Public Health England

Alcohol treatment: improving services after the reforms?

Exploring the evidence for effectiveness and local innovation in alcohol treatment delivery

26 February 2014: Birmingham Event summary notes

On the 26 February 2014 the Alcohol Academy and Public Health England jointly hosted the afternoon event to explore alcohol treatment and supporting NICE alcohol guidance. This followed a similar event in Nottingham held in January 2014.The event was arranged for members of the West Midlands Alcohol Network and attended by local commissioners, service providers and other related alcohol roles. The below captures the key discussion points captured on the day.

Session 1: Alcohol treatment: evidence and effectiveness

First off, Ed Day, a former NICE advisor and Senior Clinical Lecturer in Addiction Psychiatry, opened the day with a presentation on NICE: seeking the gold standard in alcohol treatment [prezi link.].

In summary, Ed's presentation covered a rapid overview of what NICE guidance says and the key areas of considerations for provision of alcohol treatment.

Setting the scene, the 3 key NICE alcohol guidance documents; PH24, CG115 & CG100 were highlighted, which are complimented by NICE alcohol pathways and the 13 Quality Standards (QS11). These were derived using NICE's evidence criteria, though crucially although there was lots of research to review, most of it comes from the US in the 80s and 90s. In addition this research typically used non-standardised measurements and definitions.

Onto some key themes of the guidance, crucial aspects under **organisation and delivery of care** were explored. Building trusting relationships with service users was emphasised as a crucial starting point, and it is clear that the best outcomes occur when a case management happens.

The principle of **'stepped care'** was also addressed, where the minimum level of treatment necessary was offered first, but followed up by the next 'level' if no response. A newer but promising area of research at the higher intensity level was 'assertive community treatment', a mental health model being adapted for alcohol services.

With regards to **residential treatment**, the evidence is considered somewhat limited. Indeed there is no evidence to show that outcomes in inpatient settings were any better than the same interventions delivered in community settings. However full residential

approaches like therapeutic communities have not been properly evaluated. Another big issue exists with hospitals not admitting/holding people with alcohol dependence, so assertive outreach may play an important role here.

Onto aspects of **psychological and psychosocial interventions**, further emphasis on the importance of a **good relationship/alliance** between the practitioner and client. This can be considered especially so given the well known 'Dodo bird' effect, i.e. 'all shall win prizes'. Essentially all psychological interventions are found equal. However **Motivational Interviewing** (MI) and **Twelve Step Facilitation** (TSF) should be components all interventions.

Also crucial is **therapist competence.** Ensuring that therapists are delivering what providers say they are doing is essential. Proper supervision and audio/video recording of sessions to review practice may be considered crucial for this. On **principles for all interventions**, motivational interviewing, supervision and outcome monitoring were also crucial.

Onto **pharmacological treatments**, the well known traditional abstinence treatments have a strong evidence base. Acamprosate had 19 Randomised Control Trials (RCTs) with 27 RCTs for Naltrexone. Disulfiram has less strong evidence as is hard to test. With regards to treatment length for pharmacology, patients doing well may be advised to remain on medication for at least 6 months. Continuation beyond 12 months would need to be justified. Stopping medication until the patient engages with treatment may be necessary.

With regards to **research updates** since publication, new research doesn't affect existing guidance. However Nalmafene has been receiving a lot of attention recently following a UK launch last year. However the evidence is not clear as only a limited number of studies. Nalmafene is essentially very similar to Naltrexone. NICE are currently reviewing it, but one crucial note is that is must be accompanied by psychological intervention.

Next up, Don Lavoie, Public Health England gave a presentation on Clustering alcohol treatment patients & packages of care [PPT].

Don firstly outlined the **history of Payment by Results** (PbR), which the NHS first started in 2003. NHS Trusts as businesses generally didn't like block contracts, so PbR was trailed. However this early stage 'PbR' was more payment by 'activity', so actual outcome based PbR is still considered a relatively new and experimental development. However Mental Health PbR is quite advanced and alcohol PbR feeds into the model.

So onto the development of alcohol **packages of care**, in which a national approach to clustering people into needs based packages was required. Alongside this, outcome measures and a minimum data set was needed to allow local tariff setting.

The **four alcohol treatment clusters** were identified as:

1. Harmful & Mild Dependence
2. Moderate Dependence
3. Severe Dependence
4. Moderate & Severe + Complex Need

For the **pilot findings**, 4 areas and 7 agencies participated with a total cohort of 788 patients. AUDIT, SARN, SADQ and Units per day were recorded by all agencies, with SSI and HoNOS used by some agencies. However data quality was varied.

AUDIT scores for clients showed 85% (N=668) scored 20+ (indicating possible dependence) 6% (N=49) scored 40 (maximum score).

In terms of assessing the clusters, it was found that a range of assessment tools to cluster effectively was required, although AUDIT was found as a useful indicator.

Packages of care were identified as important as NICE shows we should stop looking at 'service' elements and look at whole 'packages of care':

- Assessment & engagement
- Care planning & case management
- Withdrawal management
- Addressing physical and psychiatric co-morbidity
- Psychosocial interventions
- Pharmacotherapy
- Recovery, aftercare & reintegration

Clinician assigned cluster	Mean AUDIT [SD]
Cluster 1	23 [8]
Cluster 2	27 [6]
Cluster 3	31 [7]
Cluster 4	33 [7]

These packages of care are defined in NICE CG115 guidance.

Nonetheless, some **key challenges** were presented from the packages of care approach and pilot findings. Training in the use of HoNOS / SARN was a challenge with regards to the assessment stage, and assigning packages wasn't always simple.

Providing **case management for up to a year** was also a challenge given this is not typical within services. Also challenging is the NICE recommendation of being able to "offer an intensive community programme following assisted withdrawal in which the

service user may attend a day programme lasting between 4 and 7 days per week over a 3-week period."

Challenges related to psychosocial interventions included being able to deliver **'manual based' CBT** in a consistent way or as a 12 week package. **Rates of prescribing** were also considered low at around 9%, given pharmacology could be useful in up to one third of patients.

Discussion & Q&A from the floor

Question 1: *'Motivational Interviewing and Twelve Step Facilitation etc happen, but there are 22 recommended NICE interventions many of which are not delivered. Would there be better outcomes if what was offered was the full NICE guidance?*

Ed's response [paraphrased]:

RCTs are most suited to medications not psychological therapies as addiction is so complex. So many other factors affect outcomes e.g. a new relationship in a client's life. Rudy Mooos has written a number of papers saying there are 4 components of effective treatment whether a community treatment service or *Twelve Step Facilitation*. The most effective single thing would be to improve the least effective therapist in any service.

Question 2: *What are those 4 elements Rudy Moos identifies?*

Ed's response [paraphrased]:

From memory, they are along the lines of:

- Therapist alliance and set goals and structure.
- Having an abstinence based norm
- Goals & rewarding positive behaviour
- Building Self efficacy and skills (e,g CBT).
- With this all being underpinned by social support.

Question 3: *This research on what works isn't exactly new. Why does it always feel like there is still such a chasm between academia and practice?*

Ed's response [paraphrased]:

There was a talk in states in 2006 on projects that didn't work which was very interesting – we need to learn as much from these. One of the problems is that research studies take place in 'perfect conditions' rather than the reality of the situation in real life. For example studies don't consider that a practitioner may have 60 cases to manage,

no supervision, an overwhelming burden of risk management… staff can feel like rabbits in the headlights with all the pressure.

Question 4: *Why aren't there more studies that have operated in pragmatic 'real world' conditions?*

Ed's response [paraphrased]:

Increasingly the studies do. However the US spends something like 100 times more than we do and so are more able to fund them.

Question 5: *In terms of 'Twelve Step Facilitation' (TSF) and this needing to be part of core practice and routinely offered, what about mutual aid or 'peer support' that is not 12 step or abstinence based?*

Ed's response [paraphrased]:

Yes absolutely it means promoting 'Mutual Aid' rather the TSF only. However most of the research in this area is based on TSF, so has been phrased as this. Although there are some alternatives, it still seems like SMART Recovery is struggling to get a proper foothold.

Commissioning alcohol treatment – a 'NICE' based approach

James Morris, The Alcohol Academy, gave a presentation on Local alcohol systems: Do 'NICE' based examples exist? [PPT].

James first asked what do we mean by a **NICE based system**, and whether they exist at all. If we assume that a treatment service fits as part of a service that broadly meets the 13 NICE Quality Standards, it could be argued that some are 'NICE based'.

However if a system needs to meet NICE standards and CG115 guidance to a comprehensive and thorough degree, then probably we cannot say there a NICE based systems. However, alcohol has been increasingly prioritised, and there are certainly some **examples or elements of NICE based systems**.

One example suggested was the Lambeth **'Alcohol Brief Treatment' (ABT) project in Primary Care**. This involved two practitioners providing 'brief psychosocial treatment' approaches to harmful or **mildly dependent drinkers only**. The rational for the project is that the vast majority (85%) of people with some level of alcohol dependence only have mild dependence.

Indeed the NICE CC115 costing report identifies that this type of treatment should be a key priority:

Table 2: Recommendations with a significant resource impact

High-cost recommendations	Recommendation number	Key priority?
For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks	1.3.3.1	✓
Service users who need assisted withdrawal should usually be offered a community-based programme, which	1.3.4.2	

In addition to this, the business case was based on NICE statements including:

- National proportion of people with ***mild*** alcohol dependence provided with evidence-based specialist treatment is estimated at 1.13%
- Increasing …access to psychological interventions [for harmful/mildly dependent drinkers] will decrease development of moderate or severe dependence.
- Harmful alcohol use is also associated with increased criminal activity and domestic violence and employee absenteeism. **Implementing the guidance is expected to reduce the significant costs to society**

The Lambeth ABT pilot demonstrated positive outcomes from its first year, including:

- AUDIT scores at start (25), review* (22) and end*[1] of treatment (12)
- Units per day at start (14), review (8) and end of treatment (5)
- Drinking days per month 21 at start to 10
- Overall Health Rating improvement 11 to 15
- Feedback from clients and GPs was also recorded as highly positive.

In conclusion, there is a large gap in 'brief treatment' approaches for mildly dependent drinkers. These need to be provided outside of traditional substance 'services' e.g. in Primary Care, and funded in a sustainable manner.

[1] *Outcomes recorded at review stage (average 6 weeks in) and at exit (average 4 months after start)

Also highlighted was the **Durham Community Alcohol Service** (CAS) as an example of a whole system approach to commissioning. Durham were able to significantly increase investment in alcohol services and developed a model running from IBA through to structured treatment across the County. This includes three core locality teams and a number of additional services including hospital, Older Adults, Peer Mentoring, Couples Counselling, Mutual Aid, etc.

In **summary**, James suggested that funding for alcohol services will remain scarce, so it will still be about trying to 'do more with less'. Overlooked areas such as NICE recommended interventions that are not commonly provided, such as Social Network Behaviour Therapy and better use of pharmacological interventions may be worth focusing on.

Crucially, **investing more 'upstream' to address mild dependence,** as well as highlighting other areas that are doing well or showing good practice. Support from PHE is also available.

Workshop groups

Attendees joined specific workshops to discuss and respond to several questions including a case study scenario. The scenario asked the groups to consider three key questions. Summarised verbal feedback following the task is summarised first, followed by full written notes.

Summary points from each of the four groups

1. Apart from money, what are the most valuable things/actions that can help effective commissioning/service improvement? Why?

A. Better communication, pathways – developing a systematic approach
B. Push services out geographically and add some up-streaming
C. Effective partnership strategy with buy in from all stakeholders
D. supervision, effective workforce and broad consultation with good needs assessment with NICE guidance as part of system

2. Referring to the NICE and PHE tools and resources, how can you improve treatment effectiveness and numbers in treatment in "Stanbury Vale", without any increase in your budget?

E. Get more people through the door by taking door into community and reaching out to different groups in upstream way with hubs and satellite services
F. Skills audit of providers and GPs and develop plan to address gaps and skills

G. Can have combined drugs and alcohol service without need to deliver service together. Service needs to be commissioned after needs assessment to deliver across the gambit, from IBA through to structured treatment in primary care. Voice of experience says this can be done without more money.

H. Framework around commissioning. NICE is health orientated and can turn elected members off. Range of tools needed, not just NICE, to include jobs, houses etc.

3. Which aspects of the NICE guidance/tools and PHE stocktake where most relevant or helpful in answering question 2?

I. PHE stocktake tools. Ed's presentation flow chart of pathway shows flow from primary to tertiary prevention.

J. Packages of care useful. NICE pathways, i.e. clustering for benchmark.

K. James – Referred to quality standards. PHE stocktake is useful but should be seen as an ongoing work rather than something to 'tick off' the list.

L. Stock take tool – does it really reflect the system, as it is a bit health orientated. Could be expanded by recovery and LA i.e. employment and better functioning families – could include outcomes and also "Why Invest" elements.

Full written notes from each of the four groups

Q1	Most Valuable Actions

	Iain's group:
	• Consider more "at risk" drinkers in targeted way
	• Treatment heavy model
	• No structured provision in acute/prison
	• Address revolving door
	• Not to capacity –how might this capacity be best utilised
	
	Don's group:
	• GPs are a key asset
	  ○ IBA
	  ○ DES
	  ○ Giving simple advice
	• Need to bring people together
	  ○ Conduct needs assessment
	  ○ May not know pathways – systems
	  ○ Explore the need for more satellite services
	• User insight
	• Recruit a local champion
	• **CONCLUSIONS**

	○ **Better communications** ○ **Develop pathways and 'system' of care** **Sean's group** • Supervision ○ Effective workforce – better interventions • Broad consultation ○ Get needs assessment data ○ Agree outcome framework ○ Service user consultation ○ Agree direction of travel ○ *Information most valuable ○ Mapping out MA and assets (Row/accommodation/Services/SUs ○ Maximise services via pharmacy – use NICE guidance **James' group:** • Needs assessment • Understanding the history of service provision in the area • Developing a 'whole systems approach' • A more effective 'partnership approach' with leadership and buy-in • Better promotion of services
Q2	**Improvements to 'Stanbury Vale' scenario**
	Iain's group: • Redesign • Outreach/increase access • Upstream • Assess impact of 'integrated service' • Speak to community – what type of service needed • Transport units **Don's group:** • Develop treatment pathways • Explore the need for more satellite services in health centres or other locations • Opportunities for health promotion ○ Police ○ Housing • Ensure NHS Health Check is incorporating alcohol • **CONCLUSIONS**

	○ **Training** ○ **Skills audit** **Sean's group:** • NICE = health – reframe for LA elected members > outcomes balanced score card of measures • Re-framing what the value of the exercise is • Framework – common aspiration • Change the systems • Shift investment – more upstream • Too easy to tick the boxes • NICE give inspiration – don't get too obsessed with standards • Asking service users • Recovery peers/mentors **James' group:** • Satellites or 'hubs' of provision in the community • Prison 'in-reach' from services and work with released offenders • Sufficient Alcohol Liaison Nurses • Ensuring a 'recovery orientated' system • Proper IBA & referral within Primary Care
Q3	**Guidance and resources**
	Don's group: • Skills survey • Family and carer involvement • Stepped Care approach • **CONCLUSIONS** ○ **Importance of self-audit / stocktake** ○ **Packages of care** **Sean's group** • Stocktake – medical based, discussions re adding to it? • Interactive spread sheet tool – investment/disinvestment **James' group:** • Stocktake tool useful but a continuous process not tick box exercise