Significance
<u>Shared learning database</u>	NICE	2011	<ul style="list-style-type: none"> • Examples of how organisations have implemented NICE guidance locally
<u>Alcohol pathway</u>	NICE	2011	<ul style="list-style-type: none"> • Provides a visual representation of NICE guidance on alcohol
<u>Screening and Intervention Programme for Sensible drinking (SIPS)</u>	Kings College London / SIPS	2011	<ul style="list-style-type: none"> • Research and findings on the most effective methods of targeted screening and brief interventions
<u>Local Initiatives</u>	Alcohol Learning Centre	2011	<ul style="list-style-type: none"> • Resource for accessing and sharing information about alcohol services and policies
<u>A review of the cost effectiveness of individual level behaviour change interventions</u>	North West Public Health Observatory	2011	<ul style="list-style-type: none"> • Examines cost effectiveness of behaviour change interventions, including alcohol screening and brief interventions.
<u>Guidelines for commissioning identification and brief advice (IBA) training</u>	Alcohol Learning Centre	2010	<ul style="list-style-type: none"> • Guidance for commissioners and providers who need to commission IBA training for staff
<u>Clarifying brief interventions</u>	Alcohol Academy	2010	<ul style="list-style-type: none"> • Summary of terminology surrounding screening, brief advice and brief interventions
<u>Public health guidance 6 on behaviour change</u>	NICE	2007	<ul style="list-style-type: none"> • Guidance and advice on how to plan and run initiatives that focus on behaviour change

3.2 Diagnosis, assessment and management of harmful drinking and alcohol dependence in adults

Commissioning an integrated specialist community-based alcohol service, underpinned by NICE guidance and quality standards, is likely to contribute to the overarching outcomes of reducing alcohol-related harm, alcohol-related hospital admissions and mortality, by:

- increasing the proportion of people in the local population with alcohol dependence who enter and complete treatment in a setting appropriate to their need
- increasing the proportion of dependent drinkers who achieve their treatment goals including abstinence (or a reduction in alcohol consumption for service users who do not agree to a goal of abstinence)
- preventing unnecessary hospital admissions or re-admissions because of acute alcohol withdrawal or other alcohol-related physical complications
- reducing the proportion of dependent drinkers who receive medically assisted alcohol withdrawal in an inpatient setting, who could withdraw safely in the community
- reducing complications arising from unplanned acute alcohol withdrawal
- reducing length of hospital or inpatient stay for medically assisted alcohol withdrawal
- preventing the development of – and subsequently reducing the numbers of people diagnosed with – alcohol-related physical complications such as Wernicke-Korsakoff syndrome, alcohol-related liver disease and pancreatitis
- increasing the number of dependent drinkers who achieve and maintain abstinence and reducing rates of relapse to heavy drinking.

Table 4 summarises the range of interventions recommended by NICE for the treatment of adults with alcohol dependence and adults who are harmful drinkers but who have not responded to brief interventions. The table identifies **packages of care** that may be used for the treatment of these groups.

These interventions and packages of care should be commissioned as part of an **integrated specialist community-based alcohol service**. Specialist inpatient or residential care may be spot-purchased or commissioned separately for people with severe alcohol dependence and/or people with alcohol dependence and complex comorbidities. The need for inpatient or residential interventions should be identified in the care plan developed in the community-based service.

Table 4 Evidence-based interventions and packages of care for adults delivered in specialist alcohol services

- Ticks (✓) indicate treatments for this group
- Question marks (?) indicate treatments that may occasionally be considered for people in this group.
- N/A is used when the intervention is not applicable for this group

Intervention	Harmful drinking and mild dependence	Moderate dependence	Severe dependence	Moderate and severe dependence plus complex needs
	AUDIT 16+ SADQ <16 Units/day <15	AUDIT 20+ SADQ 16–30 Units/day >15	AUDIT 20+ SADQ >30 Units/day >30	AUDIT 20+ SADQ >15 Units/day >15
Initial assessment	✓	✓	✓	✓
Comprehensive assessment	?	✓	✓	✓
Psychological interventions	✓	✓	✓	✓
Care coordination	✓	✓	✓	✓
Community-based medically assisted withdrawal	?	✓	?	?
Inpatient or residential medically assisted withdrawal	n/a	?	✓	✓
Relapse prevention medication	?	✓	✓	✓
Aftercare	?	✓	✓	✓
Case management	n/a	?	✓	✓
Residential rehabilitation	n/a	n/a	?	?
Preventing Wernicke’s encephalopathy	✓	✓	✓	✓
Mutual aid, peer support and re-integration support	✓	✓	✓	✓
Supporting families and carers	✓	✓	✓	✓

3.2.1 Commissioning a specialist community-based alcohol service for adults

Models of specialist community-based alcohol treatment services vary across the country, and they are typically composed of a range of partner agencies that may deliver some or all of the interventions within the package of care. When commissioning specialist community-based alcohol treatment services, commissioners should:

- Use the [commissioning and benchmarking tool](#) to estimate local need, and use this information to ensure the treatment service has sufficient capacity. Commissioners should be aware that referrals may increase after the implementation of opportunistic screening and brief interventions and by actively promoting the service. They should also take into account the demand for the service from people receiving aftercare or who relapse after treatment. However, effective screening and brief interventions may help to reduce referrals for specialist treatment and alcohol-related hospital admissions in the longer term.
- Specify that services are situated in a discrete location and ensure that staff adhere to confidentiality policies because there is evidence that the perceived stigma of treatment for alcohol dependence can inhibit the uptake of services¹⁴. Commissioners could consider using home-based assessment and treatment to improve engagement, particularly among people with complex additional needs.
- Work with GPs to consider the possibility of delivering treatment such as psychological interventions in GP surgeries, and to commission GPs to deliver services such as aftercare and pharmacotherapy to prevent relapse as part of the specialist alcohol service.
- Enable flexible and needs-based contact between staff and the service user to optimise treatment outcomes.

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states that:

People receiving specialist treatment for alcohol misuse have regular treatment outcome reviews, which are used to plan subsequent care (quality statement 13).

Therefore commissioners should satisfy themselves that:

- Service user care plans are recovery focused, and detail the desired treatment outcomes including a reduction in drinking or

¹⁴ National Collaborating Centre for Mental Health (2011) [Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#). London: Royal College of Psychiatrists.

abstinence, and other social or health aspirations such as achieving social stability, secure housing and employment.

- The outcomes of service user's care plans are subject to routine outcomes monitoring by health professionals and involve the service user. This is so that the treatment or care plan can be stopped or reviewed in line with the stepped care model, if there are signs of deterioration or no indications of improvement.
- Outcomes monitoring uses a suitable tool and where possible can demonstrate clinical effectiveness (for example reducing alcohol intake or maintaining abstinence), cost effectiveness (for example reducing emergency department attendance or hospital admissions) and person-measured outcomes (for example improved quality of life).
- Outcomes monitoring is compatible with the [National Alcohol Treatment Monitoring System](#) (NATMS).

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states:

People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff (quality statement 4).

Therefore commissioners should:

- Specify that there is an adequately trained multidisciplinary team with an appropriate mix of skills. This should take into account the different competencies required for prescribing and delivering psychological interventions. Within the NHS the team is likely to include specialist alcohol or substance misuse workers, community mental health nurses, psychologists, health visitors, midwives, pharmacists, emergency department nurses, practice nurses, GPs, hospital based consultants and addiction psychiatrists. Other partners include housing, social care, criminal justice and education.
- Work with appropriate service managers to identify funding for ongoing programmes of workforce training and development.
- Ensure that all training provided is specific to alcohol (or substance misuse) and enables staff to meet the [nationally transferrable occupational standards for alcohol and drugs](#).

3.2.2 Referral and access to a specialist community-based alcohol service

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states:

People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment (quality statement 3).

To ensure appropriate referral to specialist alcohol services, and between providers, commissioners should satisfy themselves that:

- Alcohol treatment pathways identify the referral procedures for harmful drinkers who have not responded to brief interventions, repeat referrals, people with alcohol dependence who are identified via screening, and people with alcohol dependence who are identified in other settings such as hepatology clinics, mental health services or social care.
- The thresholds for referral, assessment and treatment are consistent between settings and providers, so there is treatment to suit every person's needs and to facilitate smooth transition between partner services.
- Relevant staff are aware of treatment pathways and procedures to refer people for assessment, including locally agreed waiting time targets.

Commissioners should seek evidence of local evaluation in specialist alcohol services of waiting times from initial referral to assessment, assessment to starting treatment, and total waiting time from referral to starting treatment.

3.2.3 Assessment in a specialist community-based alcohol service

Assessment is a vital stage in determining the most clinically and cost-effective treatment for harmful drinkers and people with alcohol dependence. The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states:

Adults accessing specialist alcohol services for alcohol misuse receive a comprehensive assessment that includes the use of validated measures (quality statement 5)

[NICE clinical guideline 115 on alcohol dependence](#) states that a comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools and cover the following areas:

- alcohol use, including:
 - consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)

- dependence (using, for example, Severity of Alcohol Dependence Questionnaire [SADQ] or Leeds Dependence Questionnaire [LDQ])
- alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
- other drug misuse, including over-the-counter medication
- physical health problems
- psychological and social problems
- cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
- readiness and belief in ability to change.

Commissioners should specify that specialist alcohol treatment services provide:

- an initial assessment, which includes a motivational intervention, to all people referred for treatment
- a comprehensive assessment for all people who require structured community-based treatment, which includes all of the components listed above. Commissioners should note NICE recommendations about the use of breath alcohol measurements, blood tests to help identify physical needs and measures of cognitive functioning, and ensure these are being used appropriately during assessment and to inform treatment and care planning.

Understanding an individual's alcohol misuse, and the appropriate treatment, requires an understanding of their wider personal and social circumstances. Therefore commissioners should specify that people receive an assessment of their re-integration support needs, including social support, training, employment, education and housing, as part of their comprehensive assessment, and to engage these partners in the commissioning of their specialist alcohol service (see also section 3.2.7).

3.2.4 Psychological interventions

Commissioners should consider commissioning psychological interventions, such as cognitive behavioural therapy, behavioural couples therapy or social network and environment-based therapies, as a key component of their specialist alcohol service. The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states:

Adults who misuse alcohol are offered evidence-based psychological interventions, and those with alcohol dependence that is moderate or severe can in addition access relapse prevention medication in accordance with NICE guidance (quality statement 11).

Commissioners should:

- specify that psychological interventions are provided according to the structure and duration recommended in NICE clinical guideline CG115 on alcohol dependence, including the length, number and frequency of sessions
- ensure that psychological interventions are provided as a core element of a service users package of care, so that service users can also receive relapse prevention medication where appropriate (see section 3.2.5).

When commissioning community-based psychological interventions, commissioners should specify that the staff who deliver the therapies:

- have specific training in delivering psychological interventions to people who misuse alcohol (or other substances where appropriate)
- use competence frameworks developed from evidence-based treatment manuals
- receive regular supervision from a person competent in both the intervention and supervision.

When commissioning psychological interventions, commissioners may wish to consider working with local community mental health commissioners who may be implementing [Improving Access to Psychological Therapies](#) (IAPT), to consider possible synergies in recruitment, training or service provision.

3.2.5 Pharmacological interventions

Pharmacological interventions for the management and treatment of alcohol misuse can significantly improve the likelihood of positive treatment outcomes including maintaining abstinence and preventing relapse.

There are two classes of pharmacological intervention recommended in NICE guidance:

- medication to treat medically assisted alcohol withdrawal, such as a benzodiazepine
- medication to promote abstinence or prevent relapse after withdrawal, such as acamprosate, oral naltrexone and disulfiram

Commissioners should satisfy themselves that the prescription and delivery of pharmacological interventions will support the delivery of patient outcomes. Commissioners may wish to conduct a baseline assessment of local

prescribing practices in primary, community and acute settings in order to determine compliance with NICE recommendations¹⁵.

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states:

Adults who misuse alcohol are offered evidence-based psychological interventions, and those with alcohol dependence that is moderate or severe can in addition access relapse prevention medication in accordance with NICE guidance (quality statement 11).

Commissioners may wish to work with providers to raise awareness of the benefits of prescribing relapse prevention medication. While pharmacotherapy is commonly used to assist withdrawal, it is less commonly prescribed to prevent relapse. Clinical opinion suggests that around 5% of people who withdraw each year receive medication to prevent relapse. However, around one third of patients may benefit from it. Relapse prevention medication can help to reduce the rate of relapse from around 90% to 82%¹⁶. Therefore commissioners should:

- work with GPs to raise awareness of the benefits of relapse prevention medication
- specify that any assessment for medically assisted alcohol withdrawal includes consideration of relapse prevention medication, ideally in combination with an intensive structured community-based intervention.

Commissioners should specify that people receive a comprehensive medical assessment before starting pharmacological interventions.

3.2.6 Medically assisted alcohol withdrawal

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states that:

People needing medically assisted alcohol withdrawal are offered treatment within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities (quality statement 8).

People needing medically assisted alcohol withdrawal receive medication using drug regimens appropriate to the setting in which

¹⁵ The NICE [baseline assessment tool](#) on alcohol dependence and harmful alcohol use can be used by organisations to identify if they are in line with practice recommended in NICE guidance and to help them plan activity that will help them meet the recommendations.

¹⁶ Refer to the [NICE costing report on alcohol dependence](#) for further information about the costs and savings associated with relapse prevention medication.

the withdrawal is managed in accordance with NICE guidance (quality statement 9).

When commissioning for medically assisted alcohol withdrawal, commissioners should:

- Ensure that their alcohol treatment pathways and specifications include provision for community-based medically assisted alcohol withdrawal. There is evidence that community-based settings are at least as effective as residential units for planned alcohol withdrawal, are preferred by patients and are less costly than inpatient withdrawal¹⁷.
- Enhance community-based assisted-withdrawal services to maximise potential uptake. Commissioners could work collaboratively with partners in social care and housing services to improve the social support available to people who have an identified need for planned withdrawal. They may also wish to explore the competencies of staff to deliver community-based assisted withdrawal, particularly GPs, practice nurses and community mental health nurses. Staff should have clear guidance and processes for delivering community-based medically assisted alcohol withdrawal.
- Consider working with providers and clinicians to define profiles of people who would be eligible for community- and inpatient-based withdrawal programmes. Profiles may take into account alcohol consumption, the severity of dependence, comorbidities and social needs.
- Specify that the service provides flexible needs-based contact between staff and the service users, but indicate the minimum required contact.

When commissioning inpatient and residential medically assisted alcohol withdrawal, commissioners should:

- Specify that lower thresholds are provided for high-risk groups including homeless people, older people and pregnant women who require medically assisted withdrawal¹⁸.
- Specify that community and/or residential aftercare is provided for the person once they are abstinent (see section 3.2.7).
- Consider the use of routine periodic recovery check-ups with former service users, to support the maintenance of treatment

¹⁷ National Collaborating Centre for Mental Health (2011) [Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#). London: Royal College of Psychiatrists; Scottish intercollegiate guidelines network (2003) [The management of harmful drinking and alcohol dependence in primary care: a national clinical guideline](#).

¹⁸ Refer to [NICE clinical guideline CG115 on alcohol dependence](#) recommendation 1.3.4.6 for further information on thresholds for high-risk groups.

outcomes, to prevent possible relapse and to enable prompt re-entry into treatment if this is required.

Commissioners should also satisfy themselves that the prescription and delivery of drugs is appropriate to the care setting. Commissioners should note that symptom-triggered drug regimens for medically assisted alcohol withdrawal may decrease the length of stay by around 40% and may be used in inpatient settings with appropriate staffing support structures and staff competencies¹⁹.

3.2.7 Supporting recovery through care coordination, case management, aftercare and re-integration support

Treatment outcomes can be improved by providing care planned treatment for each individual service user, with a suitable level of care coordination or active case management. All people with alcohol problems attending specialist alcohol treatment services will need varying degrees of aftercare to help them to achieve their short-term and longer-term treatment goals and build recovery and re-integration.

[NICE clinical guideline 115 on alcohol dependence](#) states that:

Care coordination should be part of the routine care of all service users in specialist alcohol services and should:

- be provided throughout the whole period of care, including aftercare
- be delivered by appropriately trained and competent staff working in specialist alcohol services
- include the coordination and assessment, interventions and monitoring of progress, and coordination with other agencies.

Care coordination can help to improve the engagement of harmful drinkers and people with alcohol dependence by ensuring they are receiving the most appropriate package of care at any time. **Aftercare** can reduce the risk of relapse by developing coping strategies to help the person maintain their treatment outcomes, and promoting re-integration support that helps mitigate against risk factors for relapse such as unstable employment, housing or relationships.

Commissioners should specify that their community-based alcohol service:

¹⁹ Refer to [NICE clinical guideline CG100 on alcohol-related physical complications](#) recommendation 1.1.3.4, [NICE clinical guideline CG115 on alcohol dependence](#) recommendation 1.3.5.2 and the [NICE costing report for CG100 on alcohol-related physical complications](#) for further information about symptom-triggered drug regimens for alcohol withdrawal.

- provides a nominated care coordinator for every person referred to the service
- offers care coordination throughout the period of treatment and aftercare
- provides a period of aftercare that is appropriate to the individual needs of the person
- reviews the outcomes of aftercare before a person is discharged from the service.

[NICE clinical guideline 115 on alcohol dependence](#) notes a category of alcohol service users who may benefit from a particularly intensive and active form of care coordination, known as **case management**. It states:

Consider case management to increase engagement in treatment for people who have moderate to severe alcohol dependence and who are considered at risk of dropping out of treatment or who have a previous history of poor engagement. If case management is provided it should be throughout the whole period of care, including aftercare.

Case management is typically provided for people who are less easy to engage or to maintain safely in treatment; these are often people with comorbidities such as mental health problems or complex needs such as homelessness or pregnancy²⁰. When commissioning case management, commissioners should specify that:

- Community-based alcohol services provide case management for people with moderate to severe alcohol dependence who are considered at risk of dropping out of treatment or who require greater support to maintain treatment safely.
- Acute hospital trusts have trained staff who can provide case management of people admitted to medical wards with unplanned acute alcohol withdrawal, and provide immediate support to access specialist alcohol services.
- Case management includes inter-agency working between relevant agencies to meet the needs of individual services users. For example case management for homeless people will involve partnerships with social care and housing commissioners to support the needs of this vulnerable group.

Commissioners should specify that:

- people who ‘do not attend’ (DNA) their initial assessment or who cease treatment before their outcomes have been realised are

²⁰ National Clinical Guideline Centre for Acute and Chronic Conditions (2010) [Alcohol-use disorders: physical complications: full guidance](#)

proactively followed up by a member of staff responsible for their care coordination or case management

- acute hospital trusts have trained staff who can identify people who misuse alcohol, provide support during their hospital stay and help them to access the specialist alcohol service when they are discharged²¹.

Re-integration (or wraparound) support is provided to assist a person who is receiving alcohol treatment with their social and personal needs, and to build resilience and support their re-integration back into society after treatment. Commissioners should specify that their community-based alcohol service provides:

- Referral to, or onsite support from, a range of services such as social support, welfare advice, training, employment, education and housing. The services should provide practical support to enable service users to develop the skills and build the resources required to re-integrate back into society after treatment.
- Appropriate support to help the service user to attend appointments with relevant advisers.

3.2.8 Mutual aid and peer support for adults who misuse alcohol and their families

Mutual aid and peer support are shown to improve treatment outcomes by empowering people who misuse alcohol and their families to change their behaviour and reduce reliance on structured alcohol treatment services²².

[NICE clinical guideline 115 on alcohol dependence](#) states that, for all people seeking help for alcohol misuse:

- give information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART recovery) and
- help them to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that they can attend.

To support the development and operation of mutual aid and peer support services, commissioners may wish to:

²¹ See examples of alcohol specialist worker and alcohol liaison workers in section 4.2.12 of this guide.

²² There are definitions of 'mutual aid' and 'peer support' in the glossary in section 8 of this guide.

- review the local provision of mutual aid, and to consider supporting the establishment of new groups and networks where there are identified gaps in service
- encourage local providers to make rooms available within treatment centres for meetings during the day, evenings and/or weekends
- ensure that case management is available to people with complex needs, so they receive additional support and/or transport to make it easier for them to attend meetings
- commission peer support workers or recovery champions to work with targeted service users.

3.2.9 Supporting families and carers

[NICE clinical guideline 115 on alcohol dependence](#) states:

Encourage families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change.

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states that:

Families and carers of people who misuse alcohol have their own needs identified, including those associated with risk of harm, and are offered information and support (quality statement 7).

Evidence shows that treatment is more likely to be successful and sustainable where families, partners and carers are closely involved in the treatment. Commissioners should specify that their community-based alcohol treatment service:

- provides information to support the families, parents and carers of people who misuse alcohol, whether or not the person who misuses alcohol is in treatment
- provides a carers assessment to all carers who consent. Commissioners may also wish to consider a family assessment to consider the needs of dependents and the wider family
- have policies and procedures in place to enable information to be shared between the service user and their family or carer, where this is agreed
- can refer people to a local support group, such as mutual aid groups specifically focused on addressing the needs of the families or carers of people who misuse alcohol
- can deliver, or refer people to, at least one session of guided self help and/or a family meeting where the need is identified

- encourage the use of behavioural couples therapy for people with alcohol dependence who have a regular partner who is willing to participate in treatment.

3.2.10 Preventing Wernicke’s encephalopathy

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states that:

People with suspected, or at high risk of developing, Wernicke’s encephalopathy are offered thiamine in accordance with NICE guidance (quality statement 10).

To prevent further Wernicke’s encephalopathy and to prevent further damage and deterioration from Wernicke-Korsakoff syndrome, commissioners should:

- Work with relevant service managers to satisfy themselves that the health and social care workforce is able to identify Wernicke-Korsakoff syndrome and associated risk factors including homelessness and malnourishment. Commissioners may wish to consider specifying that the identification and prevention of Wernicke’s encephalopathy is included within awareness raising training (see section 3.4).
- Audit the prescription of parenteral and oral thiamine, and ensure these are being appropriately prescribed for the prevention of Wernicke’s encephalopathy.

3.2.11 Service models for the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults

Quality, innovation, productivity and prevention

Commissioners may wish to work with their local [Quality, Innovation, Productivity and Prevention](#) (QIPP) lead and develop service models for implementing an alcohol treatment service, as part of a strategy to reduce alcohol-related harm. Example models are included in table 5:

Table 5 Using QIPP for alcohol treatment services for adults

QIPP model	Example output
Improving timely access to specialist alcohol treatment services	<ul style="list-style-type: none"> • Increasing the numbers of people who are referred for specialist assessment • Increasing the numbers of people who are assessed as requiring specialist treatment who are offered and receive specialist alcohol treatment • Increasing the proportion of people in the local population estimated to be dependent on alcohol who enter

	treatment
Improving access to community-based medically assisted alcohol withdrawal for dependent drinkers suitable for management in this setting	<ul style="list-style-type: none"> Reducing the proportion of dependent drinkers who receive medically assisted alcohol withdrawal in an inpatient setting, who could withdraw safely in the community
Use of case management and care coordination to engage frequent hospital attenders and people with complex needs	<ul style="list-style-type: none"> Reducing frequent and recurrent hospital attendance in acute hospital settings, including emergency departments
Use of alcohol health workers in hospital settings. Alcohol health workers may take on a number of roles including improving the management of unplanned acute alcohol withdrawal, improving the identification of alcohol misuse, coordinating referrals to community based services and/or providing peer support to hospital staff in identifying and managing alcohol misuse	<ul style="list-style-type: none"> Reducing alcohol-related repeat attendances to accident and emergency departments Reducing alcohol-related hospital admissions and readmissions Reducing cases of unplanned acute alcohol withdrawal Reducing length of stay for acute alcohol withdrawal Increasing referrals to community-based alcohol treatment services from acute hospital trusts

Commissioning for quality and innovation

Commissioners may wish to consider using the [Commissioning for Quality and Innovation \(CQUIN\) payment framework](#) as a lever for improving quality through a change in practice or service redesign in acute settings. Examples may include:

- reducing frequent visitors to emergency departments and readmissions to acute settings through care coordination, case management or assertive outreach
- reducing length of stay for planned and unplanned acute alcohol withdrawal by using symptom-triggered drug regimens where these can be safely applied
- reducing inappropriate alcohol-related admissions through the employment of alcohol-specialist health or liaison workers.

Case studies

Commissioners may wish to refer to examples of commissioned alcohol services. Examples are included in table 6.

Table 6 Case studies for the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults

Example	Case studies
---------	--------------

GP-led alcohol treatment services	<ul style="list-style-type: none"> • Fresh Start Clinics in Wandsworth NHS Primary care (see case study 1) • Shared care services in Tameside and Glossop PCT, as part of the Local Enhanced Service for Alcohol (see case study 2)
Case management	<ul style="list-style-type: none"> • Salford Royal NHS Trust has a multi-agency assertive outreach project to proactively identify and case manage alcohol treatment for frequent visitors to hospital settings (see case study 3) • Birmingham total place pilot – repeat attendances at A&E and acute units
Alcohol health workers (AHWs) in hospital settings	<p>AHWs may take on a number of roles including:</p> <ul style="list-style-type: none"> • screening and brief interventions • improving the management of unplanned acute alcohol withdrawal • improving the identification of hazardous and harmful drinking and alcohol dependence • coordinating patient care • coordinating referrals to community based services and/or providing peer support to hospital staff in identifying and managing alcohol misuse. <p>AHWs may be based in several settings, for example emergency departments, or gastroenterology or hepatology clinics. See examples of:</p> <ul style="list-style-type: none"> • Bristol hospital based alcohol nurse specialist • Paddington alcohol health work in St Mary's hospital • Royal Bolton Hospital collaborative care for alcohol related liver disease and harm • Nottingham city alcohol nurse liaison team • Oldham hospital alcohol liaison team
Service redesign using a health economics approach	See example of system dynamic modelling in Blackpool
Specialist whole system alcohol treatment services	See examples in section 4: whole system commissioning of high quality alcohol services
Intensive structured community-based intervention	The County Durham Whitehouse Project is an intensive structured community-based intervention targeted at older people with moderate to severe alcohol dependence. It aims to engage people in structured treatment, including psychological interventions, re-integration support, promoting abstinence and recovery, and continued social support. It provides free transport and collects and returns people to their homes.
Outcomes based tariff for drug and alcohol services	A pathfinder GP consortium in Kingston, Surrey, is pioneering outcomes-based tariffs for mental health services , including substance misuse services. Work includes defining patient outcomes, developing patient cluster subgroups and improving care coordination.

Please note – these case studies are offered to share examples of practice and NICE makes no judgement on the compliance of these services with its guidance.

Additional resources

Commissioners may also find the resources in table 7 useful when commissioning services for the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults.

Table 7 Additional resources for commissioning services for the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults

Document	Source	Year	Significance
Shared learning database	NICE	2011	<ul style="list-style-type: none"> • Examples of how organisations have implemented NICE guidance locally
Local Initiatives	Alcohol Learning Centre	2011	<ul style="list-style-type: none"> • Resource for accessing and sharing information about alcohol services and policies
Building recovery in communities (BRiC)	National Treatment Agency for Substance Misuse	2011	<ul style="list-style-type: none"> • Framework assessing and meeting the wider physical, mental and social needs of alcohol and substance misusers • Will help services promote recovery and further integrate drug and alcohol treatment services
National Alcohol Treatment Monitoring System (NATMS)	National Treatment Agency for Substance Misuse	2011	<ul style="list-style-type: none"> • Key national and local monitoring information on alcohol treatment services
NICE clinical guideline CG120: psychosis with coexisting substance misuse: assessment and management in adults and young people	NICE	2011	<ul style="list-style-type: none"> • Provides guidance on the assessment and management of psychosis with substance misuse
Skills for Health: alcohol and drugs	Skills for Health	2011	<ul style="list-style-type: none"> • Range of products and services to support the development of a drug and alcohol workforce
Alcohol pathway	NICE	2011	<ul style="list-style-type: none"> • Provides a visual

			representation of NICE guidance on alcohol
<u>Alcohol care teams</u> : to reduce acute hospital admissions and improve quality of care	NHS Evidence, provided by the British Society of Gastroenterology and the Royal Bolton Hospital NHS Foundation Trust	2011	<ul style="list-style-type: none"> • QIPP quality and productivity case study, evaluated by NHS Evidence, on the cost effectiveness of hospital-based alcohol care teams
<u>Alcohol-related disease: meeting the challenge of improved quality of care and better use of resources</u>	Kieran Moriarty et al.	2010	<ul style="list-style-type: none"> • Makes 11 recommendations on service design in secondary care
<u>Alcohol health workers</u> : description and review of the alcohol health worker posts	Department of Health and Alcohol Concern	2010	<ul style="list-style-type: none"> • Summarises the variety of alcohol health worker models being used nationally
<u>NICE clinical guideline CG110: pregnancy and complex social factors</u> : a model for service provision for pregnant women with complex social factors	NICE	2010	<ul style="list-style-type: none"> • Describes how access to care can be improved for pregnant women with complex social factors, including alcohol misuse
<u>Signs for improvement</u> - commissioning interventions to reduce alcohol-related harm	Department of Health	2009	<ul style="list-style-type: none"> • Identifies high-impact changes to reduce alcohol-related harm
<u>Models of care for alcohol misusers (MoCAM)</u>	Department of Health and National Treatment Agency for Substance Misuse	2006	<ul style="list-style-type: none"> • Recognises range of health, social and criminal problems associated with alcohol misuse • Identifies best practice interventions for treatment of alcohol misuse • Introduces 'stepped care' model

3.3 Services for children and young people who are vulnerable to alcohol-related harm

Commissioning specialist alcohol services for children and young people who are vulnerable to alcohol-related harm, underpinned by NICE guidance and quality standards, is likely to contribute to the overarching outcome of reducing alcohol-related harm in children and young people, by:

- delaying the age at which children and young people begin to drink alcohol, and preventing the escalation of drinking at a young age
- promoting a healthy culture of drinking among young people
- reducing the risk of physical harm from alcohol use
- promoting a whole family approach to treatment and multisystemic therapy, thus reducing the risk of relapse and breaking the cycle of alcohol related harm within families
- improving family relationships and support and helping to prevent family breakdown.

It is recognised that the lead commissioner for children's and young people's alcohol services may be different to the lead adult commissioner. However, commissioning children's and young people's services as part of a whole system approach may deliver a number of benefits, including:

- better integration between children's, young people's and adult's services
- promoting the development of a 'whole-family' approach
- improving the transition between young people's and adult's services.

Children and young people who are vulnerable to alcohol-related harm may fall into one or both of the following categories. In both instances a specialist family-focused alcohol service may be well placed to provide support to:

- children and young people who are at risk from alcohol-related harm
- children and young people who are at risk of harm because their parents or carers misuse alcohol²³.

The treatment of children and young people who are vulnerable to alcohol-related harm may be commissioned as part of other services for vulnerable children or as part of a wider substance misuse service, particularly as the polydrug use (the use of alcohol in combination with other illicit drugs) is more

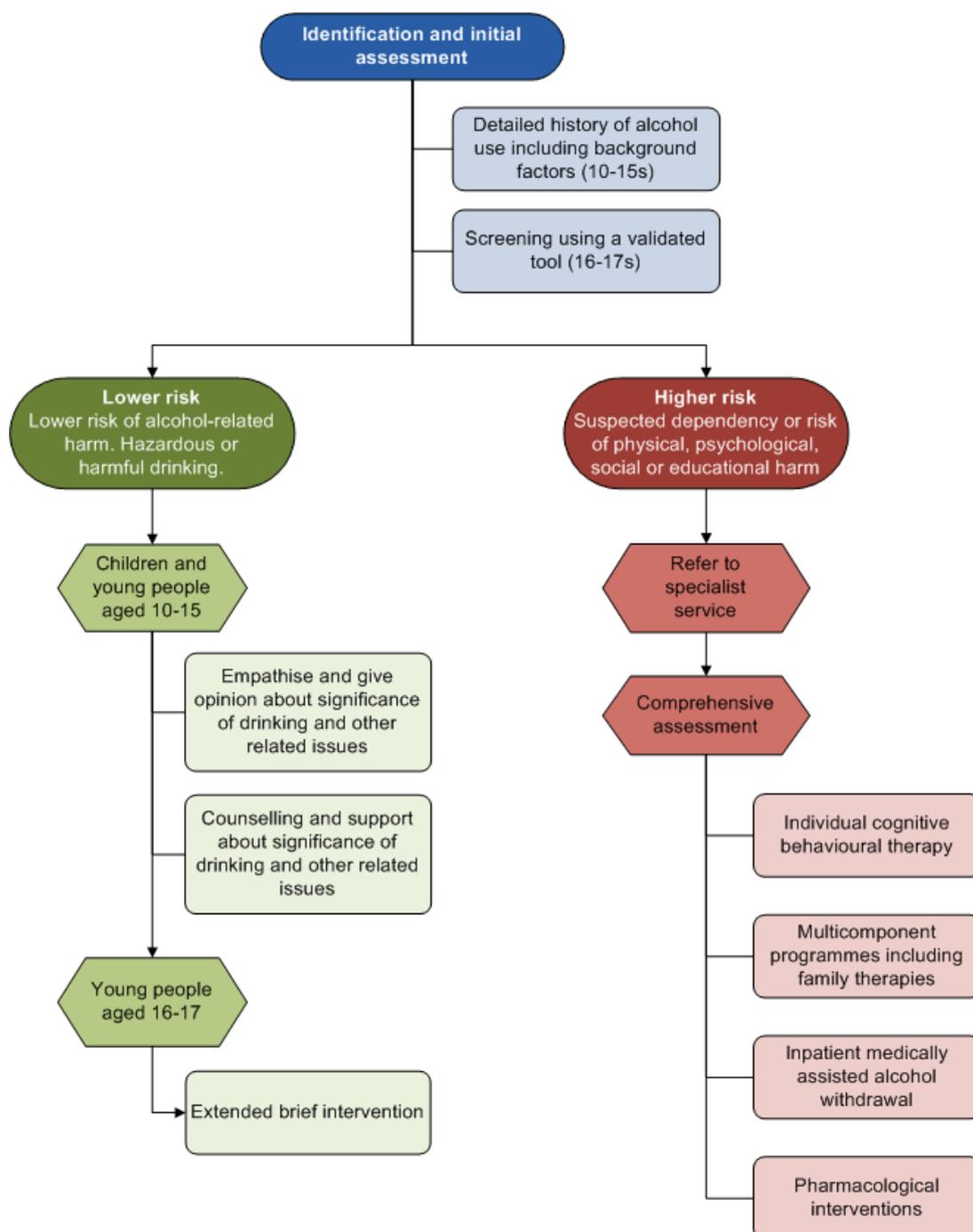
²³ Refer to [NICE clinical guideline 115 on alcohol dependence](#) recommendation 1.1.2.5 for further information about parents who misuse alcohol and who have care of, or regular contact with their children.

common among children and young people than adults. Commissioners should ensure that their children's and young people's substance misuse service is well integrated into wider children's services commissioning.

3.3.1 Integrated alcohol services for children and young people at risk of alcohol-related harm

NICE makes recommendations on the identification, assessment, referral and treatment of children and young people aged 10 to 17 years who are at risk of alcohol-related harm (see figure 3).

Figure 3 Identification, assessment and treatment of children and young people who are at risk of alcohol-related harm²⁴



Children’s and adults’ commissioners may wish to work in partnership to commission specialist services for children, young people and young adults **up to the age of 25 or 30 years**, because the pattern and culture of drinking,

²⁴ National Institute for Health and Clinical Excellence (2010) Alcohol-use disorders: preventing the development of hazardous and harmful drinking. London: NICE; National Institute for Health and Clinical Excellence (2011) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. London: NICE

and the social circumstances of this group are often different to those of older adults. Children and young people are less likely to have alcohol dependence than adults but hazardous drinking behaviours such as binge-drinking are more common.

Commissioners may wish to distinguish between the commissioning of services for children and young people at:

- **lower risk of alcohol-related harm**, such as tailored empathy, counselling or short interventions delivered by trained professionals in targeted universal and specialist partner agencies. An example would be a young person who attends an accident and emergency department after drinking too much but who does not have any significant social, family, health or education problems.
- **higher risk of alcohol-related harm**, delivered by a specialist alcohol or substance misuse service. Most young people who enter specialist alcohol treatment have other, often multiple needs such as mental health issues, involvement with criminal justice, poor education attendance or unemployment²⁵.

The [full clinical guideline on managing alcohol dependence](#) highlights the need to develop a multi-systems, multi-level approach to developing integrated alcohol services for children and young people. Therefore commissioners should:

- Develop close commissioning relationships between their children's and young people's partnerships and other commissioning partnerships who may have a responsibility for commissioning alcohol services.
- Work with directors of finance to ensure that funds from children's services, social care, criminal justice and health can be pooled and made available for commissioning alcohol services.
- Develop clear pathways between all agencies who may work with children and young people who may be vulnerable to alcohol-related harm, which cover the identification, assessment and treatment of all children and young people who are at risk of alcohol-related harm or whose parents misuse alcohol.
- Specify that alcohol treatment with children and young people promotes the goal of abstinence, because of the potential for

²⁵ DrugScope (2010) [Young people's drug and alcohol treatment at the crossroads: What it's for, where it's at and how to make it even better](#). London: DrugScope.

long-term harm among children and young people who misuse alcohol²⁶.

- Satisfy themselves that approaches to behaviour change and delivery of the key messages are appropriate to children and young people.
- Conduct timely regular audit of local pathways, policies and protocols relating to the identification, referral and treatment of children and young people who are at risk of alcohol-related harm, including child protection, consent and confidentiality and information sharing. Policies should be agreed by local safeguarding children's board.
- Encourage services to include parents or carers in any intervention, especially where the child or young person has intellectual or learning difficulties.

3.3.2 Identification and initial assessment of children and young people

For children and young people aged 10 to 15 years, [NICE public health guidance 24 on alcohol-use disorders: preventing harmful drinking](#) states:

Obtain a detailed history of their alcohol use (for example, using the Common Assessment Framework as a guide). Include background factors such as family problems and instances of child abuse or under-achievement at school.

For young people aged 16 and 17 years, [NICE public health guidance 24 on alcohol-use disorders: preventing harmful drinking](#) recommends completing a validated alcohol-screening questionnaire.

There is a large number of universal services (such as schools, colleges and accident and emergency departments) and specialist services (such as social care, Connexions and youth offending teams) that may encounter children and young people who are vulnerable to alcohol-related harm (see the list of partner agencies section 3.3.5). Therefore commissioners should work with relevant service managers and clinicians to:

- Agree the validated tools that will be used to obtain a detailed history of alcohol use or to provide screening, and to ensure the tools have been adapted for use with children and young people.
- Ensure the tools use the lower threshold for the identification of alcohol-related harm in children and young people.
- Ensure that initial assessment considers the child or young person's drinking behaviour, their parent's drinking behaviour and wider issues such as the risk to their physical or mental

²⁶ National Institute for health and Clinical Excellence (2011) [CG115 Alcohol-use disorders: alcohol dependence: costing report](#). London: National Institute for Health and Clinical Excellence.

health, or social or educational harm. This information should be used to determine the most appropriate service for children and young people, depending on their risk of alcohol-related harm.

- Ring-fence resources for awareness raising and training to equip relevant staff to identify children and young people who are at risk of alcohol-related harm, and to make an appropriate referral.
- Ensure their local Common Assessment Framework (CAF) and Child in Need process are able to identify children and young people at risk of alcohol-related harm²⁷.

3.3.3 Services for children and young people with lower risk alcohol misuse

In order to reduce alcohol consumption and alcohol-related harm in children and young people, and to reduce the pressure on specialist services, commissioners may wish to work with partners to identify targeted settings where children and young people who use alcohol but who have a lower risk of alcohol-related harm can be identified, assessed and offered a short intervention.

For children and young people aged 10 to 15 years who are thought to be at risk from their alcohol use, [NICE public health guidance 24 on alcohol-use disorders: preventing harmful drinking](#) states:

Use professional judgement to decide on the appropriate course of action. In some cases, it may be sufficient to empathise and give an opinion about the significance of their drinking and other related issues that may arise. In other cases, more intensive counselling and support may be needed.

For young people aged 16 and 17 years who are thought to be at risk from their alcohol use, [NICE public health guidance 24 on alcohol-use disorders: preventing harmful drinking](#) recommends arranging an extended brief intervention for them (see section 3.1).

The aim of services for children and young people who have a lower risk of alcohol-related harm is to identify alcohol use early and to offer an intervention to reduce the risk of hazardous drinking behaviour escalating to harmful drinking or alcohol dependence. Shorter interventions may be provided to children and young people at critical moments, for example after they have missed school or attended an emergency department after an episode of heavy drinking.

The method and duration of shorter interventions will vary according to the individual development of children and young people. [NICE public health guidance 24 on preventing harmful drinking](#) notes that the problems young

²⁷ Department of Health (2009) [Guidance on the consumption of alcohol by children and young people](#). London: Department of Health.

people aged under 16 years may face and their susceptibility to alcohol will vary greatly depending on their physical and emotional development, including gender (girls often experience puberty earlier than boys). Thus it takes professional judgement to decide how to deal with children and young people who drink early in life.

When commissioning effective brief interventions for children and young people, commissioners should:

- Work with relevant service managers to identify and ring-fence resources to develop a programme of early and short interventions in appropriate targeted universal and specialist services for children and young people. Examples may include schools and colleges, sexual health services and youth services (see the list of partner agencies in section 3.3.5).
- Work with relevant service managers to identify where staff may benefit from additional training to deliver short interventions to children and young people who are at lower risk of alcohol-related harm.
- Ensure pathways identify the action that should be taken to refer children to specialist services, such as substance misuse services, child and adolescent mental health services (CAMHS) or safeguarding, where there is suspected alcohol dependence or a high risk of alcohol-related harm with potential physical, psychological, education or social consequences.

Commissioners may wish to consider combining the commissioning of identification and effective brief intervention for alcohol, with brief interventions for other relevant risk-taking behaviours in children and young people, including smoking, diet, physical activity, sexual health and drug misuse.

3.3.4 Specialist treatment for children and young people who have a higher risk of alcohol-related harm

Commissioners should commission a specialist alcohol service for children and young people who have a high risk of alcohol-related harm with potential physical, psychological, educational or social consequences.

[NICE clinical guideline CG115 on alcohol dependence](#) states:

If alcohol misuse is identified as a potential problem, with potential physical, psychological, educational or social consequences, in children and young people aged 10–17 years, conduct an initial brief assessment to assess:

- the duration and severity of the alcohol misuse (the standard threshold on the AUDIT for referral and intervention should be lowered for young people aged 10–16 years because of the more harmful effects of a given level of alcohol consumption in this population)

- any associated health and social problems
- the potential need for assisted withdrawal.

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states:

Children and young people accessing specialist services for alcohol use receive a comprehensive assessment that includes the use of validated measures (quality statement 6).

Commissioners should specify that all children and young people who are referred to their children's and young people's alcohol service receive a comprehensive assessment which includes:

- their alcohol and other substance use, using lower thresholds than for adults because of the more harmful effects of alcohol consumption in children and young people
- background factors including family support and social stability
- a clinical interview structured around a validated clinical tool that has been adapted for use with children and young people, for example the Adolescent Diagnostic Interview (ADI) or the Teen Addiction Severity Index (TASI).

The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states:

Children and young people accessing specialist services for alcohol use are offered individual cognitive behavioural therapy, or if they have significant comorbidities or limited social support, a multicomponent programme of care including family or systems therapy (quality statement 12).

When commissioning specialist children's and young people's alcohol treatment services, commissioners should:

- Specify that the service can provide behavioural interventions including cognitive behavioural therapy and multicomponent programmes of care.
- Specify that alcohol interventions are delivered by a workforce that is experienced at working with vulnerable children and young people who may have complex needs, and who have also had appropriate additional training in alcohol treatment.
- Specify that the outcomes of treatment are routinely monitored, so the recovery plan can be updated according to need.
- Ensure that alcohol treatment services for children and young people are well integrated into adult services. This is important

to meet the needs of young adults aged 18 to 25 years who may be transitioning between young people and adult services.

Commissioners should be aware of the importance of engaging the family in a multicomponent programme of treatment. Family-based services can improve the effectiveness of treatment by improving families' coping mechanisms and communication, and reducing alcohol consumption among both parents and their children. Therefore commissioners should specify that their children's and young people's alcohol treatment service:

- engages parents and carers, and other significant family members, in treatment
- provides assessment for the parents or carers
- provides multidimensional family therapy, brief strategic family therapy or functional family therapy, including the length and duration of treatment recommended by NICE
- provides, or can refer, parents and carers to a service providing parenting support, such as parenting skills courses, or intensive family interventions, such as family meetings, when appropriate
- includes a programme of planned aftercare for all children, young people and their families in order to prevent and manage relapse.

Commissioners should be aware that although there may be significant numbers of children and young people who may have increased vulnerability to alcohol-related harm because of their personal social and health circumstances, such as family breakdown or mental health problems, rates of alcohol dependency are very small among children and young people. However, commissioners should have care pathways and processes in place for the minority of children who need low-volume high-cost inpatient medically assisted alcohol withdrawal, and adjunctive prescribing to prevent relapse. This may require close working between health and social care commissioners.

Commissioners should note that [NICE clinical guideline 115 on alcohol dependence](#) recommends:

Refer all children and young people aged 10–15 years to a specialist child and adolescent mental health service (CAMHS) for a comprehensive assessment of their needs, if their alcohol misuse is associated with physical, psychological, educational and social problems and/or comorbid drug misuse.

[NICE public health guidance 24](#) on preventing harmful drinking recommends:

If there is a significant risk of alcohol-related harm, consider referral to child and adolescent mental health services, social care or to

young people’s alcohol services for treatment, as appropriate and available.

It is not thought that the majority of children and young people who have problems with alcohol use are likely to require treatment in CAMHS, or that CAMHS will always be best placed to treat children who use alcohol. However, some children and young people with complex needs or other behavioural and/or mental health problems may benefit from coordinated treatment with CAMHS. Therefore commissioners should:

- specify that their substance misuse service includes a liaison worker who works closely between CAMHS and their local substance misuse service
- work closely with CAMHS to ensure that local alcohol treatment pathways include guidance for practitioners on making appropriate referrals to CAMHS for young people with mental health problems, and for CAMHS workers to make appropriate referrals to substance misuse services where a risk of alcohol-related harm is identified.

3.3.5 Service models for children and young people who are vulnerable to alcohol-related harm

Partner agencies

Table 8 lists some of the agencies working with vulnerable children and young people where staff may benefit from awareness raising and training to identify alcohol-related harm, and training to provide brief interventions where appropriate.

Table 8 Partner agencies for children’s and young people’s alcohol services

Setting	Agency
Education	<ul style="list-style-type: none"> • Pastoral staff • Teachers and tutors
Health	<ul style="list-style-type: none"> • Health visitors • School nurses • Children’s and young people’s community mental health nurses • Accident and emergency staff • Alcohol specialist nurses • Teenage pregnancy/sexual health staff • GPs • Practice nurses
Social care	<ul style="list-style-type: none"> • Social workers • Child and family workers • Children’s home staff • Foster carers

Criminal justice	<ul style="list-style-type: none"> • Police officers • Probation officers • Youth offending team staff • Secure training centres • Secure children's homes
Other youth services	<ul style="list-style-type: none"> • Children's centre staff • Youth workers • Career advice services • Children's and young people's counseling/advice services

Case studies

Commissioners may wish to refer to examples of commissioned alcohol services for children and young people. Examples are included in table 9.

Table 9 Case studies of services for children and young people

Example	Details of case study
Specialist children, young people and families treatment service	<ul style="list-style-type: none"> • See example from Stockport Mosaic whose service works with young people up to the age of 25 years, and their families. • Stockport Mosaic also offers services for children of substance misusing parents and a school-based project providing identification and brief interventions to prevent alcohol-related harm. • See also the article on page 26 of the Cocaine Dossier.
Services for children whose parents also misuse alcohol	<ul style="list-style-type: none"> • See example from Bury Holding Families pilot project
Health mentors providing early intervention in schools, youth clubs and other settings used by children and young people	<ul style="list-style-type: none"> • Tameside and Glossop health mentors scheme offers early intervention, screening and brief interventions (with a focus on behavioural change) for children and young people aged 4 to 16 years on a range of adverse health issues. These include alcohol and common comorbidities including drugs, emotional wellbeing, smoking, sexual health and obesity. • See also the Nursing Times child health award 2010.
Developing pathways with accident and emergency departments	<ul style="list-style-type: none"> • See example from Liverpool hospital young person alcohol related attendance

Please note – these case studies are offered to share examples of practice and NICE makes no judgement on the compliance of these services with its guidance.

Additional resources

Commissioners may also find the resources in table 10 useful when commissioning children's and young people's alcohol services.

Table 10 Additional resources for commissioning children's and young people's alcohol services

Document	Source	Year	Significance
<u>Shared learning database</u>	NICE	2011	<ul style="list-style-type: none"> • Examples of how organisations have implemented NICE guidance locally
<u>Local Initiatives</u>	Alcohol Learning Centre	2011	<ul style="list-style-type: none"> • Resource for accessing and sharing information about alcohol services and policies
<u>Young people's specialist substance misuse treatment planning guidance 2011/12</u>	National Treatment Agency for substance misuse	2011	<ul style="list-style-type: none"> • Advice and checklists for commissioners when developing specialist children's and young people's substance misuse services
<u>Alcohol pathway</u>	NICE	2011	<ul style="list-style-type: none"> • Provides a visual representation of NICE guidance on alcohol
<u>Young people's drug and alcohol treatment at the crossroads</u>	DrugScope	2010	<ul style="list-style-type: none"> • Results from consultation with people working in young people's drug and alcohol treatment, with key messages on how to improve treatment
<u>Joint guidance on development of local protocols between drug and alcohol treatment services and local safeguarding and family services</u>	Department of Children, Schools and Family, Department of Health and National Treatment Agency for Substance Misuse	2010	<ul style="list-style-type: none"> • Helps commissioners to improve joint working between local services, thereby ensuring that children of substance misusing parents are protected from harm and have their welfare needs met
<u>Right time, right place</u> : alcohol-harm reduction strategies with children and young people	Alcohol Concern	2010	<ul style="list-style-type: none"> • Recommendations on service models to intervene and reduce alcohol-related harm in children and young people
<u>Alcohol and young people: a toolkit</u> – supporting vulnerable young people at risk of	Alcohol Concern	2010	<ul style="list-style-type: none"> • Toolkit on supporting young people who are at risk of alcohol-related harm. Includes guidance for commissioners

alcohol related harm			
<u>Guidance on the consumption of alcohol by children and young people</u>	Sir Liam Donaldson	2009	<ul style="list-style-type: none"> • Guidance on key commissioning priorities when developing alcohol services for children and young people
<u>Guidance on commissioning young people's specialist substance misuse treatment services</u>	National treatment agency for substance misuse	2008	<ul style="list-style-type: none"> • Information on the specialist commissioning of substance misuse services for children and young people as part of an integrated commissioning approach within the Children's Trust
<u>NICE public health guidance 7: school-based interventions on alcohol</u>	National Institute for Health and Clinical Excellence	2007	<ul style="list-style-type: none"> • Guidance on school-based interventions that encourage children not to drink, delay the age at which young people start to drink and reduce the harm caused by drinking

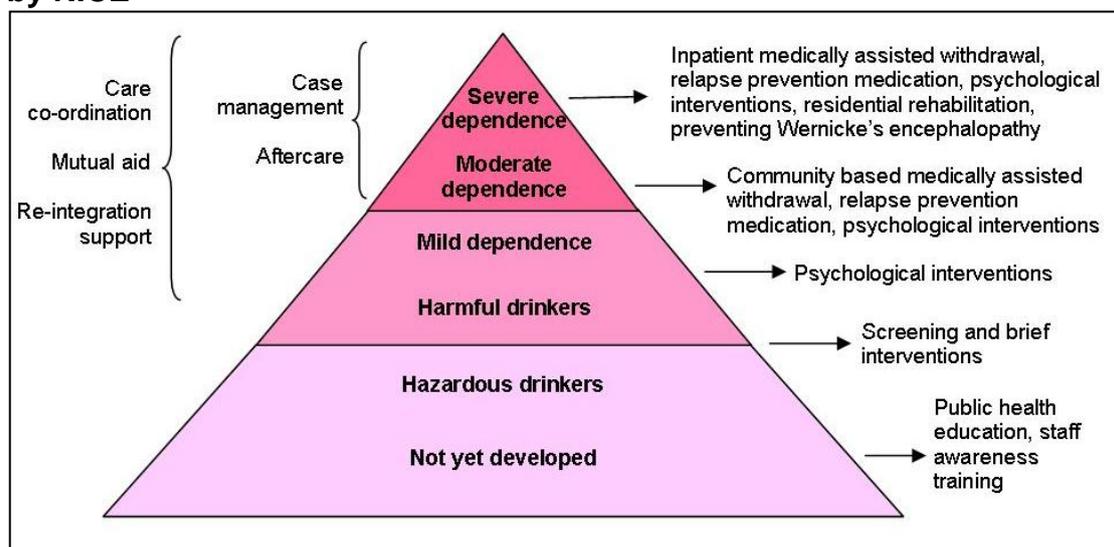
3.4 Whole system commissioning of high quality alcohol services

[NICE public health guidance 24 on preventing harmful drinking](#) states that commissioners should make provision for a likely increase in the number of referrals to alcohol services as a result of opportunistic screening. Therefore commissioners may wish to:

- Nominate a lead agency, such as the local authority or health and wellbeing board, and a lead commissioner to commission local alcohol services.
- Work closely with local multi-agency partnerships such as clinical commissioning groups, the health and wellbeing board, children's and young people's partnerships and drug and alcohol action teams, taking into account the policy of Public Health England and the views of the Local Authority Director of Public Health.
- Ensure that the individual remits of the different partnerships are clearly mapped out.
- Work within partnerships to identify, ring-fence and pool budgets and other resources, including relevant staff, for commissioning alcohol services.
- Use partnerships to map out and understand the 'whole system' of alcohol interventions, treatment and alcohol-related harm in the local area, involving criminal justice, social care, physical and mental health.
- Keep an up-to-date joint strategic needs assessment of alcohol-related harm.
- Use partnerships to ensure there is a streamlined and robust process for commissioning and contract managing alcohol services. Commissioners should ensure good coordination of care between treatment settings in primary, community, secondary and tertiary care settings and between their partners in health, social care, education, housing and criminal justice.

Recommendation 5 of [NICE public health guidance 24 on preventing harmful drinking](#) recommends that services should be properly resourced to support the stepped care approach recommended in [Models of care for alcohol misusers \(MoCAM\)](#). Under the stepped care model, people are initially offered the least intensive, most cost-effective intervention that is likely to be acceptable and effective for them, and are able to move up or down within the system depending on their treatment outcomes. Therefore commissioners should commission a full-range of recovery-focused services recommended by NICE, from low-intensity screening and brief advice through to structured-community-based services for dependent drinkers (represented in figure 4 below).

Figure 4 Range of alcohol treatments and interventions recommended by NICE²⁸



Commissioners may wish to consider delivering alcohol treatment services in a number of different ways, and mixed models of provision are likely to be appropriate within a local area. Commissioners may wish to take action to stimulate the local market if there are identified shortages of providers for any interventions and should note that potential providers may include providers from the health, local authority, other statutory partners, or private or third sectors. Commissioners must ensure that providers can provide the quality of care stipulated in the NICE guidelines and quality standard. To maximise cost efficiency, commissioners may wish to consider:

- working with local or regional partners to tender for low-volume high-cost specialist services such as inpatient alcohol withdrawal and residential rehabilitation
- developing partnerships with other local areas when commissioning community-based services.

The Department of Health recommends that commissioners work alongside clinicians, service providers and managers to develop [alcohol treatment pathways](#). Commissioners should ensure that they monitor the implementation and variance of practice within the alcohol pathways. Local alcohol treatment pathways should:

- involve service users in their development and review
- provide good continuity of care between service providers and settings for all age groups
- be flexible enough to meet the outcomes of individual service users

²⁸ Department of health (2009) [Signs for improvement – commissioning interventions to reduce alcohol-related harm](#). London: Department of Health.

- enable decisions to take place on the basis of individuals' changing needs.
- be responsive to people with comorbid physical or mental health problems
- allow for recurrent treatment episodes, concurrent treatments and extended periods of intervention
- clearly identify referral thresholds
- clearly identify the action that health and social care professionals should take to refer people who require specialist alcohol treatment services
- Include separate pathways for vulnerable groups such as children and young people, pregnant women and homeless people.

To ensure the alcohol pathway for people who misuse alcohol operates effectively, commissioners may wish to work with relevant service managers to develop plans to ensure that all staff that may come into contact with children, young people and adults who misuse alcohol have access to programmes of general alcohol awareness training. The NICE [quality standard on alcohol dependence and harmful alcohol use](#) states:

Health and social care staff receive alcohol awareness training that promotes respectful, non-judgemental care of people who misuse alcohol (quality statement 1).

Commissioners should note that some staff who work with vulnerable people who may misuse alcohol might not work in the NHS or social care. Examples of relevant settings include:

- health settings such as primary care, secondary care, mental health services, sexual health services and pharmacies
- social care
- criminal justice settings, including prisons
- local authority settings such as welfare advice and job centre plus
- voluntary sector settings
- education settings such as schools and colleges
- youth services.

When commissioning general alcohol awareness training, commissioners may wish to:

- Commission ongoing programmes of peer-led and/or internet-based training to improve staff awareness of alcohol misuse, and of local referral and treatment pathways

- Specify that training promotes a respectful and non-judgemental attitude to people misusing alcohol, and which takes into account the stigma and discrimination often associated with alcohol misuse.

Training may be provided internally using alcohol specialists or using free online training modules.

Commissioners should work with relevant service managers to develop **shared governance procedures** for their integrated alcohol service. This will support the delivery of the whole pathway of care. Commissioners should ensure that they have the policies and procedures in place for:

- data protection, information sharing and confidentiality
- referral, assessment, treatment and discharge processes
- safeguarding vulnerable children, young people and adults, including adults who misuse alcohol and care for children and young people
- serious untoward incident reporting
- workforce development, including recruitment, training, induction, appraisal, supervision and continuing professional development
- communications, promotion and marketing
- service user, carer and public engagement and involvement.

Where possible commissioners should ensure that their information technology (IT) is compatible across providers, including GPs, community-based alcohol services, mental health services, social care and local acute hospital trust. Where shared IT systems, such as case management databases, are not possible, commissioners should ensure that there are clearly documented processes for passing referral, assessment and treatment information between partner services.

To ensure that alcohol treatment services are well integrated into other services for people who misuse alcohol, commissioners may wish to consider commissioning alcohol treatment services as one component within a wider treatment pathway for substance misuse. This may contribute to economies of scale in employing and training staff and for overhead costs such as facilities, and improve the coordination of care for people with comorbid drug and alcohol problems.

3.4.1 Service models for whole system commissioning of high quality alcohol services

Commissioners may wish to refer to examples of whole system commissioning of alcohol services:

- [County Durham](#)

- [Lancashire \(see case study 4\)](#)
- [Stoke on Trent](#)
- [Wakefield.](#)

Examples of mapping alcohol-related care pathways include:

- [Bexley](#)
- [Blackpool.](#)

Commissioners should ensure that alcohol pathways are well integrated into pathways for criminal justice, social care, housing and mental health. An example is:

- [London pathway for homeless people.](#)

Please note – these case studies are offered to share examples of practice and NICE makes no judgement on the compliance of these services with its guidance.

Additional resources

Commissioners may also find the resources in table 11 useful when commissioning services for the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults.

Table 11 Additional resources for whole system commissioning of integrated alcohol services

Document	Source	Year	Significance
Local routes: guidance for developing alcohol treatment pathways	Department of Health	2009	<ul style="list-style-type: none"> • Good practice guidance on the development of care pathways, or alcohol treatment pathways, for people with alcohol problems.

4 Service specification

Commissioners should collaborate with clinicians, service managers, providers, local stakeholders, [people who misuse alcohol](#) and their families, when determining what is needed from alcohol services. The service should be person-centred and integrated with other elements of care for people who misuse alcohol.

Commissioners should ensure the services they commission represent value for money and offer the best possible outcomes for their service users. Commissioners should refer to the NICE [quality standard on alcohol dependence and harmful alcohol use](#) when commissioning services and should include quality statements and measures within the service specification element of the standard contract.

[NICE quality standards](#) provide commissioners with definitions of high quality care across a care pathway. Commissioners can use the quality standards to improve services by including quality statements and measures within the service specification element of the standard contract and by measuring performance against them. If poor performance is identified, commissioners can discuss the level of performance with their providers and address any issues and concerns before introducing more formal contractual remedies.

Commissioners may use quality standards to ensure that high quality care is being commissioned through the contracting process, to establish key performance indicators as part of a tendering process and/or to incentivise provider performance by using the indicators in association with incentive payments such as [Commissioning for Quality and Innovation](#) (CQUIN).

Table 12 provides a framework service specification and includes examples of areas that should be defined in a contract service specification for an alcohol service. Different services may require different aspects of the specification.

Table 12 Considerations for commissioners when developing a contract service specification for an alcohol service

Heading	Section	To be described in service specification
Purpose	Policy context	<ul style="list-style-type: none"> National policy drivers (see section 2.3) Evidence base (NICE guidance and quality standards, NHS evidence, others)
	Local strategic context	<ul style="list-style-type: none"> Local commissioning drivers (reducing alcohol-related harm, consumption, limiting availability, culture of drinking, reducing anti-social behaviour, reducing hospital admissions, QIPP, CQUIN, others) Invest to save Local alcohol joint strategic needs assessment and health and wellbeing assessment
	Aims and objectives of service	<ul style="list-style-type: none"> Outcomes for commissioner, provider, patient Shift resources towards early intervention and prevention in primary and community settings

		<p>based on local need</p> <ul style="list-style-type: none"> • Whole system commissioning to ensure integrated, streamlined service
Service scope	Define service user groups	<ul style="list-style-type: none"> • Demographic profile of the local population (age, gender, ethnicity, socio-economic status), impact on need. • Local estimated prevalence of hazardous, harmful and dependent drinking in children, young people and adults • Estimated prevalence of comorbidities (e.g. Wernicke-Korsakoff syndrome, alcohol-related liver disease, pancreatitis, hypertension, stroke, depression, etc.) • Evidence of inequalities in outcomes between specific groups • Number of wholly and partially attributable alcohol-related emergency department attendance hospital admissions and deaths • Number of people currently being treated in community-based alcohol treatment services • Number of people who see their GP and have a recorded incidence of alcohol-related ill health • Population groups that will be targeted for opportunistic screening and brief interventions
	Exclusion criteria	<ul style="list-style-type: none"> • Pathways for children, young people and adults who are referred for assessment and treatment but who are not eligible for treatment • Thresholds for individual service elements
	Geographical population	<ul style="list-style-type: none"> • Proportion of people living in urban/rural areas • Areas of higher-than-average need, for example areas of deprivation, areas with an ageing population, areas with high student populations • Impact of night-time economy • Population coverage required
	Service description /care package	<ul style="list-style-type: none"> • Commissioning of core service components (opportunistic screening, brief advice and interventions, assessment, treatment, care coordination and/or case management, aftercare, prescribing) • Settings that will be targeted to deliver opportunistic screening and brief interventions • Interface with services that identify people with alcohol use disorders • Interface with existing alcohol and/or substance misuse services

		<ul style="list-style-type: none"> • Interface with wraparound support services • Interface with peer support and mutual aid
Service delivery	Location	<ul style="list-style-type: none"> • Service location(s), defining accessibility requirements and discreet location • Integration with other services for people who misuse alcohol • Use of care coordination and case management to improve accessibility
	Days/hours	<ul style="list-style-type: none"> • Provision in the day, evenings and weekends • Expected number of people for screening, assessment, treatment, care coordination or case management, aftercare, taking into account potential increased flow through the system over defined periods (see the commissioning and benchmarking tool)
	Referral processes	<ul style="list-style-type: none"> • Referral criteria and processes for children, young people and adults who are screened and who misuse alcohol • Referral processes between interventions/providers/settings • Management of 'did not attends' (DNAs)
	Response times	<ul style="list-style-type: none"> • Needs and outcomes based • Setting specific • Identify a maximum timescale for referral to assessment, and assessment to treatment
	Care pathways	<ul style="list-style-type: none"> • Agreed clinical protocols or guidelines to support decision making in the patient pathway • Define validated screening tools to be used for identification, initial assessment and comprehensive assessment, and the action to be taken depending on the score, for children, young people and adults • Pathway for adults or children and young people for whom there are safeguarding concerns, in all settings • Pathways for people with complex needs (e.g. referrals from criminal justice, homeless people, pregnant women, older people, people with comorbidities such as mental health problems and/or liver disease) • See Department of Health's Local routes: guidance for developing alcohol treatment pathways
	Discharge Processes	<ul style="list-style-type: none"> • Process for discharge, including aftercare
	Staff / training / education / research	<ul style="list-style-type: none"> • Profile of existing health and social care workforce; are new staff required? • Skills mix and competencies of staff across the whole pathway. See national occupational standards on drugs and alcohol

		<ul style="list-style-type: none"> • Include training as part of continuing professional development (CPD); useful resources may include: <ul style="list-style-type: none"> ○ Opportunistic screening and brief interventions – see Department of Health guidelines for the commissioning identification and brief advice training, The Alcohol Learning Centre e-learning on IBA and Department of Health Identification and brief advice tools and techniques ○ Behaviour change – see City and Guilds certificate for health trainers ○ Psychological therapies – see Commissioning IAPT for the whole community: improving access to psychological therapies ○ GPs – see Royal College of General Practitioners alcohol certificate
	Information sharing	<ul style="list-style-type: none"> • Define information sharing, data protection, confidentiality and audit requirements, including IT support and infrastructure • Raising awareness of alcohol services; ensuring patients and health and social care professionals know how to access services • Marketing and communications strategies
Quality assurance	Quality indicators	<ul style="list-style-type: none"> • Use NICE quality standards to define quality standard • Referral to treatment waiting times • Uptake of treatment following referral • Number of initial/comprehensive assessments • Treatment starts and completion • Planned and unplanned discharges • Numbers of people exiting treatment having met their care plan goals (this can be measured through discharge codes in NATMS) • Patient views on alcohol services and access to treatment • Define local outcomes and (proxy) measures
	Performance monitoring	<ul style="list-style-type: none"> • Local need and uptake of brief interventions • Referrals to and uptake of community based treatment • Referrals to community based and inpatient alcohol withdrawal and residential rehabilitation • Alcohol-related admissions to A&E, inpatient hospital care and deaths • Number of referrals, number of people who start treatment, number of people who

		<p>complete treatment</p> <ul style="list-style-type: none"> • Aftercare and follow-up appointments • Relapse rates • Outcomes monitoring
	Equality	<ul style="list-style-type: none"> • Measures to ensure equality of access to community-based treatment services, taking into account the risks of unintentional discrimination against groups who are often under-represented in alcohol treatment services, such as younger or older people and people with caring responsibilities. • Consider needs of people with additional needs such as homeless people and people in or recently released from prison.
	Clinical governance	<ul style="list-style-type: none"> • Clinical governance framework for whole service • Information sharing protocols • Detail of how failure will be dealt with • Audit arrangements: see NICE audit support for PH24: preventing harmful drinking; CG100: alcohol-related physical complications; CG115: alcohol dependence • Baseline assessment: see NICE self-assessment tool for PH24: preventing harmful drinking and NICE baseline assessment tools for CG100: alcohol-related physical complications and CG115: alcohol dependence • Audit may include prescribing practices, successful treatment outcomes, relapse and withdrawal episodes (planned and unplanned)
	Patient experience	<ul style="list-style-type: none"> • Understand patient experience of alcohol identification and treatment pathways • Involvement of third sector • Representation of patient voice, including children and young people and older people • Use patient experience information to inform service delivery
Activity Plan	Activity plan	<ul style="list-style-type: none"> • Plans for managing short- and long-term impact of increasing targeted screening and increasing access to community-based treatment, on referrals and alcohol-related hospital admissions • Planned service developments
Cost	Value for money	<ul style="list-style-type: none"> • Likely cost of new or additional services • Anticipated set-up costs • Potential for better value for money • People receive most appropriate services for treatment of alcohol problems (stepped care) • Demonstrate value for money

5 Determining local service levels for the identification and treatment of alcohol misuse

Available data suggest that the indicative benchmark rate for:

- **hazardous drinking** is around 24.2% or 24,200 per 100,000 of the population aged 16 years and above
- **harmful drinking** is around 3.8% or 3,800 per 100,000 of the population aged 16 years and above. Two-thirds of harmful drinkers show signs of **alcohol dependence**.

The population benchmark is based on the following sources of information:

- **epidemiological data** on the prevalence of alcohol misuse
- **morbidity and mortality data** to establish alcohol-related hospital admissions and alcohol-attributable mortality
- **current practice** where there is an existing alcohol treatment service in place.

Further information about alcohol misuse in children and young people is also included in section 6.4 to support the commissioning of services for children and young people.

Use the alcohol services commissioning and benchmarking tool section within this guide (section 6) to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

5.1 Epidemiological data on the prevalence of alcohol misuse

The population benchmark is calculated using data from the 2007 Adult Psychiatric Morbidity Survey (APMS)²⁹. The APMS used:

- the Alcohol Use Disorders Identification Test (AUDIT) to measure hazardous and harmful drinking
- the Severity of Alcohol Dependence Questionnaire – Community version (SADQ-C) to measure mild, moderate or severe alcohol dependence, for all people who scored 10 or more on AUDIT.

The 2007 APMS found that around a quarter of the population (24.2%) scored 8 or more on the AUDIT test and are defined as **hazardous drinkers**. This is 24,200 per 100,000 population aged 16 or over. This group will be targeted for opportunistic screening and effective brief interventions.

²⁹ The NHS Information Centre (2008) [Adult Psychiatric Morbidity Survey, 2007](#) Leeds: The NHS Information Centre for health and social care.

The [NICE clinical guideline 115 on alcohol dependence](#) recommendation

1.2.2.6 states: “consider a comprehensive assessment for all adults referred to specialist alcohol services who score more than 15 on the AUDIT”.

The 2007 APMS found that harmful or dependent drinking is present in around 3.8% of the adult population aged 16 years and above scored 15 or more on AUDIT. Over 2/3 of this group have mild, moderate or severe dependence. This is 3,800 per 100,000 population aged 16 years or over (see table 13 and figure 5).

The [NICE clinical guideline CG115 on alcohol dependence](#) recommends:

For service users who typically drink over 15 units of alcohol per day and/or who score 20 or more on the AUDIT, consider offering:

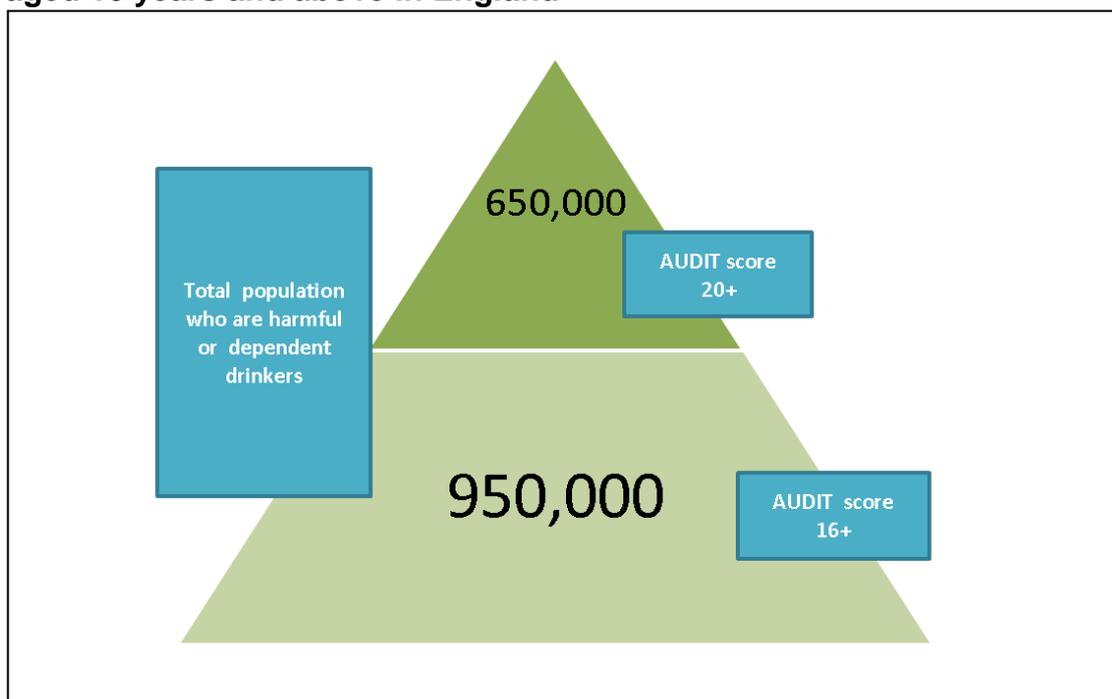
- an assessment for and delivery of a community-based assisted withdrawal, or
- assessment and management in specialist alcohol services if there are safety concerns (see 1.3.4.5) about a community-based assisted withdrawal (1.3.4.1).

The 2007 APMS found that around 650,000 people, or 1.5% of the adult population aged 16 years and above score 20 or more on the AUDIT¹⁰. This is 1,540 per 100,000 people aged 16 years and above (see table 13 and figure 5).

Table 13 Alcohol misuse in the population of England aged 16 years or above, measured using AUDIT

AUDIT Score	Population
8+	24.20%
16+	3.80%
20+	1.50%

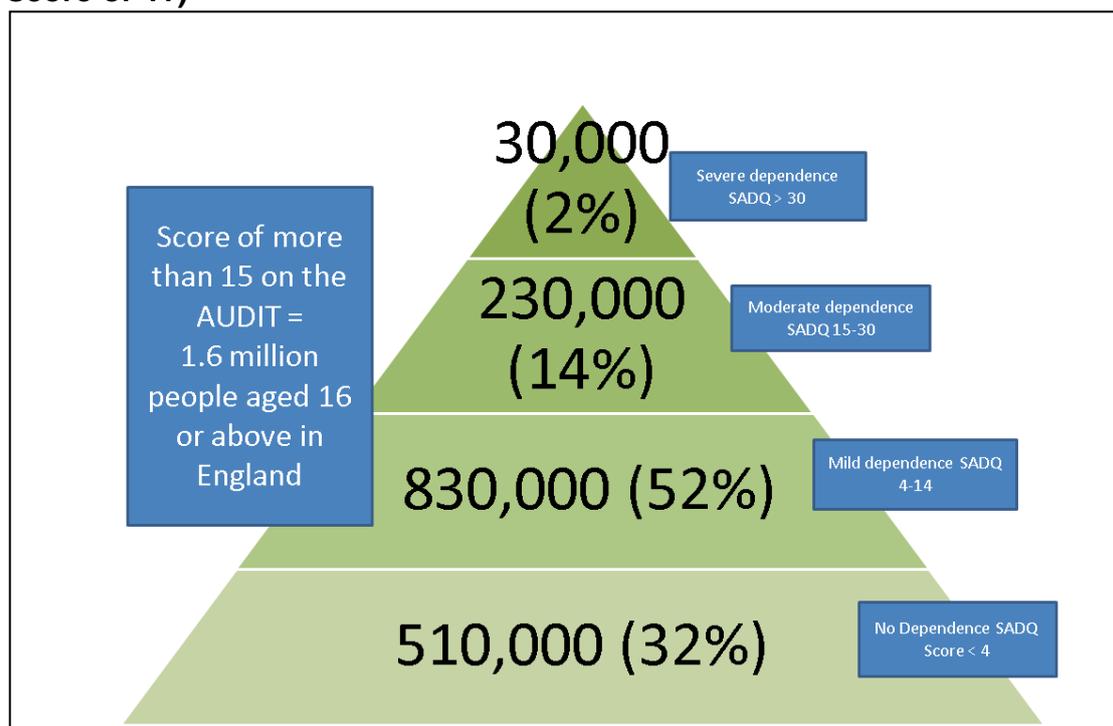
Figure 5 Harmful and dependent drinking (AUDIT 16+) among adults aged 16 years and above in England³⁰



Not all harmful drinkers will have alcohol dependence; a subset of the group scoring 16+ on AUDIT will meet the criteria for harmful drinking whilst another subset will meet the criteria for mild, moderate or severe alcohol dependence. Figure 6 illustrates the levels of harmful drinking and alcohol dependence in the population aged 16 years and over. Of the 1.6m (3.8%) people aged 16 and above in England who are 'clustered' as harmful or dependent drinkers, 68% are estimated to dependent (mildly, moderately or severely). Therefore it is calculated 2.6% or 2,600 per 100,000 population aged 16 and above has alcohol dependence.

³⁰ The NHS Information Centre (2008) [Adult Psychiatric Morbidity Survey, 2007](#) Leeds: The NHS Information Centre for health and social care.

Figure 6 Adults aged 16 years and above who are harmful drinkers (AUDIT score of 16+) and their measure of alcohol dependence (SADQ score of 4+)³¹



In the 2007 APMS, people who scored more than 10 on the AUDIT were asked to complete the SADQ-C to measure the severity of their alcohol dependence. People scoring 4 or more on the SADQ-C were considered to have alcohol dependence³². Table 14 summarises definitions of alcohol dependence using SADQ-C scores.

Table 14 Definitions of alcohol dependence using SADQ-C

	SADQ-C score	Population
Mild dependence	4–15	5.4%
Moderate dependence	16–30	0.4%
Severe dependence	30+	0.1%

Alcohol dependence is associated with high levels of physical morbidity and premature mortality. An assessment of the severity of alcohol dependence will contribute to decisions about the appropriate treatment for people. People with alcohol dependence can be a high-cost group to treat, especially where they have severe dependence and/or additional social, mental health or alcohol-related physical comorbidities.

³¹ The NHS Information Centre (2008) [Adult Psychiatric Morbidity Survey, 2007](#) Leeds: The NHS Information Centre for health and social care.

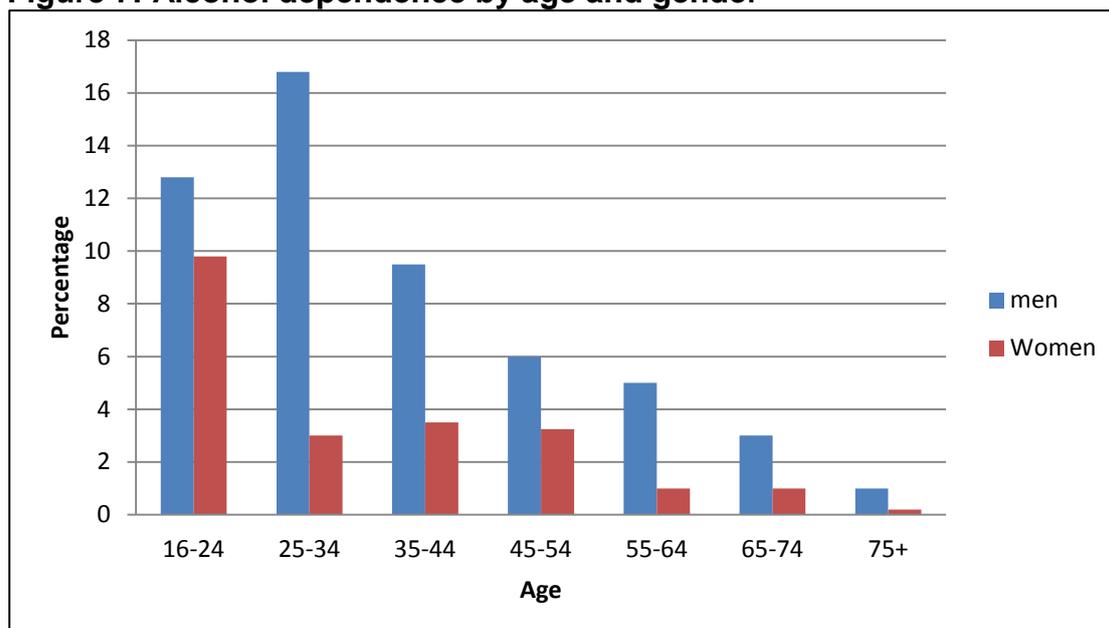
³² The NHS Information Centre (2008) [Adult Psychiatric Morbidity Survey, 2007](#) Leeds: The NHS Information Centre for health and social care.

5.1.1 Age and gender

The prevalence of harmful drinking and alcohol dependence is influenced by age and gender. The 2007 APMS showed that the prevalence of alcohol dependence is 8.7% of men compared with 3.3% of women.

For men, the highest prevalence of alcohol dependence is those aged between 25 years and 34 years (16.8%), whereas for women it is most common in those between aged 16 years and 24 years (9.8%) (see figure 7).

Figure 7: Alcohol dependence by age and gender³³



The 2004 Alcohol Harm Reduction Strategy for England identified that hazardous or harmful binge drinking is most common in young adults under the age of 25 years, while people with chronic alcohol problems tend to be older and are more likely to be male. Chronic alcohol problems include an increased risk of alcohol-related physical complications and an increased likelihood to commit the offences of domestic violence and drink-driving³⁴. Therefore commissioners should use local data on the prevalence and patterns of drinking behaviour and hospital admissions by age and gender to commission alcohol services that are appropriate to their needs.

³³ The NHS Information Centre (2008) [Adult Psychiatric Morbidity Survey, 2007](#) Leeds: The NHS Information Centre for health and social care.

³⁴ Prime Minister's Strategy Unit (2004) [Alcohol Harm Reduction Strategy for England](#). London: The Cabinet Office.

5.2 Alcohol-related morbidity and alcohol-attributable mortality

Harmful drinking is linked to a number of negative health outcomes, including increased risks of hypertension, stroke, coronary heart disease, liver cirrhosis and some cancers³⁵.

The Hospital Episode Statistics (HES) database contains details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. The [North West Public Health Observatory](#) analysis of HES data for alcohol-attributable hospital admissions³⁶ found that:

- The rate of admission in 2009/10 in England was 1,743 per 100,000 population; an increase of 10% on 2008/09 admissions.
- The total number of admissions for 2009/10 was 1.1 million, an increase of 12% on the number in 2008/09.
- The rate of admission per 100,000 population differs across England. It is highest in the North East (2,420) and North West (2,300); and lowest in South Central SHA (1,299) and South East Coast SHA (1,451). This highlights the significant regional variation in alcohol-related harm, which may impact on local commissioning decisions (see section 5.2.1)³⁷.

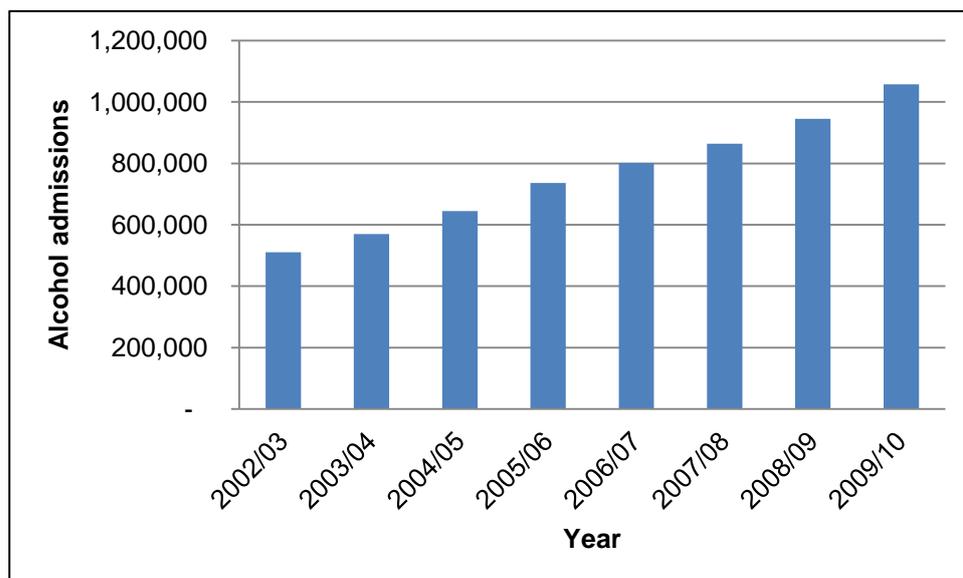
Figure 8 below illustrates the increase in hospital admissions in England since 2002. Commissioners may be able to reduce the need for alcohol-related hospital admissions by commissioning services that identify and provide early intervention for hazardous and harmful drinkers, and provide recovery-focused treatment for people with alcohol dependence.

³⁵ The NHS Information Centre (2008) [Adult Psychiatric Morbidity Survey, 2007](#). Leeds: The NHS Information Centre for health and social care.

³⁶ There is a definition of 'alcohol-related harm', including alcohol-attributable harm, in the glossary in section 8 of this guide.

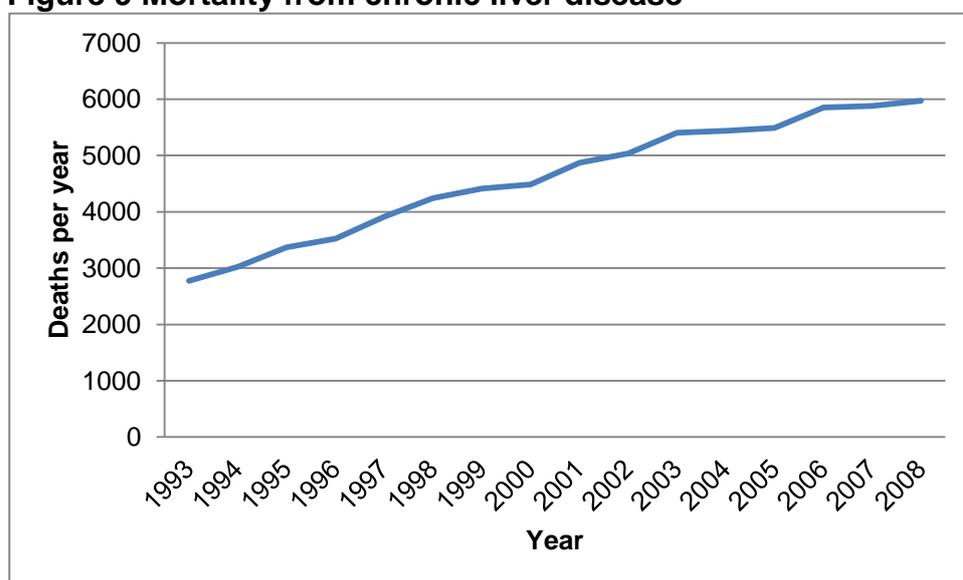
³⁷ North West Public Health Observatory (2010) [Local Alcohol Profiles for England](#). Liverpool, England: Association of Public Health Observatory

Figure 8. Alcohol-related hospital admissions 2002 to 2010³⁸



The 2010 NWPHO³⁹ estimate that 14,982 deaths were attributable to alcohol consumption (3.1% of all deaths). Approximately a third (4,699) of these deaths occurred from conditions wholly attributable to alcohol consumption. Overall, the largest number of alcohol-related deaths were from alcoholic liver disease. Figure 9 demonstrates the trend of increasing deaths due to chronic liver disease.

Figure 9 Mortality from chronic liver disease⁴⁰



³⁸ The NHS Information Centre (2010) [Hospital episode statistics](#). Leeds, England. The NHS Information Centre for health and social care.

³⁹ North West Public Health Observatory (2010) [Local Alcohol Profiles for England](#) Liverpool, England. Association of Public Health Observatory

⁴⁰ ONS (2010) [Mortality statistics Deaths registered in 2009](#) London, Office for National Statistics

5.2.1 Geographical variation in alcohol misuse

There is significant regional variation in the rate of alcohol-related hospital admissions per 100,000 population in England. HES data shows⁴¹ shows that, over the past 5 years, alcohol-related hospital admissions in the North East Strategic Health Authority (SHA) have been 140% of the England average compared with South Central SHA where they are 70% of the England average.

There is also significant variation in alcohol misuse within regions, therefore locally available data should be used to inform commissioning. The [North West Public Health Observatory](#) Local Alcohol Profiles for England has a range of alcohol indicators at local authority and primary care trust level. There are many interrelated factors that contribute to regional variations including cultural factors such as drinking behaviours, historical factors such as industrialisation and urbanisation and socio-economic factors such as unemployment.

5.2.2 Deprivation and household income

There is a relationship between alcohol misuse and deprivation. The 2009 general lifestyle survey shows that an increase in gross weekly household income is associated with an increase in the proportion of people who:

- drank alcohol during the previous week
- proportion of people exceeding 3 to 4 units in a day
- proportion of people drinking heavily⁴¹.

Conversely, Indications of Public Health in the English Regions⁴² shows that alcohol-related harm is higher among low income groups:

- Alcohol-attributable hospital admissions and mortality are two to five times greater among the 20% most deprived populations in the United Kingdom.
- The most deprived lifestyle groups have 4 to 15 times greater alcohol-specific mortality and up to 10 times greater alcohol-specific hospital admissions.
- Men aged over 35 years, unskilled or manual workers or unemployed people are at the highest risk of being admitted to hospital with an alcohol-related problem.
- 50% of homeless people are dependent on alcohol.

Therefore commissioners should use local data on social exclusion when targeting appropriate local services and estimating local need.

⁴¹ Simon Robinson, Helen Harris (2010) [Smoking and drinking among adults, 2009](#) London: The Office for National Statistics.

⁴² North West Public Health Observatory (2010) [Local Alcohol Profiles for England](#) (2010), Liverpool, England. Association of Public Health Observatory.

5.3 Current practice

Data from the 2009/10 National Alcohol Treatment Monitoring System (NATMS)⁴³ reports that 111,000 people aged 18 years and over were in contact with structured treatment for substance misuse and cited alcohol as their primary problematic substance. This is around 0.26%, or 260 per 100,000 population aged 18 years and over per year.

There were also around 30,000 clients aged 18 years and over who cited alcohol misuse as an adjunctive problem to a range of other primary problematic substances. This highlights the considerable prevalence of comorbid alcohol and drug misuse, and the benefit of ensuring integration between drug and alcohol treatment services.

5.3.1 Levels of service

There has been research into optimum levels for alcohol treatment provision⁴⁴. [NICE Public Health guidance 24 on preventing harmful drinking](#) recommends that:

Commissioners should ensure at least one in seven dependent drinkers can get treatment locally, in line with 'Signs for Improvement'.

Around 68% of the 1.6 million harmful drinkers have alcohol dependence. Providing treatment for 15% of the 1.08 million harmful drinkers and people with alcohol dependence would mean that around 163,000 people per year should have access to treatment. Data from the NATMS⁴⁵ shows that two thirds of this number, 111,000 are currently receiving treatment.

5.3.2 Access to treatment

The APMS 2007 showed that alcohol dependence in men is highest in the 16–34 age group; 55% of all dependent men are in this age range. In comparison, NATMS data shows that 30% of men being treated in specialist alcohol services are in the 18–34 age group⁴⁶.

⁴³ The National Treatment Agency for Substance misuse (2010) [Statistics from the National Alcohol Treatment Monitoring System \(NATMS\) 1st April 2009 – 31st March 2010](#). London: National Alcohol Treatment Monitoring System

⁴⁴ For example Rush B (1990) [A systems approach to estimate the required capacity of alcohol treatment services](#). British Journal of Addiction 85 (1): 49–59.

⁴⁵ The National Treatment Agency for Substance misuse (2010) [Statistics from the National Alcohol Treatment Monitoring System \(NATMS\) 1st April 2009 – 31st March 2010](#). London: National Alcohol Treatment Monitoring System.

⁴⁶ The NHS Information Centre (2008) [Adult Psychiatric Morbidity Survey, 2007](#). Leeds: The NHS Information Centre for health and social care, and The National Treatment Agency for Substance Misuse (2010) [Statistics from the National Alcohol Treatment Monitoring System \(NATMS\) 1st April 2009 – 31st March 2010](#). London: National Alcohol Treatment Monitoring System.

The APMS 2007 also showed that alcohol dependence in women is highest in the 16–34 age group; 59% of female dependent drinkers are in this age range. In comparison, NATMS data shows that 27% of women being treated in specialist alcohol services are in the 18–34 age group⁴⁷.

This data indicates that young adults aged 16 to 25 years and adults aged 26 to 34 years are under-represented in specialist treatment services when compared with older adults. Commissioners should consider the needs of younger people when commissioning alcohol services.

5.4 Children and young people aged 10–17 years

Evidence from the [Smoking, drinking and drug use among young people in England in 2009](#) survey shows that alcohol consumption in children and young people is falling. The survey reported that the proportion of pupils who reported that they drink alcohol at least once at week has decreased from 20% in 2001 to 12% in 2009⁴⁸.

The report also found that 18% of pupils reported drinking in the last week. This was more common among older pupils (38% of 15-year-olds compared with 3% of 11-year-olds). Drinking alcohol in the last week was found to be associated with other risk-taking behaviour such as smoking, drug taking and truancy. This highlights the need for commissioners to commission services for effective identification, targeted short brief interventions and specialist substance misuse services for children and young people who misuse alcohol with other services for children who are at risk of harm.

The National Drug Treatment Monitoring System 2009/10 report on 'substance misuse among young people' reported that around 8,200 children and young people aged 18 years and under received treatment from a specialist substance misuse service in England, whose primary substance was alcohol. This is a decrease from the 2008/09 figure of around 8,800. The majority of young people accessing services in 2009–10 received psychological and behavioural therapies to address the underlying causes and consequences of their alcohol use⁴⁹.

⁴⁷ The NHS Information Centre (2008) [Adult Psychiatric Morbidity Survey, 2007](#) Leeds: The NHS Information Centre for health and social care, and The National Treatment Agency for Substance misuse (2010) [Statistics from the National Alcohol Treatment Monitoring System \(NATMS\) 1st April 2009 – 31st March 2010](#) London, National alcohol Treatment Monitoring System.

⁴⁸ The NHS Information Centre (2010) [Smoking, drinking and drug use among young people in England in 2009](#) Leeds, England. The NHS Information Centre for health and social care.

⁴⁹ National Drug Treatment Monitoring System (2010) [Substance misuse among young people: the data for 2009–10](#). London, National alcohol Treatment Monitoring System.

5.5 Conclusion

Table 15 summaries the headline benchmark data for services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults.

Table 15 Benchmark data for the identification and treatment of alcohol misuse

Hazardous drinkers	24.2% of people in England aged 16 years or over drink hazardously.
Harmful and dependent drinkers	Around 1.6 million people (3.8%) are drinking harmfully or in a dependent way.
Alcohol dependence	Around 68% of the group identified as harmful and dependent drinkers actually have some degree of alcohol dependence, or 2.6% (around 1.1 million) of people aged 16 years and above.
Alcohol-related hospital admissions	In 2009/10 there were 1.1 million alcohol-related hospital admissions; this was an increase of 12% on 2008/09.
Deprivation	The most deprived 20% of the UK population suffer two to five times greater alcohol-related admissions to hospital or alcohol-related mortality, compared with the least deprived.
Mortality	Around 15,000 deaths each year (3.1% of all deaths) are attributable to alcohol consumption.
Treatment	Around 1 in 10 dependent drinkers (with AUDIT scores of 16+ and SADQ-C score of 4+) are currently receiving specialist alcohol treatment. Younger adults are under-represented in treatment services.
Children and young people	Alcohol misuse in children and young people is difficult to estimate. Alcohol use in children and young people is declining. Around 8,000 children and young people received specialist treatment last year, but many more will require short interventions to reduce the risk of alcohol-related harm.

Use the alcohol services [commissioning and benchmarking tool](#) to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

It should be noted that commissioners should use their local needs assessment to determine optimum levels for local service provision and should note that the benchmark rates do not represent NICE's view of desirable, or maximum or minimum, service levels.

Additional resources

Commissioners may also find the resources in table 16 useful to determine a local benchmark for alcohol misuse and to commission service based on local need, which contribute to reducing local health inequalities.

Table 16. Additional resources for estimating a population benchmark for alcohol misuse

Document	Author	Year	Significance
<u>Local alcohol profiles for England</u>	Association of Public Health Observatories (APHO)	2011	<ul style="list-style-type: none"> • Provide PCT-level prevalence estimates
<u>Commissioning framework for health and well-being</u>	Department of Health	2007	<ul style="list-style-type: none"> • Annex A outlines the process and data needed to undertake a joint strategic needs assessment.
<u>Delivering quality and value: focus on benchmarking</u>	Department of Health	2006	<ul style="list-style-type: none"> • Poster provides information on benchmarking tools, techniques, good practice and data
<u>Health equity audit</u>	National Institute for Health and Clinical Excellence	2006	<ul style="list-style-type: none"> • Learning from practice briefing
<u>NHS comparators</u>	NHS Information Centre	2011	<ul style="list-style-type: none"> • Analytical service for commissioners and providers. It helps improve the quality of care delivered by benchmarking and comparing activity and costs on a local, regional and national level
<u>The disease management information toolkit (DMIT)</u>	Department of Health	2009	<ul style="list-style-type: none"> • The toolkit presents data on conditions that contribute to high numbers of emergency bed days
<u>Predicting and reducing re-admission to hospital</u>	The Kings fund	2009	<ul style="list-style-type: none"> • The tool is a risk prediction system to identify patients at high risk of hospital re-admission

<u>PRIMIS+</u>	NHS Information Centre	2011	<ul style="list-style-type: none"> Provides support to general practices on information management (recording and analysis of) data quality, plus a comparative analysis service focused on key clinical topics
<u>NHS Evidence – Quality and Productivity</u>	NHS evidence	2011	<ul style="list-style-type: none"> NHS Evidence – QIPP is a collection of evidence to support quality and productivity at a local level
<u>Indicators for Quality Improvement</u>	NHS Information Centre	2011	<ul style="list-style-type: none"> A resource of robust indicators to help local clinical teams select indicators for local quality improvement. Assured by clinicians for use by clinicians. Published with full metadata for transparency

6 Commissioning and Benchmarking Tool

[Download the alcohol services commissioning and benchmarking tool](#)

Use the **commissioning and benchmarking tool** for alcohol services to determine the levels of opportunistic screening and brief interventions and specialist alcohol services for adults that might be needed locally, and to calculate the costs and savings of commissioning the service, as described below.

6.1 Identify indicative local service requirements

There are 4 indicative benchmark rates used in the tool:

- The indicative benchmark rate for **hazardous drinkers** is 24.2% or 24,200 per 100,000 population aged 16 years and above. Hazardous drinkers will be targeted for screening and brief interventions.
- The indicative benchmark rate for **harmful drinkers** is 3.8% or 3800 per 100,000 population aged 16 years and above. Harmful drinkers will be targeted for screening and brief interventions. Harmful drinkers who have not responded to brief interventions will require specialist alcohol services.
- The indicative benchmark rate for **alcohol dependence** is 2.6% or 2600 per 100,000 population aged 16 years and above. People with alcohol dependence will require specialist treatment.
- The rate of **alcohol-related hospital admissions** is 1.74% or 1743 per 100,000 population. Commissioning screening and brief advice and specialist alcohol services for children, young people and adults may help to reduce alcohol-related hospital admissions.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmarks as a starting point. With knowledge of your local population and its demographic, you can amend the benchmarks to better reflect your local circumstances. For example, if your population is significantly younger or older, has significant pockets of socioeconomic deprivation or has an ethnic composition different from the national average, or has a significantly higher or lower rate of hazardous drinking, harmful drinking or alcohol dependence, you may need to provide services for relatively fewer or more people.

6.2 Review current commissioned activity

You may already commission alcohol services for your population. The tool provides tables that you can populate to help you calculate your total current commissioned activity and costs.

6.3 Identify future change in capacity required

Using the indicative benchmarks provided, or your own local benchmarks, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

6.4 Model future commissioning intentions and associated costs

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark levels, and to model the required changes over a period of 4 years.

Use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which the alcohol services may be provided, comparing the costs of commissioning the service across the various settings. The tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.

6.5 Potential savings

You can use the commissioning and benchmarking tool to calculate the potential savings associated with commissioning alcohol services.

Increasing the number of people provided with specialist alcohol services will increase the total costs of treatment. However, providing evidence-based packages of care using the stepped-care model may reduce the unit cost of treatment per person by offering the least intensive, most cost effective intervention that is appropriate. This is likely to reduce the proportion of people with alcohol dependence receiving expensive inpatient and residential care.

Investing in opportunistic screening and brief interventions and specialist community based treatment may reduce the number of hazardous and harmful drinkers, and people with alcohol dependence.

Whole system commissioning of alcohol services is likely to generate significant savings by reducing the number of adverse events associated with alcohol-related harm, including alcohol-attributable hospital admissions. Some of these potential savings have been identified and can be modelled in the 'Potential savings' worksheet in the commissioning and benchmarking tool.

7 Glossary

Alcohol misuse	This commissioning guide refers to harmful drinking and alcohol dependence collectively as ‘alcohol misuse’. The term alcohol misuse is a working definition taken from NICE guideline 115 on alcohol dependence and is not used as a diagnostic term or to imply intentionality.
Alcohol-related harm	Physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as ‘alcohol specific’. If it is only partly caused by alcohol it is described as ‘alcohol attributable’.
Alcohol-use disorder	Alcohol-use disorders cover a wide range of mental health problems as recognised within the international disease classification systems (ICD-10, DSM-IV). These include hazardous and harmful drinking and alcohol dependence. See ‘Harmful’ and ‘Hazardous’ drinking and ‘Alcohol dependence’.
Dependence	A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations. For further information, please refer to: ‘Diagnostic and statistical manual of mental disorders’ (DSM-IV) (American Psychiatric Association 2000) and ‘International statistical classification of diseases and related health problems – 10th revision’ (ICD-10) (World Health Organization 2007).
Brief intervention	This can comprise either a short session of structured brief advice or a longer, more motivationally based session (that is, an extended brief intervention – see also below). Both aim to help someone reduce their alcohol consumption or abstain, and can be carried out by non-alcohol specialists.
Extended brief intervention	This is motivationally based and can take the form of motivational-enhancement therapy or motivational interviewing. The aim is to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change. In this guidance, all motivationally based interventions are referred to as ‘extended brief interventions’.
Harmful drinking	Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis.
Hazardous drinking	A pattern of alcohol consumption that increases

	someone's risk of harm. Some would limit this definition to the physical or mental health consequences (as in harmful use). Others would include the social consequences. The term is currently used by WHO to describe this pattern of alcohol consumption. It is not a diagnostic term.
Motivational interventions	Extended brief interventions that aim to motivate people to change their behaviour, by exploring with them why they behave the way they do and identifying positive reasons for making change.
Mutual aid	A range of self-help and support groups where a person receives and gives support based on their experience of misusing alcohol. For example Alcoholics Anonymous (AA).
Peer support	A service where a person who currently or formerly misused alcohol provides voluntary or paid support and guidance to other people who misuse alcohol.
Recovery	The commissioning guide focuses on commissioning for recovery as defined in the Drug Strategy 2010 . Building recovery is a person-centered approach to commissioning that empowers people to tackle their alcohol misuse within their community, and make permanent changes to their lifestyle that will free them from dependence and enable them to successfully contribute to society.
Screening	Screening is used to define the initial process of identifying people who are not seeking treatment for alcohol problems but who may be a hazardous or harmful drinker, or who have alcohol dependence.
Stepped care	The stepped care model provides a framework in which to organise the provision of services, and supports patients, carers and practitioners in identifying and accessing the most effective interventions. In stepped care the least intrusive, most effective intervention is provided first. If a person does not benefit from the intervention initially offered, or declines an intervention, they should be offered an appropriate intervention from the next step.
Whole system commissioning	The commissioning guide uses a whole system approach to the commissioning of alcohol services. A whole system approach, advocated in the Drug Strategy 2010 , explores the issue of alcohol misuse in a defined population, across the whole spectrum of identification, treatment and aftercare. It brings partners together to make integrated commissioning decisions, to pool investment and share risk. The aim of a whole system approach is to commission services that ensure the targeted population can access well integrated, high quality and clinically effective alcohol services.

8 Topic Advisory Group: alcohol services

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

Adrian Brown

Clinical Nurse Specialist: alcohol liaison, St Mary's Hospital London

Professor Colin Drummond

Professor of Addiction Psychiatry, Kings College London

Mark Gillyon

Head of Delivery (North), National Treatment Agency

Dr Eilish Gilvarry

Consultant Psychiatrist in Addictions, and Assistant Medical Director, Northumberland, Tyne and Wear NHS Foundation Trust

Clive Henn

Senior Alcohol Advisor, Department of Health

Karen Kyle

Senior Commissioning Manager, NHS North Lancashire

Dr Jack Leach

GP, Wigan and Royal College of General Practitioners Alcohol Clinical Lead

Chris Lee

Locality Commissioning Manager (North), Lancashire Drug and Alcohol Action Team

Andrew MacDonald

Alcohol Coordinator, Salford Drug and Alcohol Action Team

Dr Marsha Morgan

Reader in Medicine and Honorary Consultant Physician, University of London Medical School

Dr Mark Prunty

Senior Medical Officer for Substance Misuse Policy, Department of Health

Steve Simmonds

Head of Salford Drug and Alcohol Services

Acknowledgements

Thank you to the following for their contribution to developing this guide:

Alan Alker

Acting Service Manager, Tameside and Glossop Drugs and Alcohol Service,
Pennine Care NHS Foundation Trust

Deryn Bishop

West Midlands Regional Alcohol Manager, Department of Health

Mandy English

Strategic Alcohol Commissioning Manager, County Durham Drug and Alcohol
Action Team

Dr Ian Guinan

Medical Director, Delphi Medical Consultants Ltd

Dr Linda Harris

Chief Executive Officer and Clinical Director, Spectrum Community Health

Don Lavoie

Alcohol Adviser, Department of Health

Damian Mitchell

Alcohol Improvement Programme Lead, Department of Health

James Morris

Director, Alcohol Academy

Martyn Penfold

Alcohol Strategy Lead, NHS Wandsworth Primary Care Trust

Heidi Shaw, Louise Lees and Joanne Harris

Stockport Mosaic

Case study 1: Fresh Start Clinics in Wandsworth NHS Primary Care

In 2008/09 Wandsworth NHS Primary Care Trust piloted two models for treating people with mild to moderate alcohol dependence in primary care:

- (1) a standard alcohol local enhanced service (LES), led by GPs with support from specialist nurse
- (2) a dedicated GP-led clinic supported by a nurse prescriber (Fresh Start clinic).

Over a 12-month period the Fresh Start clinic was more cost effective in terms of 'cost per case' and demonstrated better outcomes than the LES, including low 'did not attend' (DNA) rates, high rates of treatment completion and high rates of sustained abstinence at 3-month follow-up. Interventions provided by the Fresh Start clinic include:

- alcohol screening
- brief and extended brief interventions
- motivational support and harm reduction/education groups
- assessment and follow-up clinics for people with abnormal liver function tests.

The success of the Fresh Clinics is attributed to several factors including:

- clinical leadership from a committed GP with an interest in alcohol and experience in treating addiction
- experienced nurse prescriber
- robust treatment planning
- ease of access, including the ability to self refer
- anonymity
- clear and responsive pathways into structured interventions
- a proactive approach to post-treatment follow-up and aftercare.

The measurable benefits of the Fresh Start clinic include:

- 97% of clients completed community-based medically assisted withdrawal overseen by the GP-led clinic; 85% of these engaged in structured interventions
- improved treatment outcomes for alcohol dependence in primary care including 65% abstinence at 3 months
- contributing to a reduction in waiting times for the community alcohol team, from an average of 13 weeks to 4 weeks
- a 50% improvement in mental wellbeing measured by the Beck Depression Inventory

- a reduction in working days lost due to alcohol dependence.

The clinic will expand to three sites in 2011/12 and will also begin to take referrals from the alcohol liaison nurses at St George's Hospital. It is hoped this will make a significant contribution to the target of reducing alcohol-related hospital admissions.

Please note – this case studies is offered to share an example of practice and NICE makes no judgement on the compliance of this service with its guidance.

Case study 2: Tameside and Glossop Primary Care Trust National Enhanced Service for Alcohol

Tameside and Glossop has some of the most severe alcohol-related problems in England, with high rates of hazardous and harmful drinking and alcohol-attributable hospital admissions.

The local primary care trust established England's first National Enhanced Service (NES) for alcohol in 2005, operated by a partnership of local GPs, a third sector organisation and Pennine Care NHS Foundation Trust. Ten GP practices are involved in the service, each with at least one accredited GP and supported by one primary care alcohol worker (a qualified nurse) and 1.5 whole-time equivalent project workers.

The NES is targeted at harmful drinkers and people with mild to moderate alcohol dependence. People with more complex needs such as significant mental health problems are referred to the district drug and alcohol service.

The service provides a range of interventions for up to 500 people per year, including:

- brief advice
- extended brief interventions including motivational enhancement
- relapse prevention using psychological interventions and/or prescribing
- community-based medically assisted alcohol withdrawal
- individual outcomes monitoring
- 'fast-track' service for hospital patients admitted for alcohol-related conditions such as gastric and hepatic disease (in development).

The service also delivers training to other primary care teams on screening, brief interventions and referral. Outcomes of the service have included:

- improved awareness and identification of alcohol misuse among GP practices
- over 90% of service users successfully complete their programme of medically assisted withdrawal
- high patient satisfaction, with the majority of service users preferring to receive treatment in primary care rather than at the local substance misuse centre.

The NES team are conducting a promotional campaign to raise awareness of the service in practices outside of the scheme, in order to try to increase the low number of referrals received from these practices where there are high levels of unmet need.

Please note – this case studies is offered to share an example of practice and NICE makes no judgement on the compliance of this service with its guidance.

Case study 3. The Acute Hospital Assertive Outreach at Salford Royal NHS Trust

A 2008 data analysis by the Salford Drug and Alcohol Action Team and its partners revealed that only 100 patients form 13% of all alcohol-related hospital presentations to Salford Royal Hospital accident and emergency department. These patients have a mortality estimate of less than 3 years. The costs, risks and needs of these patients are exceptional. However, the system was ineffective at managing their needs.

The assertive outreach project is funded as part of the Alcohol Harm Reduction Strategy 2010–2020. The roles in the multi-agency team include: gastroenterologist, hepatologist, psychiatrist, community psychiatric nurse, social worker, clinical psychologist, tenancy support worker, health improvement trainer, police, probation officer, fire safety officer, alcohol specialist nurse, and data and administrative support.

The nurse, social worker, tenancy support worker, health improvement trainer, and police and probation elements assertively engage patients with complex needs in the community to reduce or prevent hospital attendance. The patients are actively case managed if they present at accident and emergency, during admission and following discharge.

The project aims to reduce presentations to emergency departments, hospital admissions and re-admissions by helping patients cope better with their lives. This means a caseload of no more than 10 high risk patients per worker and fast track access to community alcohol treatment services. The model improves case management and data sharing among partners.

Please note – this case studies is offered to share an example of practice and NICE makes no judgement on the compliance of this service with its guidance.

Case study 4: Modernisation of the treatment system – commissioning an integrated drug and alcohol service in Lancashire

Lancashire Drug and Alcohol Action Team (LDAAT) operate across three locality areas that are coterminous with North, East and Central Lancashire PCTs. Between 2008 and 2010 LDAAT recommissioned their adult substance misuse treatment services across the county, in conjunction with local PCTs, using a 'whole system approach' to integrate drug and alcohol provision. This large-scale modernisation process had three stages, one for each locality, building on local need to develop treatment systems designed for the local population:

- Stage 1: North Lancashire – integrated community drug and alcohol treatment services
- Stage 2: East Lancashire – integrated drug and alcohol treatment services across community and criminal justice
- Stage 3: Central Lancashire – integrated drug and alcohol treatment services across the community, criminal justice and prisons.

The commissioning exercise was based on local needs assessments and engagement activities, a partnership approach, the need to commission recovery-based services that meet the needs of the local population and evidence-based treatment following NICE guidance.

The process encouraged provider partnerships, with a 'lead provider' commissioned in each area to coordinate and deliver local drug and alcohol treatment services. The aim is to provide outcome-focused and recovery-based services with a stepped care model of treatment, delivered in accessible community locations, which normalise treatment for recovery and include appropriate aftercare.

There have been several positive outcomes from the tendering exercise and the new service models, including:

- Improved coordination and delivery of treatment and a move towards focusing on recovery-based outcomes.
- Modernisation of treatment practices, with an increase in the number of patients accessing psychological support, a reduction in the use of isolated drug-based treatments and an increase in community-based detoxification.
- Provision of services across the range of need. Treatments include brief advice and extended brief interventions, one-to-one case management, access to psychological support and a choice of either community or inpatient medically assisted alcohol withdrawal.
- Training across the partnership on screening and brief interventions to widen access to treatment and make the whole system more robust.
- A more efficient, streamlined contract management process and constructive relationships between lead providers and commissioners.

- An increase in demand and activity, particularly for alcohol treatment.

Please note – this case studies is offered to share an example of practice and NICE makes no judgement on the compliance of this service with its guidance.