Alcohol treatment: improving services after the reforms?

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

Event summary notes

On the 20 January 2014 the Alcohol Academy and Public Health England jointly hosted the afternoon event to explore alcohol treatment and supporting NICE alcohol guidance. The event was arranged for members of the East Midlands Alcohol Network and attended by approximately 36 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, Trevor McCarthy, an independent Consultant and former NICE advisor opened the day with a presentation on 'alcohol & NICE: a rapid review' [ppt.].

In summary, Trevor's presentation covered a policy perspective of both alcohol treatment guidance through NICE and the wider alcohol policy history. Firstly the new commissioning landscape was outlined and how NICE alcohol guidance came about. Trevor outlined the hierarchy of evidence used in the development of NICE guidance, followed by his views on 'what is NICE for?' – in simple terms, promoting an effective, evidence based approach to alcohol interventions.

Next came a recent history of specific alcohol policy and guidance, starting with the first national strategy in 2004. Taking us through subsequent policy and guidance, Trevor critiqued the current 2012 alcohol strategy. For example, its repeated use of the term 'drunks' to describe people with alcohol problems as counter-productive to a the population level approach seeking to motivate more people to reflect about their alcohol use.

Back onto the NICE guidance CG115 itself, the 12 key recommendations were introduced. Emphasis was placed on a key component of recommendation 5 that "Commissioners should include formal evaluation within the commissioning framework so that alcohol interventions and treatment are routinely evaluated and followed up".

Also emphasised were the NICE guidance key principles of care: building trusting and engaging relationships with clients by appropriately trained staff being key elements. The importance of identification and assessment, and ensuring alcohol services offer support to those seeking moderation rather than abstinence goals are also crucial elements. Motivational approaches should be recognised as part of initial assessment and integrated within further care coordination.

For harmful drinking & mild dependence, NICE states psychological intervention (CBT, behavioural therapies (MI / MET) or social network & environment-based therapies

SBNT) focus on alcohol-related cognitions, behaviour, problems & social networks should be offered.

Finally, a further look at the possible negative effects of politics on evidence based approaches, punctuated by punchy quotes from famous scientists and writers alike. A view on incentivisation – although the process of focussing on performance and outcomes is valid, the important concept in '*Payment by Results*' is the Results – the payment process itself may be a perilous distraction.

Next up, Tanzeel Ansari, a Consultant Psychiatrist & Richard Gray, Nurse Specialist both from Nottinghamshire Healthcare NHS Trust gave a presentation on 'Best Packages of Care: Implementing NICE guidelines' [PPT].

The presentation first outlined the context of a 'packages of care' model, derived from Payment by Results (PbR) pilots. PbR was introduced for acute sector 2003/04, subsequently developed for the Mental Health sector and piloted in 4 areas for alcohol treatment in 2011/12.

The key approach to alcohol based 'packages of care' as derived from the PbR pilots is a 'clustering' approach, the four alcohol treatment clusters as:

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

The clusters are indicated by a variety of methods including alcohol and health based assessments, mainly AUDIT, SADQ, HoNOS and SARN. Once a cluster is determined, a client will then be expected to be given a 'package of care' to potentially include (to differing extents):

- Assessment
- Care planning
- Withdrawal management
- Psychosocial interventions
- Pharmacotherapy
- Aftercare

In summary, the presenter's experience of 'packages of care' highlighted a number of benefits. The approach was easily adapted locally as part of an established treatment pathway, and allowed for services to be restructured to optimise provision. Measuring outcomes and feedback from clients were also viewed as positive aspects. Perhaps of most value was that the approach allowed for 'effective crystallisation of treatment' and as a useful agent of change.

Discussion & Q&A from the floor

Question 1: *'NICE CCG 115 states **Social Behavioural Network Therapy** (SBNT) CBT, MET etc as part of recommended psychosocial interventions... But not much SBNT seems to be provided – does NICE say much about this?*

Trevor's response [paraphrased]:

NICE looks at what evidence has been published, rather than what is being delivered. Behavioural couples therapy is also advised but very rarely delivered. The UKATT trial mainly involved people who turned up for treatment. MATCH had a lot of exclusion criteria. NICE is therefore aspirational in terms of us being able to offer all interventions recommended.

Question 2: *How can we link the two presentations? What is your view of the PbR pilots?*

Trevor's response [paraphrased]:

Crucial to commissioning is to get the outcome measurements right. Assessment is vital in the new framework – it's an intervention not an interrogation. At the moment measuring outcomes 'finish' at the end of treatment. 'Readiness to Change' is highly predicative of how people will do, which can be an indicative of what we should offer them. Packages of Care can offer an independent measurement of outcomes.

Iain Armstrong (Public Health England) responded [paraphrased]:

PbR was more payment by activity rather than outcomes for the alcohol pilots. 'Packages of care' is about moving to a needs based system, from a MoCAM tiered based system. Packages of Care will be rebranded and made available as treatment planning tools. These should be useful to help improve outcomes.

Question 3: *We have been moving away from HONOS and SARN as was extremely onerous. We didn't feel it was clear and sensitive so put clients and practitioner off. Do you still use/advocate HONOS/SARN?*

Response from the Apollos Clifton-Brown [paraphrased]:

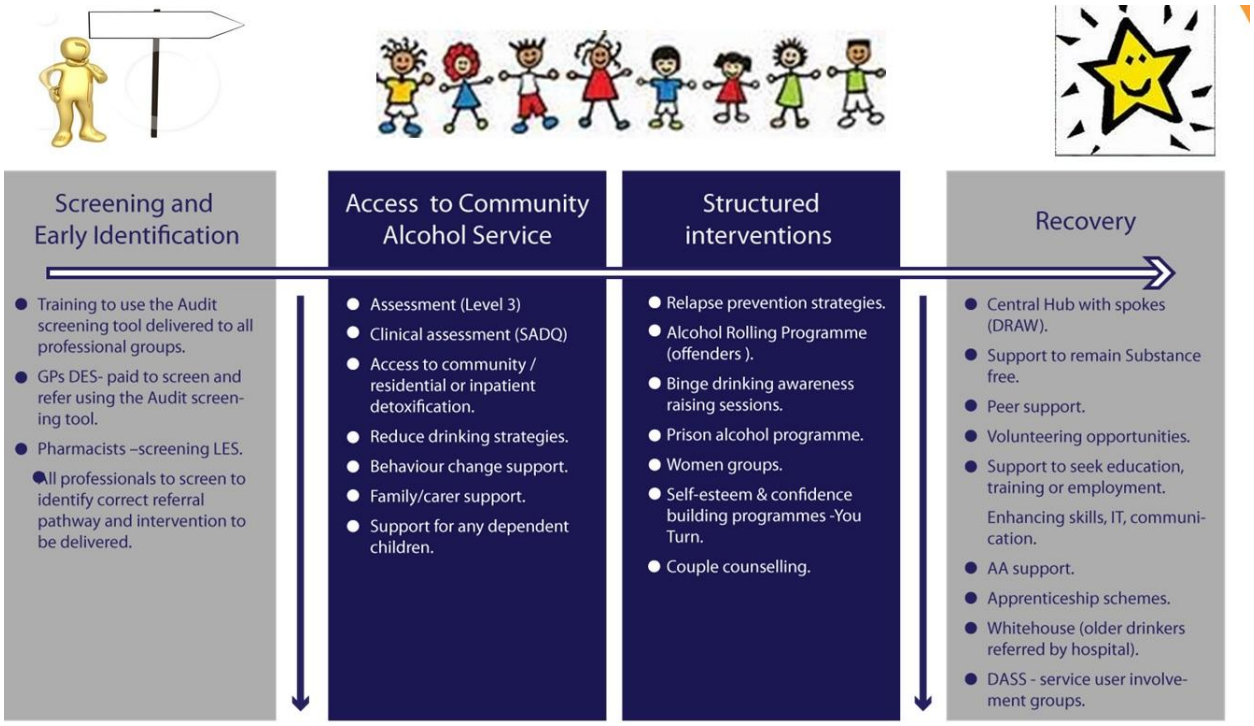
The HoNOS/SARN process can be clunky. There are quirks/anomalies. It is essentially a Mental Health tool so there isn't enough reliable about physical health issues. We use it as part of the clustering process. However we rarely have to 'override' the clustering outcomes as usually they're right, but occasionally we do.

Commissioning alcohol treatment – a 'NICE' based approach

Mandy English, Alcohol Commissioning Manager, and Anne Bell, service manager gave a presentation on Durham's Community Alcohol Services [PPT].

Mandy spoke about the alcohol service commissioning history, particularly securing funding to massively increase investment in services that could support needs across the county. The model starts with widespread screening and brief intervention (IBA), to offering a range of structured NICE recommended interventions available for dependent drinkers. Some specialised aspects of the service had been particularly successful, such as the Older Drinkers service picking up those discharged from hospital with an alcohol issue.

Anne then described the range of interventions being offered by Durham's Community Alcohol Services (CAS) as summarised below:



The organisational structure was also described, including three main geographical teams each including nurses, peer mentors, recovery workers, a social worker, a Housing Support Worker and others.

A breakdown of the services outcomes were explored before a powerful video telling a number of service user's stories was shared.

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 with responses outlined below.

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

- Education/Quality of SVC
- What have you got, how is it being developed – talking to SVCS
- Self-assessments and audits
- Pathways
- Knowing demographic – who are the service users
- Integration of resources i.e. take the worker and put them into primary care
- Why aren't people engaging? – barriers
- Data – Hospital – alcohol related admissions via A & E (to identify dependence levels)
- Hospital pharmacy detox meds
- Identify wards then ask staff why they are not referring to HALT
- Mutual Aid – talk to them – can they identify barriers?
- Areas where dependent drinkers are (probation, hostels – why aren't they referring?)
- GP's – Review/find GP with specific interests (Champions)
- Spread knowledge and good practice
- GP clinics (for Cluster 1 – mild dependent)
- Accessibility of service – waiting lists etc
- Pathways – referrals between teams
- Refreshing pathways and what is available to all staff/service users
- Consultation with Service Users – Needs?
- Identify gaps in the model – GP's, Hospitals etc.
- Review Assessment Model
- Education/Visibility
- Staff Training

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?

- Secondary Service outreaching into Primary Care
- Open Access, pathways – networking
- Recovery focus
- Segmentation through clustering

- Primary Care IBA
- If staff using MI need training and supervision
- CBT handbooks/structured sessions (consistency) (expensive for all staff to be fully CBT trained)
- External auditors for outcome measures
- Exit questionnaires
- Revolving door patients – monitor and review
- Independent Service User Group
- Robust ownership of IBA and referral
- Targeting interventions (25 – 44 eg)

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

- Expectations around commissioners/providers