

# Models of care for alcohol misusers (MoCAM)



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**DH INFORMATION READER BOX**

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# Foreword



I am pleased to be able to introduce this document to you at this time. With rapid progress towards the devolution of NHS commissioning to a local level, we need this document to guide local NHS organisations as they strive to deliver a planned and integrated local treatment system for alcohol misuse. Even though we are working hard to improve health and reduce inequalities, we recognise that more progress needs to be made towards addressing the different and complex causes of poor health and health inequalities, including harm caused by alcohol.

There is no doubt that alcohol misuse is associated with a wide range of problems, including physical health problems such as cancer and heart disease; offending behaviours, not least domestic violence; suicide and deliberate self-harm; child abuse and child neglect; mental health problems which co-exist with alcohol misuse; and social problems such as homelessness.

We know that much of this harm is preventable and that the introduction and development of comprehensive, integrated local alcohol treatment systems can have a beneficial impact on many areas of health and social care. This considerably benefits hazardous, harmful and dependent drinkers, their families and social networks, and the wider community.

Screening and brief interventions for harmful and hazardous drinkers, as well as treatment for dependent drinkers, when delivered as part of a planned and integrated local treatment system, can offer economic benefits in other NHS priority areas.

Recent studies suggest that alcohol treatment has both short and long-term economic benefits. The *Review of the effectiveness of treatment for alcohol problems*<sup>1</sup> suggests that provision of alcohol treatment to 10 per cent of the dependent drinking population within the UK would reduce public sector resource costs by between £109 million and £156 million each year, and analysis from the United Kingdom Alcohol Treatment Trial suggests that for every £1 spent on alcohol treatment, the public sector saves £5.

I recommend this guidance and I know that it will help commissioners to provide the effective and comprehensive local frameworks that will support our citizens and communities to lead healthier, happier and longer lives.

A handwritten signature in black ink, appearing to read "Liam Donaldson". The signature is written in a cursive, slightly slanted style.

**Sir Liam Donaldson**  
*Chief Medical Officer*

# Executive summary

*Models of care for alcohol misusers* (MoCAM) provides best practice guidance for local health organisations and their partners in delivering a planned and integrated local treatment system for adult alcohol misusers. It will be relevant to primary care trusts (PCTs) who will play a leading role, in partnership with other local agencies, to commission appropriate alcohol services. MoCAM is explicitly identified as a significant milestone towards achieving the second aim of the *Alcohol harm reduction strategy for England*<sup>2</sup> (2004), 'to better identify and treat alcohol misuse', and is a direct commitment in the *Choosing Health*<sup>3</sup> White Paper (2004).

Alcohol misuse is associated with a wide range of problems, including physical health problems such as cancer and heart disease; offending behaviours, not least domestic violence; suicide and deliberate self-harm; child abuse and child neglect; mental health problems which co-exist with alcohol misuse; and social problems such as homelessness.

The evidence base indicates that much of this harm is preventable. The introduction and development of comprehensive integrated local alcohol treatment systems considerably benefits hazardous, harmful and dependent drinkers, their families and social networks, and the wider community.

Recent studies suggest that alcohol treatment has both short and long-term economic benefits. The *Review of the effectiveness of treatment for alcohol problems*<sup>1</sup> suggests that provision of alcohol treatment to 10 per cent of the dependent drinking population within the UK would reduce public sector resource costs by between £109 million and £156 million each year. Furthermore, analysis from the United Kingdom Alcohol Treatment Trial suggests that for every £1 spent on alcohol treatment, the public sector saves £5.

MoCAM is informed by the document *Models of care for the treatment of adult drug misusers*<sup>4</sup> (2002), which had drug treatment as its primary focus, but was acknowledged to be of 'great relevance' for alcohol service provision.

This document will assist in:

- improving practice in the commissioning and delivery of alcohol treatment services
- developing integrated local treatment 'systems', through the tiered framework of provision
- improving the effectiveness of screening and assessment
- improving care planning in structured treatment
- developing integrated care pathways ('alcohol treatment pathways')
- meeting national quality standards by providing key quality criteria for the commissioning and provision of services for alcohol misusers
- identifying appropriate interventions and specific treatment options that could be commissioned to meet local need.

The approach described in this document is consistent with, and supported by, the Department of Health guidance *Alcohol misuse interventions: guidance on developing a local programme of improvement* (2005).<sup>5</sup> MoCAM should also be read alongside the linked National Treatment Agency for Substance Misuse guidance documents *Review of the effectiveness of treatment for alcohol problems* (2006),<sup>1</sup> and *Alcohol treatment pathways* (2006),<sup>6</sup> both of which are aimed at supporting effective interventions at a local level.

# 1 Setting the scene

## 1.1 Purpose of *Models of care for alcohol misusers*

*Models of care for alcohol misusers* (MoCAM) provides best practice guidance for commissioning and providing interventions and treatment for adults affected by alcohol misuse. It has been developed by the National Treatment Agency for Substance Misuse (NTA), with support from the Department of Health (DH). MoCAM is explicitly identified as a significant milestone towards achieving the second aim of the *Alcohol harm reduction strategy for England*,<sup>2</sup> 'to better identify and treat alcohol misuse', and is a direct commitment in the *Choosing Health*<sup>3</sup> White Paper.

The approach described in this document is consistent with, and supported by, the DH guidance *Alcohol misuse interventions: guidance on developing a local programme of improvement*.<sup>5</sup> MoCAM should also be read alongside the linked NTA guidance documents *Review of the effectiveness of treatment for alcohol problems*<sup>1</sup> and *Alcohol treatment pathways*,<sup>6</sup> both of which are aimed at supporting effective interventions at a local level.

MoCAM is informed by the document *Models of care for the treatment of adult drug misusers* (2002)<sup>4</sup> (MoCDM), which had drug treatment as its primary focus, but was acknowledged to be of 'great relevance' for alcohol service provision. MoCAM:

- builds on all the key foundations laid down in MoCDM
- develops the notion of integrated local treatment 'systems', the tiered framework of provision, effective use of screening and assessment, a central role of care planning in structured treatment and the development of integrated care pathways to enhance pathways of care ('alcohol treatment pathways')
- describes key quality criteria for the commissioning and provision of services for alcohol misusers
- describes the interventions and specific treatment options that could be commissioned for people affected by alcohol misuse
- integrates the evidence base on interventions for hazardous and harmful consumption with that for dependent drinking to suggest the use of alcohol brief interventions and a range of treatment options in a system of care.

MoCAM provides best practice guidance on commissioning alcohol services for local commissioners and therefore will also be relevant to providers of alcohol treatment.

The DH-commissioned report *The Alcohol Needs Assessment Research Project*<sup>7</sup> (ANARP) provides useful information on current needs and provision of alcohol treatment in England. Existing Public Health Observatory work on alcohol-related health will be supported by regional information from ANARP.<sup>7</sup> This can supplement other local information and may be used by primary care trusts (PCTs) to help determine local numbers of hazardous, harmful and dependent drinkers, and to identify gaps in local provision, which will be of practical value to commissioning bodies and partnerships. A web-based tool is available at [www.nwph.net/alcohol](http://www.nwph.net/alcohol) providing prevalence data and other information from the ANARP<sup>7</sup> report.

Between 2006 and 2008, DH will support the delivery of 'trailblazer' projects to explore the practical applications of screening and brief interventions in various settings. The findings of these projects will serve to inform the further development of local systems.

It is expected that MoCAM will be used by PCTs working in partnership with local commissioning groups and local service providers. The purpose will be to develop and build integrated systems to meet the needs of local people whose alcohol misuse is harmful and requires intervention or treatment, benefiting them, their families and communities. This process should be informed by service user input.

The DH guidance document *Alcohol misuse interventions: guidance on developing a local programme of improvement*<sup>5</sup> is also key to the implementation of MoCAM. The guidance is aimed at senior decision-makers and commissioners within local health organisations, local authorities and other stakeholders seeking to work with the NHS to tackle alcohol misuse. It provides guidance on developing and implementing programmes to improve the care of hazardous, harmful and dependent drinkers. It describes both the policy context and the evidence on the harm caused by alcohol misuse to individuals, families and communities, and it sets out practical steps to improve local arrangements for commissioning, monitoring and delivering alcohol interventions.

The harms caused by hazardous, harmful and dependent drinking are associated with many other problems to individuals and society, such as inequalities in life expectancy, cancer, stroke and coronary heart disease, many of which are themselves areas of high priority to local communities and commissioners of care.

Local organisations may wish to consider the contribution that alcohol treatment can make to achieve improvements in these areas, and to any related local targets. For a more detailed analysis of the wider potential benefits to be derived from effective alcohol interventions and treatment, see *Alcohol misuse interventions: guidance on developing a local programme of improvement*,<sup>5</sup> particularly Annexes A and B.

## 1.2 The basis for policy on reducing alcohol-related harm and encouraging sensible drinking

Around 90 per cent of adults consume alcohol and the majority do not experience problems. The *ONS general household survey*<sup>8</sup> identified that over three-quarters of the adult population in England are either non-drinkers (4.7 million people) or drink less than the Government's previously recommended weekly guidelines (26.3 million people).

ANARP<sup>7</sup> found that 23 per cent of the population (aged 16–64) drink hazardously or harmfully, which equates to approximately 7.1 million people in England. A further 1.1 million people in England are dependent on alcohol.

The Prime Minister's Strategy Unit's *Interim analytical report*<sup>9</sup> identified different types of harm associated with alcohol misuse and estimated the annual costs of these harms to be in excess of £15 billion.

The *Alcohol harm reduction strategy for England*<sup>2</sup> draws together a range of government interventions – to prevent, minimise and manage alcohol-related harm – into a single strategy. It sets out the Government's four aims for reducing alcohol-related harm:

- improved and better-targeted education and communication
- better identification and treatment of alcohol problems
- better co-ordination and enforcement of existing powers against crime and disorder
- encouraging the industry to continue promoting responsible drinking.

Building on the *Alcohol harm reduction strategy for England*,<sup>2</sup> the *Choosing Health* White Paper delivery plan outlined the key steps that will support the DH commitments to reduce alcohol-related harm and encourage sensible drinking set out in *Choosing Health: Making healthy choices easier*.<sup>3</sup>

### 1.3 Types of alcohol misuse and links with interventions required

There is no single concise way of categorising individuals in need of alcohol treatment. The extent to which individuals would benefit from interventions depends on a number of factors. Key factors include:

- the level of consumption
- the context in which alcohol is used
- the seriousness of the alcohol-related problems
- the severity of the dependence on alcohol.

MoCAM identifies four main categories of alcohol misusers who may benefit from some kind of intervention or treatment: hazardous drinkers; harmful drinkers; moderately dependent drinkers and severely dependent drinkers. The categorisation should be seen as a conceptual framework to assist commissioners in planning for a full range of services for a local area. Individual drinkers may move in and out of different categories over the course of a lifetime.

It is important to understand that there can be no precise mapping of categories of drinkers to the level and tier of provision required. This is because a number of other factors are taken into account in determining such decisions for each individual. However, the use of these categories enables broad mapping across levels of need and against the range of provision required for any area, and assists in conceptualising the range of provision that needs to be commissioned.

The majority of the adult population of England are either non-drinkers (12 per cent), or are low-risk drinkers who drink within the DH's sensible drinking guidelines and hence are at low risk of harmful effects (67.1 per cent). These people are not considered to be alcohol misusers, although a proportion in each group will have previously had alcohol problems and may still need some continuing support and intervention.

#### 1.3.1 Alcohol misusers

ANARP<sup>7</sup> found 32 per cent of men and 15 per cent of women (age 16–64) drink at hazardous or harmful levels (23 per cent overall), equating to approximately 7.1 million people in England.

Six per cent of men and two per cent of women (approximately 1.1 million people in England) are dependent drinkers.

Twenty-one per cent of men and nine per cent of women are binge drinkers.

### 1.3.2 Hazardous drinkers

The World Health Organization (WHO) defines hazardous use of a psychoactive substance, such as alcohol, as 'a pattern of substance use that increases the risk of harmful consequences for the user... In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user.'<sup>10</sup>

Hazardous drinkers are drinking at levels over the sensible drinking limits, either in terms of regular excessive consumption or less frequent sessions of heavy drinking. However, they have so far avoided significant alcohol-related problems. Despite this, hazardous drinkers, if identified, may benefit from brief advice about their alcohol use.

### 1.3.3 Harmful drinkers

The WHO International Classification of Diseases (ICD-10)<sup>11</sup> defines harmful use of a psychoactive substance, such as alcohol, as 'a pattern of use which is already causing damage to health. The damage may be physical or mental.' This definition does not include those with alcohol dependence.

Harmful drinkers are usually drinking at levels above those recommended for sensible drinking, typically at higher levels than most hazardous drinkers. Unlike hazardous drinkers, harmful drinkers show clear evidence of some alcohol-related harm. Many harmful drinkers may not have understood the link between their drinking and the range of problems they may be experiencing.

### 1.3.4 Identification of and intervention for hazardous and harmful drinkers

Simple and reliable instruments, such as the alcohol use disorders identification test (AUDIT) and derivatives such as the fast alcohol screening test (FAST) tool (see *Review of the effectiveness of alcohol treatment*<sup>1</sup>), can be used to identify hazardous and harmful drinkers and provide an indication of the likely extent and severity of their alcohol-related problems. As these drinkers do not have significant evidence of alcohol dependence, advice and brief interventions are often suitable to meet the needs of both these groups.

### 1.3.5 Dependent drinkers and drinkers with complex problems

Dependence is essentially characterised by behaviours previously described as 'psychological dependence', with an increased drive to use alcohol and difficulty controlling its use, despite negative consequences. More severe dependence is usually associated with physical withdrawal upon cessation, but this is not essential to the diagnosis of less severe cases.

The main groups of alcohol users who clearly may benefit from specialist alcohol treatment are those who are moderately and severely dependent. This categorisation into those with moderate and those with severe dependence is supported in the NTA *Review of the effectiveness of treatment for alcohol problems*<sup>1</sup> as a pragmatic classification. The review suggests that, for treatment planning purposes, the most useful categorisation is into 'moderate dependence' and into 'severe dependence/dependence with complex needs'. This is because the latter 'severe and complex' group is likely to require a higher level of intervention at the outset than those with moderate dependence. The actual level of intervention to be provided initially, or subsequently, in individual cases can only be determined following comprehensive assessment, but broadly this is suggested as a valuable pragmatic categorisation.

### 1.3.6 Moderately dependent drinkers

Moderately dependent drinkers may recognise that they have a problem with drinking, even if this recognition has only come about reluctantly through pressure, for example from family members or employers.

The level of dependence of drinkers in this category is not severe. For example, they may not have reached the stage of 'relief drinking' – which is drinking to relieve or avoid physical discomfort from withdrawal symptoms. This is a very broad category and includes a wide range of severities and types of problem. Nevertheless, in older terminology, drinkers in this category would probably not have been described as 'chronic alcoholics'. Moderately dependent drinkers' treatment can often be managed effectively in community settings, including medically assisted alcohol withdrawal in the community. The choice of setting in each individual circumstance will depend on the range of accompanying physical, psychological or social problems, including risks posed to the drinker and risks to others from the drinker's behaviour. Some in this category will be identified as needing interventions more typically provided to severe or complex dependent drinkers.

### 1.3.7 Severely dependent drinkers

People in this category may have serious and long-standing problems. This category includes individuals described in older terminology as 'chronic alcoholics'.

Typically, they have experienced significant alcohol withdrawal and may have formed the habit of drinking to stop withdrawal symptoms. They may have progressed to habitual significant daily alcohol use or heavy use over prolonged periods or bouts of drinking.

Given adequate risk assessment and a comprehensive and intensive care plan, medically assisted alcohol withdrawal can safely be provided to many severely dependent drinkers in the home or in community settings. However, more drinkers in this category may be in need of inpatient assisted alcohol withdrawal and residential rehabilitation. Some may have special needs, such as treatment for co-existing psychiatric problems, polydrug dependence or complicated assisted alcohol withdrawal; others may need rehabilitation and strategies to address the level of their dependence, or to address other issues, such as homelessness or social dislocation. Some may have had multiple previous episodes of treatment. Some will respond to community interventions more typically successful when provided to moderately dependent drinkers.

### **1.3.8 Drinkers with complex problems**

Those with additional and co-existing problems, including people with mental health problems, people with learning disabilities, some older people, and some with social and housing problems, may be particularly vulnerable. They may have complex needs that require more intensive or prolonged interventions, even at lower levels of alcohol use and dependence. Complex problems may also include difficulties that have significant impact on others, such as domestic abuse, whether as victim or perpetrator.

### **1.3.9 Personal characteristics and patient choice**

The personal characteristics of alcohol misusers, their social circumstances and individual preferences influence decisions about the nature, timing and place of treatment.

Patient choice is a key theme in the DH's *Standards for better health*<sup>12</sup> and it is important that individuals' preferences, guided by the professionals, are taken into account when developing their care plans. This is not merely because it is their entitlement; it is also because a treatment approach has a greater chance of a successful outcome if it has been selected and committed to by the individual.

When commissioning alcohol treatment systems, it is important to recognise the diverse requirements of a local population. Black and minority ethnic population groups may require approaches that are sensitive to cultural or religious attitudes to alcohol, or that can be provided in a range of settings including the home. Alcohol-misusing parents may be simultaneously concerned at the impact of alcohol on their children and worried they may get into trouble for being 'poor parents' – even if their parenting is adequate. Those living in rural areas may benefit from domiciliary appointments or help with transport. Alcohol-misusing

offenders may benefit from a variety of assessments, referrals or treatments in custodial or community settings, where appropriate. Whatever an individual's circumstances, a local system of alcohol intervention and treatment should seek to maximise engagement with those in need and ensure that provision is as appropriate as possible, to meet a range of diverse needs. Alcohol treatment interventions should always be designed to meet needs and reduce risk, both to the individual drinker and to others affected by their drinking, including partners, children, family and the wider community.

### 1.3.10 Co-existing health conditions or drug misuse problems

If an individual has other physical or mental health conditions or drug problems, in addition to requiring alcohol intervention or treatment, these issues can be crucial in deciding on appropriate alcohol treatment and treatment goals. For example:

- A quarter to one-third of drug misusers also misuse alcohol. The National Treatment Outcome Research Study<sup>13</sup> (NTORS) found that drug treatment services were having little or no impact on drug service users' drinking behaviour, despite half having identified alcohol problems. These individuals should be offered treatment for both drug and alcohol misuse. Drug users in treatment should have their alcohol use and treatment needs routinely and continually assessed, and it is good practice for drug users in treatment to have their alcohol problems treated in the same setting where possible. Referrals to specialist alcohol treatment, and guidance from specialist alcohol workers, should be a routine feature in the treatment and care of drug misusers. Where drug misusers are already attending a combined drug and alcohol treatment service, where external referral may not be needed, it is vital that the management of alcohol misuse is clearly identified for action as part of the service user's formal care plan. In addition, just over 40 per cent of drug misusers in drug treatment in 2004 were hepatitis C virus infection positive. Alcohol use and misuse is the single biggest contributory factor to those with hepatitis C virus infection developing fatal liver disease. These individuals and others suffering from liver disease, or other medical conditions exacerbated by alcohol, should all receive alcohol interventions or treatment.
- Pregnant women and those who are trying to become pregnant should be informed of the current advice on alcohol and its effects on conception and during pregnancy. This includes advice that if they do drink, they should not get drunk and should not consume more than one or two units once or twice per week during pregnancy. Women who are dependent on alcohol and are pregnant, or currently trying to become pregnant, should receive immediate treatment for their alcohol problems.

- Some alcohol misusers may also have co-existing mental health needs. The DH document *Dual diagnosis good practice guide*<sup>14</sup> provides guidance on effective approaches to the commissioning and provision of treatment for those with substance misuse and severe mental illness.

The importance of all aspects of physical health for people with severe mental illness is recognised in *Choosing Health*.<sup>3</sup> This states that people with poor mental health tend to experience worse physical health, but that a healthier lifestyle will help improve mental health, mood and well-being. As such, local treatment systems should work together to avoid alcohol misuse being addressed in isolation from other physical and mental health issues.

## 2 A commissioning framework to deliver alcohol treatment systems

### 2.1 Commissioning alcohol screening and brief interventions and treatment: a PCT responsibility

As part of NHS provision, commissioning alcohol interventions and treatment is the responsibility of local Primary Care Trusts (PCTs). The following section focuses on the principles of commissioning a local system for alcohol treatment and its component parts, including a four-tiered framework of provision (see 2.2 on page 19) and local systems of screening and assessment. This section outlines the processes that should ideally be followed to meet best practice in the commissioning of alcohol treatment systems.

In line with the more devolved planning and performance system for health and social care set out in *National standards, local action: Health and social care standards and planning framework 2005/06–2007/08*,<sup>15</sup> PCTs can set local targets in response to local needs and priorities without prescriptive guidance from the Department of Health (DH) or strategic health authorities (SHAs). The system does set out a framework of principles for developing local plans and target-setting, asking PCTs to ensure that their plans:

- are in line with population needs
- address local service gaps
- deliver equity
- are evidence-based
- are developed in partnership with other NHS bodies, local authorities and other partners
- offer value for money.

*Alcohol misuse interventions: guidance on developing a local programme of improvement*<sup>5</sup> suggests practical steps that PCTs can take, using the above framework to improve the identification and treatment of individuals whose drinking is potentially hazardous, is causing harm to themselves or others, or has led to dependence on alcohol.

## 2.2 MoCAM provides in-depth guidance to local organisations commissioning alcohol misuse interventions

*Models of care for the treatment of adult drug misusers (MoCDM)*<sup>4</sup> outlined the four-tiered framework of provision for commissioning drugs (and alcohol) treatment, providing a conceptual framework to aid rational and evidence-based commissioning in England. That framework has been maintained but developed in this document and made specific for the provision of alcohol interventions.

The *MoCDM (2002)*<sup>4</sup> framework enabled a better description of provision of treatment. However, the tiers were a conceptual framework and were not intended to be a rigid blueprint for provision. They have been interpreted rather rigidly at times, with some unintended consequences which need to be rectified. It is important to note that the tiers refer to the level of the *interventions* provided and do not refer to the provider organisations (for example referring to a 'Tier 3 agency' is not correct, as such an agency will often need to provide Tier 2 interventions alongside Tier 3 interventions).

In line with *MoCDM update 2006*,<sup>16</sup> Tier 1 interventions are not the generic services themselves (for example housing, social services). Rather, Tier 1 consists of a range of interventions that can be provided by generic providers, depending on their competence and partnership arrangements with specialised alcohol services. Given this change in emphasis, interventions that were previously described in *MoCDM (2002)*<sup>4</sup> as Tier 4b (for example care provided by inpatient hepatology units) are redesignated to Tier 1.

Commissioners need to ensure that all tiers of interventions are commissioned to form a local alcohol treatment system to meet local population needs. Local systems should allow for some flexibility in how interventions are provided, with the crucial factors being the pattern of local need and whether a service provider is competent to provide a particular treatment intervention.

### 2.2.1 The four tiers of interventions

The following tables suggest what should be commissioned in local alcohol treatment systems.

<b>Tier 1 interventions: alcohol-related information and advice; screening; simple brief interventions; and referral</b>	
<b>Definition</b>	Tier 1 interventions include provision of: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions.
<b>Interventions</b>	Commissioners need to ensure that a range of generic services provide as a minimum the following Tier 1 alcohol interventions: <ul style="list-style-type: none"> <li>• alcohol advice and information</li> <li>• targeted screening and assessment for those drinking in excess of DH guidelines on sensible drinking and for those who may need alcohol treatment</li> <li>• provision of simple brief interventions for hazardous and harmful drinkers</li> <li>• referral of those requiring more than simple brief interventions for specialised alcohol treatment</li> <li>• partnership or 'shared care' with specialised alcohol treatment services, e.g. to provide specific alcohol treatment interventions within the context of their generic services.</li> </ul>
<b>Settings</b>	Tier 1 interventions can be delivered by a very wide range of agencies and in a range of settings, the main focus of which is not alcohol treatment. For example: primary healthcare services; acute hospitals, e.g. A&E departments; psychiatric services; social services departments; homelessness services; antenatal clinics; general hospital wards; police settings, e.g. custody cells; probation services; the prison service; education and vocational services; and occupational health services.  Such interventions can also be provided in highly specialist non-alcohol-specific residential or inpatient services, which have service users with high levels of alcohol-related morbidity who may require care plans and support to facilitate their access to alcohol-specific provision. Examples include: specialist liver disease units, specialist psychiatric wards, forensic units, residential provision for the homeless, and domestic abuse services.
<b>Competency</b>	This is provision that depends on at least minimal skills in alcohol misuse identification, assessment and interventions. Those delivering Tier 1 provision may require the following competences from the Drugs and Alcohol National Occupational Standards (DANOS): <sup>17</sup> <ul style="list-style-type: none"> <li>• AA1 Recognise indications of substance misuse and refer individuals to specialists</li> <li>• AF1 Carry out screening and referral assessment</li> <li>• AH10 Carry out brief interventions with alcohol users</li> <li>• AB2 Support individuals who are substance misusers</li> <li>• AB5 Assess and act upon immediate risk of danger to substance misusers.</li> </ul>

**Tier 2 interventions: open access, non-care-planned, alcohol-specific interventions**

<b>Definition</b>	Tier 2 interventions include provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.
<b>Interventions</b>	<p>Tier 2 interventions include open access facilities and outreach targeting alcohol misusers, which provide:</p> <ul style="list-style-type: none"> <li>• alcohol-specific information, advice and support</li> <li>• extended brief interventions and brief treatment to reduce alcohol-related harm</li> <li>• alcohol-specific assessment and referral of those requiring more structured alcohol treatment</li> <li>• partnership or 'shared care' with staff from Tier 3 and Tier 4 provision, or joint care of individuals attending other services providing Tier 1 interventions</li> <li>• mutual aid groups, e.g. Alcoholics Anonymous</li> <li>• triage assessment, which may be provided as part of locally agreed arrangements.</li> </ul>
<b>Settings</b>	Tier 2 provision may be delivered by the following agencies, if they have the necessary competence, and in the following settings: specialist alcohol services; primary healthcare services; acute hospitals, e.g. A&E and liver units; psychiatric services; social services; domestic abuse agencies; homelessness services; antenatal clinics; probation services; the prison service; and occupational health services.
<b>Competency</b>	<p>Tier 2 interventions require competent alcohol workers who should have basic competences in line with DANOS,<sup>17</sup> including those required for Tier 1. Competency can also depend on what cluster of services is provided. Front-line staff would normally have competence in motivational approaches and brief interventions.</p> <p>Those providing interventions at Tier 2 may require the following competences from DANOS:<sup>17</sup></p> <ul style="list-style-type: none"> <li>• AB2 Support individuals who are substance users</li> <li>• AB5 Assess and act upon immediate risk of danger to substance users</li> <li>• AF2 Carry out assessment to identify and prioritise needs</li> <li>• AG1 Plan and agree service responses which meet individuals' identified needs</li> <li>• AH10 Carry out brief interventions with alcohol users.</li> </ul>

**Tier 3 interventions: community-based, structured, care-planned alcohol treatment**

<b>Definition</b>	Tier 3 interventions include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.
<b>Interventions</b>	<p>Tier 3 interventions include:</p> <ul style="list-style-type: none"> <li>• comprehensive substance misuse assessment</li> <li>• care planning and review for all those in structured treatment, often with regular keyworking sessions as standard practice</li> <li>• community care assessment and case management of alcohol misusers</li> <li>• a range of evidence-based prescribing interventions, in the context of a package of care, including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse</li> <li>• a range of structured evidence-based psychosocial therapies and support within a care plan to address alcohol misuse and to address co-existing conditions, such as depression and anxiety, when appropriate</li> <li>• structured day programmes and care-planned day care (e.g. interventions targeting specific groups)</li> <li>• liaison services, e.g. for acute medical and psychiatric health services (such as pregnancy, mental health or hepatitis services) and social care services (such as child care and housing services and other generic services as appropriate).</li> </ul>
<b>Settings</b>	<p>Tier 3 interventions are normally delivered in specialised alcohol treatment services with their own premises in the community (or sometimes on hospital sites). Other delivery may be by outreach (peripatetic work in generic services or other agencies, or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions.</p> <p>Some of the Tier 3 work is based in primary care settings (shared care schemes and GP-led prescribing services), but alcohol specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care.</p> <p>The work in community settings can be delivered by statutory, voluntary or independent services providing care-planned, structured alcohol treatment.</p>
<b>Competency</b>	<p>Tier 3 services require competent drug and alcohol specialised practitioners who should have competences in line with DANOS.<sup>17</sup> The range of competences required will depend on job specifications and remits.</p> <p>Those delivering Tier 3 interventions may require a wide range of competences from Key Area A in DANOS<sup>17</sup> and many of the competences from Area AH, depending on the type of alcohol treatment provided.</p> <p>Medical staff (usually addiction psychiatrists and GPs) will require different levels of competence, depending on their role in alcohol treatment systems and the needs of the service user, with each local system requiring a range of doctor competences (from specialist to generalist) in line with joint guidance from the Royal Colleges of General Practitioners and Psychiatrists, <i>Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers</i>,<sup>18</sup> summarised in the National Treatment Agency for Substance Misuse briefing document <i>Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers</i>.<sup>19</sup></p>

**Tier 4 interventions: alcohol specialist inpatient treatment and residential rehabilitation**

<b>Definition</b>	Tier 4 interventions include provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.
<b>Interventions</b>	<p>Tier 4 interventions include:</p> <ul style="list-style-type: none"> <li>• comprehensive substance misuse assessment, including complex cases when appropriate</li> <li>• care planning and review for all inpatient and residential structured treatment</li> <li>• a range of evidence-based prescribing interventions, in the context of a package of care, including medically assisted alcohol withdrawal (detoxification) in inpatient or residential care and prescribing interventions to reduce risk of relapse</li> <li>• a range of structured evidence-based psychosocial therapies and support to address alcohol misuse</li> <li>• provision of information, advice and training and 'shared care' to others delivering Tier 1 and Tier 2 and support for Tier 3 services as appropriate.</li> </ul>
<b>Settings</b>	<p>Specialised statutory, independent or voluntary sector inpatient facilities for medically assisted alcohol withdrawal (detoxification), stabilisation and assessment of complex cases.</p> <p>Residential rehabilitation units for alcohol misuse.</p> <p>Dedicated specialised inpatient alcohol units are ideal for inpatient alcohol assessment, medically assisted alcohol withdrawal (detoxification) and stabilisation. Inpatient provision in the context of general psychiatric wards may only be ideal for some patients with co-morbid severe mental illness, but many such patients might benefit from a dedicated addiction specialist inpatient unit.</p> <p>Those with complex alcohol and other needs requiring inpatient interventions may require hospitalisation for their other needs (e.g. pregnancy, liver problems) and this may be best provided for in the context of those hospital services (with specialised alcohol liaison support).</p>
<b>Competency</b>	<p>Inpatient and residential interventions providing medically assisted alcohol withdrawal (detoxification) and specialist assessment and stabilisation would normally require medical staff with specialist competence in substance misuse (rather than generalist GPs). The level of specialised medical staff competence required will depend on the types of service provided and the severity of the service users' problems.</p> <p>Addiction specialist competences will be needed for inpatient units for severe and complex problems. Suitably competent GPs can provide support to some units for patients with less complex needs. Staff in residential rehabilitation units that are registered care homes will need to meet relevant social care national occupational standards. Hospital-based services will also be required to meet practitioner standards for independent or NHS hospitals.</p> <p>Those delivering Tier 4 interventions may require a wide range of competences from Key Area A in DANOS,<sup>17</sup> and in particular many of the competences from Area AH 'Deliver healthcare services, depending on the alcohol treatment provided'. All staff working in all residential settings are advised to demonstrate competence against DANOS<sup>17</sup> at both manager and practitioner levels.</p>

## **2.3 Commissioning a local system of screening and assessment**

Local commissioners should work with local providers to develop local systems of screening and assessment.

Assessment is a process by which to establish the nature and extent of alcohol (and any drug) misuse, what level of need an individual may have and what interventions are required. Assessment varies in its depth and level of detail, depending on the purpose and anticipated outcome of the assessment process. *MoCDM* (2002)<sup>4</sup> identified three levels of assessment: screening, triage and comprehensive assessment. These are reiterated here and described as they apply to assessment for alcohol problems.

### **2.3.1 Screening assessment**

Screening assessment is a brief process that aims to establish: whether an individual has an alcohol problem (hazardous, harmful or dependent use); the presence of related or co-existent problems (including any drug misuse); and whether there is any immediate risk for the service user. Screening assessment may incorporate or be followed by a brief intervention. The assessment should identify those who require referral to alcohol treatment services and the urgency of the referral. Screening is likely to be carried out in generic settings.

### **2.3.2 Triage assessment**

Triage assessment usually takes place when an individual first contacts specialist alcohol treatment services. The aim of this assessment is to determine the seriousness and urgency of a service user's problems and the most appropriate type of intervention. It involves a fuller assessment of the individual's alcohol problems than is conducted at screening, as well as assessment of a service user's motivation to engage in treatment, current risk factors and the urgency of need to access treatment. Following triage assessment, a service user might be offered services within the assessing agency or onward referral to another service. A further outcome of triage assessment is that, where appropriate, work is undertaken to further engage and prepare the service user for treatment.

### **2.3.3 Initial care plan**

Following triage-level assessment, it may be good practice in some cases to produce an initial care plan for service users, particularly for clients who are identified as being at high risk, who may have complex alcohol-related problems or who are likely to be hard to engage.

The initial care plan could be used to facilitate a focus on a service user's engagement in the treatment system, to ensure their immediate needs are met, particularly if relating to a high risk, to build a therapeutic alliance and to ensure appropriate interim support if they are waiting to undergo comprehensive assessment. Such an initial care plan, if used in such cases, would be set at Tier 2 interventions level.

#### 2.3.4 Comprehensive assessment

Comprehensive assessment is targeted at problem alcohol users with more complex needs and those who may require structured alcohol treatment interventions. The assessment aims to determine the exact nature of the service user's alcohol and other substance misuse problems, and co-existing problems, including with health (mental and physical), social functioning, offending and legal problems. A full risk assessment will also be conducted. Comprehensive assessment may be conducted by one or more members of a multidisciplinary team, because different competences may be necessary to assess different areas of service user need (for example a doctor or an independent nurse prescriber for particular prescribing interventions or a psychologist to conduct specialist assessment).

Comprehensive assessment can be seen as an ongoing process rather than a single event. Comprehensive assessment will be carried out with a service user who may:

- require structured and/or intensive intervention
- have significant psychiatric and/or physical co-morbidity
- have a significant level of risk of harm to self or others
- be in contact with multiple service providers
- have a history of disengagement from alcohol treatment services
- be pregnant or have children 'at risk'.

Comprehensive assessment provides information that will contribute to the development of a care plan for a service user.

The levels of assessment reflect different levels of complexity and expertise required to carry out screening and assessment at each stage. Validated alcohol misuse screening and assessment tools are available, which may already be used by local services and can usefully be integrated into locally agreed assessment procedures across agencies, as appropriate. Agreement on common 'standards' of screening, assessment and recording, based on the three 'Models of care' levels, is important in developing an integrated system of care in any area.

It is important to recognise that differences may be appropriate in the use of specific tools and recording forms in particular services and settings and for different levels of specialism, while sustaining the advantages of commonly agreed standards of monitoring.

### 2.3.5 Risk assessment

Assessing risk is an integral element in screening, triage assessment and comprehensive assessment. It provides information that will inform the care planning process. Risk assessment should include alcohol problems, as well as reflecting broader risks to the individual, to others and to the wider society.

Risk assessment aims to identify whether the individual has, or has had at some point in the past, certain experiences or displayed certain behaviours that might lead to harm themselves or others. The main areas of risk requiring assessment include:

- risks associated with alcohol use or other substance use (such as physical damage, alcohol poisoning)
- risk of self-harm or suicide
- risk of harm to others (including risks of harm to children and other domestic violence, harm to treatment staff and risks of driving while intoxicated)
- risk of harm from others (including being a victim of domestic abuse)
- risk of self-neglect.

When risks are identified, risk management plans need to be developed and implemented to mitigate immediate risk. As with comprehensive assessment, risk assessment is a continuing process and requires integration into care planning. Issues of risk highlight the need for appropriate information-sharing protocols between services and the need for cross-agency policies and plans, and for clarity with service users about the limits of confidentiality. If a service has concerns about the needs and safety of children of alcohol misusers, local protocols should be followed. For example if there are concerns about risk of significant harms, social services would normally be involved in further assessment of risk.

Local commissioners can usefully require local providers to:

- use clear and standardised screening procedures across all relevant agencies
- use clear assessment processes and standardised procedures to ensure adequate recording of triage or comprehensive assessment information

- use agreed assessment tools or recording forms, but only as appropriate for the particular setting or degree of specialism involved
- ensure adequate sharing of appropriate information between services in an alcohol treatment system, to minimise multiple assessment without action
- develop clear criteria for referral and eligibility for entry into each point of the alcohol treatment system
- develop protocols for joint and collaborative working between alcohol specialist treatment services and other agencies, where regular shared care and concurrent work is anticipated and required
- contribute to a locally commissioned directory of alcohol interventions and treatment, which is regularly updated and disseminated widely
- provide adequate training to staff carrying out screening and assessment.

## 2.4 A stepped care model to assist commissioning

Some service users may want to achieve a reduction in alcohol consumption to within sensible limits; some may want to abstain from drinking; others may not want to change their drinking patterns. It is important that local alcohol treatment systems are commissioned to meet a range of goals and that alcohol misusers are not excluded from all types of support, interventions or treatment if they decline to change their drinking or choose to pursue a goal of continued, moderated drinking.

Local treatment systems should provide alcohol interventions and treatments that meet a range of treatment goals. Brief intervention and the range of treatments for alcohol misuse should seek to achieve a reduction in alcohol-related harm and improvements in health and social functioning. This would normally include a reduction in alcohol consumption or changes in patterns of alcohol consumption that contribute to harm, or a significant risk of harm, to the service user or risk to others, particularly partners and family members. Abstinence will be the preferred goal for many problem drinkers with moderate to severe levels of alcohol dependence, particularly for individuals whose organs have already been severely damaged through alcohol use, and perhaps for those who have previously attempted to moderate their drinking without success. Moderation, or controlled drinking, is often a more acceptable goal for problem drinkers with low to moderate levels of alcohol dependence. Moderation can also be used as a goal with problem drinkers for whom abstinence would usually be advisable, but for whom this goal is not currently acceptable. A reduction in alcohol consumption will be likely to confer benefits and may offer a stepping-stone to abstinence in the future.

Housing and hostel provision for homeless alcohol misusers may need to be considered in tandem with developing local systems for alcohol treatment and brief interventions. This provision is not normally within the direct remit of healthcare commissioners, although there is scope for them to influence housing providers through participation in local strategic partnerships. Best practice examples involve joint commissioning mechanisms, to ensure local systems meet alcohol misusers' healthcare and housing needs.

MoCAM advocates a stepped model of care. In practice there are two main components to the stepped care model for alcohol misusers which are, broadly:

- provision of brief interventions for those drinking excessively but not requiring treatment for alcohol dependence
- provision of treatment interventions for those with moderate or severe dependence and related problems.

Hazardous and harmful drinkers without complex needs are offered simple, structured advice to encourage reduced consumption of alcohol to sensible or less risky levels. If simple or minimal intervention does not succeed, they may be offered an extended brief intervention by a suitably competent practitioner. A small number may also be reassessed as actually needing treatment for alcohol dependence (where it was not initially identified) and would enter the part of the stepped care model below for those needing treatment for dependence and related problems. In other circumstances, particular needs may be identified in relation to alcohol use, for example domestic abuse, where more complex, co-ordinated interventions are indicated. Therefore, care is stepped up only as required.

Moderately and severely dependent drinkers will require more specialised treatment for their alcohol dependence. A proportion of this group will also need treatment for physical dependence. The stepped care model suggests that new entrants for such treatment should be assessed, and initially receive the least intensive or least prolonged intervention considered suitable for the level of need and complexity identified. If response to such a limited initial intervention is inadequate, a more intensive or prolonged package of care may be needed.

It is important to recognise that the stepped care model is not rigid, so those service users identified at the outset as being unlikely to respond to a less intensive intervention, including for example some moderately dependent drinkers who have additional problems or who are already known to services and have previously been treated and relapsed, may require the more intensive or prolonged intervention from the outset.

For commissioning purposes, flexibility in applying the stepped care concept is important in ensuring a range of suitable alcohol misuse provision for the service user and effective and cost-effective use of resources.

Commissioners are therefore advised that, when planning local treatment systems:

- an estimate is made of the numbers of people by type of alcohol misuser, and likely demand is calculated (the Alcohol Needs Assessment Research Project (ANARP)<sup>7</sup> web-based tool [www.nwph.net/alcohol](http://www.nwph.net/alcohol) will assist in this process)
- alcohol interventions and treatment services are commissioned on the principle that certain types of interventions or treatments are the most successful and most cost-effective with different types of alcohol misusers
- there is flexibility in application of this model, as there is no intervention that should always be applied for a particular type of alcohol misuse. Decisions on individuals will take into account a wider assessment of need, including the needs of others affected and the availability of appropriate provision.

Thus, commissioners are advised to ensure provision of:

- **targeted and opportunistic screening systems and simple brief interventions for hazardous and harmful drinkers.** These will, by definition, be routinely provided in non-alcohol-specialist settings. While most such cases will only require information, simple advice and follow-up (i.e. more minimal brief interventions), some may need more extended brief interventions to assist them in making reductions in their excessive, but non-dependent drinking. This more extensive brief intervention and follow-up may be offered in non-alcohol-specialist settings, where the staff have the requisite levels of competence. Such staff could be employed within the agency to undertake these specific duties or may be employed by specialist alcohol treatment agencies in a liaison role
- **assessment and appropriately co-ordinated care-planned treatment for moderately dependent drinkers and for severely dependent drinkers or those with complex problems associated with their alcohol use.** This may be provided within specialist substance misuse services or within non-alcohol-specialist settings by practitioners with the necessary expertise and resources for treating alcohol misusers to meet locally identified needs. Most moderately dependent drinkers will require less intensive interventions, and higher levels of co-ordination of multidisciplinary or specialist care will be required for those with more severe or complex needs.

## 2.5 Planning for multiple alcohol treatment episodes

While many hazardous drinkers are able to modify their drinking behaviour in response to brief interventions, alcohol dependence is recognised particularly to be a commonly recurring condition. Individuals may require a number of episodes of treatment before they reach their goals, which in relation to their drinking behaviour are likely to be either lower-risk drinking or abstinence. Some more 'entrenched' or recurrent alcohol misusers with severe dependence, and who may have other problems, may not reach their drinking goals or other goals in a particular episode of care. Treatment interventions may, in some cases, need to be carried out over extended periods, or individuals may benefit from multiple treatment episodes. Research indicates that there is a positive cumulative effect of a series of alcohol treatment episodes, even if this is not immediately apparent. The *Review of the effectiveness of treatment for alcohol problems*<sup>1</sup> indicates that careful assessment and strategies to optimise the success of medically assisted withdrawal treatment should routinely be adopted.

Commissioners should ensure local treatment systems are able to respond to severe and recurrent cases, ensuring that drinkers can, when appropriate, access alcohol treatment on multiple occasions, together with appropriate concurrent interventions from other services. This would include support from groups such as Alcoholics Anonymous (AA) or other available mutual support services (which may need to be commissioned to complement existing models such as AA).

## 2.6 Commissioning psychosocial and medical prescribing treatment

Structured alcohol treatment interventions, comprising a single intervention or a combination of interventions or therapies delivered in the appropriate sequence, can be effective in helping individuals with alcohol problems either abstain from drinking or achieve a return to controlled, less risky drinking and maintain this pattern of behaviour over an extended period of time. For detailed discussion of the evidence for psychosocial and prescribing treatment, please refer to the *Review of the effectiveness of treatment for alcohol problems*,<sup>1</sup> which is particularly relevant for commissioners and service providers.

### 2.6.1 Psychosocial treatments

Most treatment for alcohol dependence and alcohol-related problems includes some form of therapy to support the individual's psychological and social development.

The *Review of the effectiveness of treatment for alcohol problems*<sup>1</sup> identifies a wide range of treatments shown to be effective in research studies, including cognitive-behavioural therapy, motivational enhancement therapy, 12-step

facilitation therapy, coping and social skills training, community reinforcement approach, social behaviour and network therapy, behavioural self-control training, and cognitive-behavioural marital therapy.

In practice, the delivery of psychosocial therapies is not necessarily discrete. Different therapies often share common components and, indeed, they are all designed to help alcohol misusers change their behaviour in some way. They also often help alcohol misusers develop new skills, allowing them to handle high-risk drinking situations without relapsing in the future.

Commissioners need to ensure the availability of a range of psychosocial therapies to meet the needs of the local population, including targeted interventions for discrete groups, and services competent to respond to specific cultural and gender issues and issues of sexuality.

### **Brief interventions**

Brief interventions are effective in a variety of settings, including medical settings, such as primary care and A&E, and in generic non-specialist services. Evidence demonstrates that properly implemented brief interventions can help hazardous and harmful drinkers and some moderately dependent drinkers.

Simple brief interventions are specific brief advisory interviews, often delivered after opportunistic screening identifies alcohol as a potential problem.

Simple brief interventions are sometimes referred to as 'minimal interventions' and are usually provided by a competent practitioner in about five minutes, immediately following a screening assessment or at another 'teachable moment'. Simple advice may include:

- information about the nature and effects of alcohol and its potential for harm
- personalised feedback on risk and harm
- emphasis on the individual's personal responsibility for change
- attempts to increase the patient's confidence in being able to reduce their alcohol consumption ('self-efficacy')
- goal-setting, for example start dates and daily or weekly targets for drinking
- written self-help material for the individual to take away, containing more detailed information on consequences of excessive drinking and tips for cutting down (this can be in a variety of media, including electronic, such as the internet)

- signposting individuals to having a wider general health check, where indicated
- arrangements for follow-up monitoring.

Extended brief interventions comprise a series of structured interviews (between three and twelve) in general or non-alcohol specialist settings. Where appropriately competent and trained staff are not available, such extended brief interventions could be delivered as part of shared care or partnership working with specialist treatment providers. The evidence shows that brief interventions are only effective if delivered in accordance with the current description of best practice for that intervention and delivered by a competent practitioner.

Brief interventions should be followed up to ensure that service users have benefited from them and to identify those for whom further, perhaps more intensive or extended, interventions are required.

Elements of training, supervision and follow-up should form an integral part of commissioning these brief interventions, as part of a stepped care local alcohol treatment system.

### **Motivational enhancement therapy**

Motivational enhancement therapy is identified as the best evidenced, most effective extended brief intervention and should be regarded as an essential element in the local treatment system. Other brief forms of treatment should also be considered and commissioned, as appropriate to local need.

### **Psychosocial treatments for alcohol dependence**

A range of more intensive, structured psychosocial treatment interventions will be required for people with moderate and severe alcohol dependence, for those with recurrent alcohol problems, for those with complex needs and for those who may be particularly vulnerable. Commissioners should identify the range of treatments to be made available and ensure that arrangements are developed to deliver care-planned structured treatment to meet service users' needs. This will include the development of integrated care pathways for alcohol problems ('alcohol treatment pathways') linked with local protocols for prescribing, when required.

## 2.6.2 Prescribed medication

Pharmacological therapies are most effective when used as enhancements to psychosocial therapies as part of an integrated programme of care. The *Review of the effectiveness of treatment for alcohol problems*<sup>1</sup> identifies three classes of pharmacotherapy that are effective in the treatment of alcohol misusers:

- medications for treating patients with withdrawal symptoms during medically assisted alcohol withdrawal
- medications to promote abstinence or prevent relapse, including sensitising agents
- nutritional supplements, including vitamin supplements, as a harm reduction measure for heavy drinkers and high-dose parenteral thiamin for the prevention and treatment of individuals with Wernicke's encephalopathy.

The availability of appropriate medications will be an essential element in any comprehensive local treatment system. Prescribed medications are not a stand-alone treatment option and are only recommended as part of care-planned treatment.

### Medication for assisted withdrawal from alcohol

In appropriate circumstances, where withdrawal from alcohol is not expected to produce complications and with the availability of appropriately trained and experienced staff, some people can safely undergo withdrawal without use of prescribed medication.

Medically assisted withdrawal from alcohol using prescribed medication can often be safely carried out in the home or other community settings, such as day centres. Only a minority of people will be so vulnerable as to require inpatient hospital treatment. Local assessment and prescribing protocols should be adopted and commissioners should ensure dissemination to all medical practitioners in all settings. There is significant research evidence and consensus on the most appropriate medications to use in managing the side effects of withdrawal from alcohol and these conventions should be followed.

Typically, the medications of choice will be benzodiazepines, such as chlordiazepoxide or diazepam. In circumstances where service users have a history of seizures, alternative medication may be indicated. In every circumstance, medically assisted withdrawal from alcohol should form part of a treatment plan that includes follow-up and strategies to maintain the benefits of the treatment.

There is some evidence that multiple episodes of assisted withdrawal can be associated with increased harmful outcomes – therefore it is important that this treatment is not used as a stand-alone treatment.

### **Medication to support relapse prevention**

Sensitising medication such as Antabuse® (disulfiram), which causes an unpleasant reaction when alcohol is used, can support abstinence, but only when service users have continuing support from professionals, and from their families or social networks.

Medications have been developed which are claimed to reduce the craving for alcohol. The evidence is that such medications should only be prescribed alongside continuing psychosocial treatment and are not appropriate as stand-alone interventions.

### **Nutritional supplements**

In general, sustained heavy drinking may result in vitamin deficiency, and prescribed vitamin supplements can be considered. When a service user is at high risk of, or has a suspected or confirmed diagnosis of, Wernicke's encephalopathy – a condition associated with severe vitamin deficiency – thiamin by injection is indicated.

## **2.7 Workforce planning to develop alcohol treatment systems**

Workforce strategies to maximise and expand the expertise in alcohol interventions and treatment should complement the development of tiered frameworks of provision in local areas. Workforce strategies will focus on ensuring there are sufficient competent staff to deliver the evidence-based treatment and interventions that comprise the commissioned local alcohol treatment system. These should be developed in partnership with those responsible for developing local workforces, including:

- workforce confederations and strategic health authorities responsible for developing NHS services
- local voluntary sector employers
- criminal justice workforce planners responsible for developing community-based and local prison workforce competence
- local training and education providers
- local Learning and Skills Councils
- local or regional representatives of Sector Skills Councils.

Alcohol training and liaison posts would be helpful in promoting alcohol interventions and treatment in primary care, acute hospital, criminal justice, domestic abuse, housing, social services and other mainstream settings.

## 2.8 Integrated care pathways for alcohol misuse – ‘alcohol treatment pathways’

*Alcohol treatment pathways: guidance for developing local integrated care pathways for alcohol*<sup>6</sup> is a companion publication to MoCAM. It details the concept and purpose of developing local pathways for alcohol treatment, which is a specific commitment in the national Alcohol Harm Reduction Strategy for England. As well as pathways for access to alcohol interventions and treatment, the guidance addresses the issue of developing detailed pathways for vulnerable service users with complex needs, including alcohol problems, for example people with mental health problems, people affected by domestic violence, homeless people or drug users.

Each alcohol treatment pathway (ATP) describes the local route for a particular alcohol treatment. Commissioners will want to ensure that the service user’s experience of treatment (described as the ‘alcohol treatment journey’) is so clear that everyone involved in the process has an agreed understanding of their role and responsibilities at every stage. An individual’s journey through alcohol treatment will usually comprise more than one ATP.

An integrated care pathway (ICP) describes the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment. A system of care should be dynamic and able to respond to changing individual needs over time. It should also be able to provide access to a range of services and interventions that meet an individual’s needs in a comprehensive way. Previous consultation has shown that the majority of respondents found that the ICPs for drug users set out in *MoCDM* (2002)<sup>4</sup> had been useful to them in their work.

ICPs should be developed for drug and alcohol misusers because:

- alcohol misusers can have multiple problems that require effective co-ordination of treatment
- several specialist and generic service providers may be involved in the care of an alcohol misuser simultaneously or consecutively
- an alcohol misuser may have continuing and evolving care needs requiring referral to services providing different tiers of intervention over time

- ICPs ensure consistency and parity of approach nationally
- ICPs ensure that access to care is not based solely on individual clinical decisions or historical arrangements.

### 2.8.1 Elements of ICPs

Commissioners should ensure that each alcohol treatment intervention has an ICP, which should be agreed with and between local providers, and built into service specifications and service level agreements. Integrated care pathways should contain the following elements:

- a definition of the treatment interventions provided
- aims and objectives of the treatment interventions
- a definition of the client group served
- eligibility criteria (including priority groups)
- exclusions criteria or contraindications
- a referral pathway
- screening and assessment processes
- development of agreed treatment goals
- a description of the treatment process or phases
- co-ordination of care
- departure planning, aftercare and support
- onward referral pathways
- the range of services with which the interventions interface.

These elements are designed to provide clarity as to the type of client the alcohol treatment intervention caters for, what the client can expect treatment services to provide, and the roles and responsibilities of the service within the integrated care system and towards the individual client.

## 2.8.2 ICPs and the treatment journey

An ICP will not necessarily be the whole description of a person's treatment journey. An individual ICP will be focused on one treatment intervention in a client's care plan, within which a client may receive a further range of interventions. Therefore, it is important that the development of local ICPs takes into account the client treatment journey through care-planned treatment and represents it in a way that clients can understand and see their experience reflected.

Local ICPs should describe the structure and content of alcohol treatment interventions, but these should be adapted to local needs and alcohol treatment providers as appropriate. As well as ICPs for specific treatment types, local ICPs will also need to be developed for specific client groups, particularly excluded groups of service users who may have difficulty in gaining access to treatment because they have complex needs and because they are vulnerable.

# 3 Criteria for commissioning and provision of local treatment systems for alcohol misusers

## 3.1 Introduction

### 3.1.1 Department of Health's *Standards for better health*

*Standards for better health*<sup>12</sup> was published in July 2004. Its purpose is to provide:

- a common set of requirements applying across all healthcare organisations, to ensure that health services are provided which are both safe and of an acceptable quality
- a framework for continuous improvement in the overall quality of care that people receive. The framework ensures that the extra resources being directed to the NHS are used to help raise the level of measurable performance year on year.

There are two sets of standards:

**Core standards** must be universal and describe an acceptable level of service. Meeting the core standards is mandatory. Healthcare organisations must comply with them from the date of publication.

**Developmental standards** are designed for a world in which patient expectations are increasing. The current levels of investment in the NHS make achievements against these standards realistic. Progress is expected to be made against the developmental standards across much of the NHS as a result of *The NHS Improvement Plan: Putting people at the heart of public services*<sup>20</sup> and extra investment in the period to 2008. The Healthcare Commission will, through its criteria for review, assess progress by healthcare organisations towards achieving the developmental standards.

Both the core and developmental standards cover seven domains: safety, clinical and cost-effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, and public health.

MoCAM supports local healthcare organisations to meet core and developmental standards, including the following domains:

**Second domain: Clinical and cost-effectiveness**

Outcome: Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

C5 Healthcare organisations ensure that:

- a) they conform to National Institute of Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care
- b) clinical care and treatment are carried out under supervision and leadership
- c) clinicians continuously update skills and techniques relevant to their clinical work
- d) clinicians participate in regular clinical audit and reviews of clinical services.

Related developmental standard:

D2 Patients receive effective treatment and care which:

- a) conforms to nationally agreed best practice, particularly as defined in the National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery
- b) takes into account their individual requirements and meets their physical, cultural, spiritual and psychological needs and preferences
- c) is well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations
- d) is delivered by healthcare professionals who make clinical decisions based on evidence-based practice.

**Fifth domain: Accessible and responsive care**

Outcome: Patients receive services as promptly as possible, have choices in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

C17 The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

C18 Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

Related developmental standard:

D11 Healthcare organisations plan and deliver healthcare that:

- a) reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice
- b) maximises patient choice
- c) ensures access (including equality of access) to services through a range of providers and routes of access
- d) uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.

### **Seventh domain: Public health**

Outcome: Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

C22 Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:

- a) co-operating with each other and with local authorities and other organisations
- b) ensuring that the local director of public health's annual report informs their policies and practices
- c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships.

C23 Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action of nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

Related developmental standard:

D13 Healthcare organisations:

- a) identify and act upon significant public health problems and health inequality issues, with primary care trusts (PCTs) taking the lead role
- b) implement effective programmes to improve health and reduce health inequalities
- c) protect their populations from identified current and new hazards to health
- d) take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services.

### 3.1.2 National standards for professionals working in alcohol services

A number of recently developed standards for individuals providing interventions and treatment for alcohol misuse are of importance in ensuring that those commissioning and providing services are clear about the required knowledge and skills of staff.

The main frameworks are:

#### **NHS Knowledge and skills framework**

The NHS Knowledge and skills framework (NHS KSF) defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff.

The NHS KSF and its associated development review process lie at the heart of the career and pay progression strand of Agenda for change. They are designed to apply across the whole of the NHS for all staff groups who come under the Agenda for change agreement.

Specific professional registration criteria and qualifications or accreditation programmes exist for groups such as nurses, general practitioners and addiction psychiatrists involved in substance misuse treatment.

## **Drugs and Alcohol National Occupational Standards**

The Drugs and Alcohol National Occupational Standards (DANOS)<sup>17</sup> describe competent performance of the functions carried out in tackling alcohol and drug misuse. They give clear descriptions of the standards required and of the knowledge and understanding necessary to perform to those standards.

DANOS, together with other National Occupational Standards – such as those for mental health and learning and development – provide every worker with the blueprint they require to perform competently in their role. A new qualification framework for DANOS is being developed which will identify a range of qualifications and awards appropriate for those who are new to the field with no relevant qualifications and for those with generic professional qualifications who are new to substance misuse work. Training providers increasingly offer programmes that are linked to National Occupational Standards which will enable employers to ensure new workers can be quickly inducted and existing workers can be provided with the knowledge and skills needed to perform their roles competently.

## **Social care standards for those working in registered care homes**

The national minimum care standards for social care are of particular relevance to those providing residential rehabilitation in registered care homes. In order to meet registration criteria, staff and managers are required to have relevant qualifications or demonstrate that they are working towards them.

## **The quality criteria**

This chapter sets out the criteria for key quality requirements which represent nationally agreed best practice for the treatment of alcohol misusers. The criteria are divided into: A – criteria for commissioners; and B – criteria for providers.

### **A Quality criteria for commissioning alcohol treatment systems**

- 1 Commissioning alcohol treatment systems
- 2 Monitoring the performance of alcohol treatment systems
- 3 Commissioning and providing an alcohol treatment system to meet a diverse range of local population needs

## **B Quality criteria for providing an evidence-based alcohol treatment system**

- 1 Screening the target population and taking action with individuals who are hazardous and harmful drinkers
- 2 Assessing the needs of individuals with identified alcohol problems and others who may be affected
- 3 Care planning to meet the assessed needs of those with alcohol problems
- 4 Providing a range of structured treatment interventions to meet the needs of alcohol misusers
- 5 Helping individuals maintain the gains they have made from alcohol treatment
- 6 Managing alcohol treatment services

The criteria are based on existing agreed sector-specific criteria and quality frameworks previously commissioned by the Department of Health, specifically:

- *Quality in Alcohol and Drug Services (QuADS) – Organisational Standards for Alcohol and Drug Treatment Services*<sup>21</sup> and *Commissioning Standards – Drug and Alcohol Treatment and Care*<sup>22</sup>
- DANOS for individuals providing drug and alcohol information, screening, brief interventions and treatment, and commissioning substance misuse systems.

These quality criteria have also been aligned with the White Paper *The New NHS*<sup>23</sup> and other standards for health, social care and criminal justice provision.

The *Choosing Health Planning and Performance Toolkit for PCTs and their Partners*<sup>24</sup> commits the Department of Health to continue to work closely with the independent inspectorates to ensure that inspection systems are consistent with each other, are aligned with national priorities to improve population health, and continue reducing the burden of bureaucracy on front-line organisations. The Department of Health is looking at how National Treatment Agency and Healthcare Commission work on drug treatment can be used as a model for alcohol interventions.

# A1 Commissioning local systems of alcohol intervention and treatment

## A1.1 Aim

To ensure that a local system of alcohol misuse screening and brief intervention, assessment and treatment is commissioned to meet the needs of the local population.

## A1.2 Criteria

### **Criterion 1: Commissioning local systems of alcohol intervention and treatment**

Every PCT identifies an alcohol treatment commissioner, responsible for identifying and quantifying the needs of the local population; identifying local resources; planning the development of a local system in consultation with key stakeholders; prioritising needs within resources; commissioning required services; and monitoring effectiveness in meeting local needs.

## A1.3 Rationale

The needs of those with alcohol misuse problems call for a range of interventions and providers of care which requires the development of a treatment system based on assessment of need.

Development standard D11 states that healthcare organisations plan and deliver healthcare which:

- a) reflects the views and health needs of the population served and is based on nationally agreed evidence or best practice
- b) maximises patient choice
- c) ensures access (including equality of access) to services through a range of providers and routes
- d) uses locally agreed guidance, guidelines or protocols for admission, referral and discharge which accord with the latest national expectations on access to services.

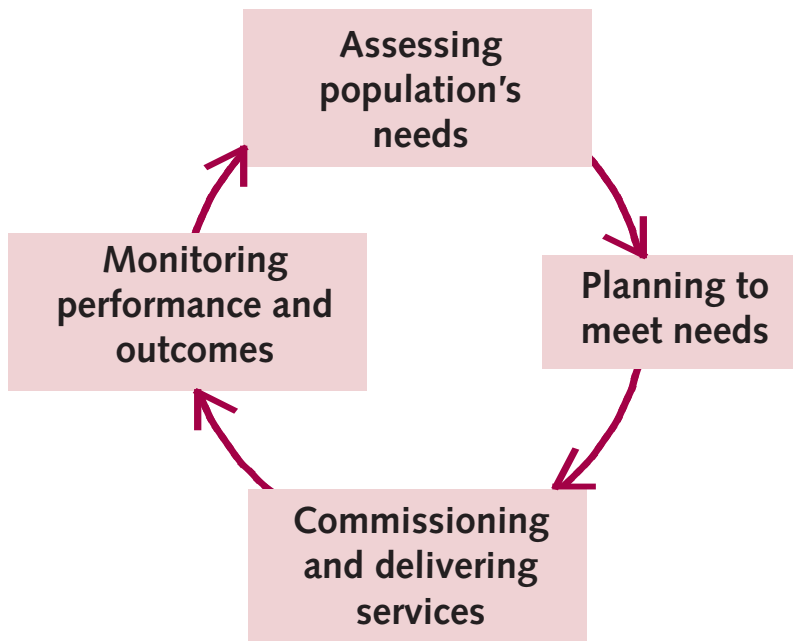
#### A1.4 Joint commissioning for alcohol and drug treatment

There may be economies of scale to be derived from commissioning, and possibly from delivering, alcohol and drug treatment services in tandem. However, the profile of most alcohol misusers may differ significantly from drug misusers and this should be reflected in the way services are designed, configured and delivered.

#### A1.5 Implementing a commissioning cycle

Local commissioners in commissioning partnerships or groups are advised to develop a rolling process of annual local needs assessment, planning, commissioning, monitoring and review, as described in Figure 1. This would involve partnership working with service providers, service users and other stakeholders including local strategic planning bodies.

Figure 1: The commissioning cycle



#### A1.6 Local alcohol treatment needs assessment

Assessing the needs of the local population in respect of alcohol interventions and treatment will involve:

- defining the geographic area
- estimating the size and composition of the population requiring treatment (with reference to the ANARP web-based tool)
- assessing current provision and spend

- describing the desired system of services
- estimating the demand for each type of service
- comparing the estimated demand with current capacity for each service and devising a means of changing the pattern of services towards the required provision
- developing alcohol integrated care pathways ('alcohol treatment pathways'). Refer to guidance accompanying *MoCAM – Alcohol treatment pathways*<sup>6</sup>
- identifying key indicators and monitoring systems to monitor provision or review progress.

### **A1.7 Components of a local system**

Local PCT commissioners should commission local alcohol treatment systems in accordance with the four tiers of interventions in MoCAM.

Commissioners should require the development of local systems of screening, triage and comprehensive assessment for alcohol misusers. Local alcohol treatment systems should develop alcohol assessment protocols, which may include adopting or integrating recognised valid alcohol dependence assessment tools, and should develop local protocols for sharing information and for joint collaborative working. The development of alcohol treatment pathways will facilitate this process.

Local areas should develop alcohol screening and brief intervention protocols, either by adopting or integrating validated screening tools, standard materials and manuals for brief intervention which exist for Tier 1 and 2 interventions into existing screening, triage or relevant associated intervention documents. The development of alcohol treatment pathways will facilitate this process.

A range of evidence-based alcohol treatment interventions, covering motivational enhancement and a range of other psychosocial therapies and pharmacological treatment, for example medically assisted withdrawal from alcohol – detoxification – will be required as part of the available Tier 3 and 4 interventions. These are described in more detail in the following sections.

The development of local pathways for integrated care ('alcohol treatment pathways') should also be required, to describe treatment pathways for types of alcohol treatment and for groups with specific needs, such as people with co-existing mental health problems, people affected by domestic abuse and pregnant alcohol-dependent women.

The process of developing a local alcohol treatment system should be seen as developmental and will require local consultation and negotiation. After consultation, when agreement has been reached, commissioners may need to develop or amend service level agreements to reflect this.

### **A1.8 Commissioning for a competent workforce**

Local commissioners are advised to develop – with local providers, employers and other strategic partners – a local workforce strategy to ensure local specialist alcohol services, general health professionals and other professionals are appropriately competent. This may require the development of skills and knowledge. DANOS will provide useful benchmarks for most staff. The Royal College of General Practitioners and the Royal College of Psychiatrists have recently produced useful benchmarks for medical practitioners in substance misuse on roles and responsibilities in delivery of care linked to training and competency requirements.

# A2 Monitoring the performance of alcohol treatment systems

## A2.1 Aim

To ensure that commissioners implement local monitoring and review protocols for alcohol treatment systems, so that resources are expended to maximise cost-effectiveness and have a positive impact on individuals with alcohol problems.

## A2.2 Criteria

### Criterion 2: Monitoring and review of alcohol treatment services

Local commissioners agree the local monitoring of services, including service user data and key indicators. Monitoring data is used to inform regular service reviews, including annual contract reviews.

## A2.3 Rationale

Monitoring alcohol treatment activity against planned activity and reviewing the initial impact of treatment provided is essential in order to:

- ensure that alcohol treatment services are meeting service level agreements on volume and quality indicators
- assist in understanding which provisions are most effective with which target groups and therefore be in a position to make incremental improvements to treatment and the targeting of treatment
- assist in understanding the relationships between the resources and treatment outcomes, to inform decisions regarding the future allocation of resources and development of the treatment system.

## A2.4 Monitoring performance

The World Health Organization defines monitoring as 'the following up of activities to ensure that they are proceeding according to plan'. Monitoring should be carried out against an agreed plan, complete with objectives, schedule and budget, and cover:

**Inputs** – what resources (funding, workforce numbers and levels of competence, buildings, equipment, medication and other consumables) have been used in the treatment and are these within budget? This information is needed when calculating unit costs of different types of treatment.

**Outputs** – what activities have been carried out as part of the treatment programme and are these according to the schedule?

**Outcomes** – what were the results, or measurable changes, that can be attributed directly or indirectly to the treatment programme and are these in line with the programme's objectives and individual treatment goals? Monitoring of outcomes allows commissioners to evaluate the impact of the programme.

### A2.5 Service user outcomes

The overall outcome sought from alcohol treatment is reduction in alcohol-related harm (to the individual, to others directly affected by their behaviour and to the wider community) and an improvement in the health and social functioning of the alcohol misuser. However, these goals are usually measured through progress towards measurable outcomes in the following domains:

- **reduction of alcohol consumption** – this may be an abstinence goal or a moderation goal
- **reduction in alcohol dependence**
- **amelioration of alcohol-related health problems** – such as liver disease, malnutrition or psychological problems
- **amelioration of alcohol-related social problems** – such as family and interpersonal relationships, ability to perform effectively at work, avoidance of criminal activity
- **general improvement in health and social functioning.**

Measurable goals can be agreed and progress towards those goals monitored and the benefits to the individual evaluated. The benefits to the health system from the individual's reduced usage of healthcare services can also be evaluated and the cost savings calculated.

Because alcohol dependence is a highly relapsing condition, it may be beneficial to maintain routine monitoring of the completion of initial treatment through a continuing care programme, with checks on the maintenance of initial gains at three, six and twelve months. Follow-up monitoring work should be commissioned as an integral element of routine treatment. For service users whose drinking problems have resumed, follow-up contact could offer an early return to intervention and treatment, thus minimising harm.

## **A2.6 Minimum data sets**

There are time and financial costs involved in data recording, analysis and reporting. These can be kept to a minimum by ensuring that the data collected is essential, to ensure resources are used cost-effectively and to inform decisions regarding resource allocation and possible improvements in treatment. Local minimum data sets should incorporate any national minimum data set for reporting requirements.

# A3 Commissioning and providing an alcohol treatment system to meet a diverse range of local needs

## A3.1 Aim

To ensure all individuals with alcohol-related problems have equal access to relevant alcohol interventions.

## A3.2 Criteria

### Criterion 3: Equal access to relevant alcohol assessment and treatment

Individuals with alcohol problems are able to access suitable assessment and treatment services locally, regardless of their geographical location, occupation, disability, family status, gender, sexuality, ethnicity, language, ability, age or legal status.

## A3.3 Rationale

Core standard C18 in the Department of Health's *Standards for better health*<sup>12</sup> requires that 'healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably'. This standard relates directly to NHS core standard C18 and other national frameworks concerning race equality (Race Relations (Amendment) Act 2000), gender identity, disability, etc.

Assessment, interventions and treatment for alcohol problems should be available to all those who need them. Commissioners and providers should consider whole population needs when establishing local alcohol treatment systems, including groups traditionally marginalised from mainstream health and other services. Specific, targeted interventions may be required for locally under-represented or hard-to-reach groups. Similarly, provider service level agreements should specify how a diverse range of needs are to be met in providing services that are relevant and appropriate for local needs, for example alcohol competence in relation to local population groups.

In commissioning an alcohol treatment system, particular consideration should be given to locally identified groups, such as individuals from black or minority ethnic groups; individuals with physical disabilities; homeless people and rough sleepers; offenders; older people; gay, lesbian, bisexual or transgender individuals; women; people affected by domestic abuse; individuals in rural communities; individuals with children; and individuals with work commitments. The development of local alcohol treatment pathways should facilitate this process.

### **A3.4 Monitoring**

Commissioners and providers should ensure that uptake of intervention and treatment services is routinely monitored, to ensure that no group suffers under-representation or poorer treatment outcomes due to services not being relevant or appropriate. If under-representation or poorer outcomes do occur, corrective action should be taken.

# B1 Screening the target population and taking action with individuals who are hazardous and harmful drinkers

## B1.1 Aim

To provide targeted screening and brief interventions for hazardous and harmful drinkers to encourage them to reduce consumption, reduce alcohol-related harm and refer dependent drinkers for structured treatment, as appropriate.

## B1.2 Criteria

### Criterion 4: Targeted screening

Hazardous and harmful drinkers are identified through targeted screening.

### Criterion 5: Brief advice and support

Identified hazardous and harmful drinkers are offered information and brief advice and intervention.

### Criterion 6: Referral to specialist alcohol services

Dependent drinkers are referred for comprehensive assessment and care-planned alcohol treatment.

## B1.3 Targeted screening

Screening for individuals who drink in excess of the recommended guidelines, combined with brief interventions for hazardous drinkers and harmful drinkers, can be cost-effective in reducing alcohol-related harm to the individuals and others they are in contact with. It can also be effective in limiting the demand for more intensive interventions in the future.

Screening also identifies those who have definite alcohol-related problems and moderate to severe alcohol dependence, so that they can be referred for specialist alcohol treatment as appropriate.

The *Alcohol harm reduction strategy for England*<sup>2</sup> recommends targeted screening rather than universal screening. With targeted screening, only those who present with symptoms and conditions that may be linked to problematic drinking are screened or those joining a new primary care practice. A number of psychological and physical symptoms and signs may suggest excessive drinking.

Screening may be carried out with the support of a simple assessment tool. Such tools include:

- the alcohol use disorders identification test (AUDIT)
- the FAST screening tool (validated in both primary healthcare and A&E settings)
- the Paddington alcohol test (effective in identifying hazardous and harmful drinkers in busy A&E departments)
- the T-ACE and TWEAK screening instruments (effective in detecting alcohol misuse among pregnant women).

These tools are described in detail in the *Review of the effectiveness of treatment for alcohol problems*.<sup>1</sup>

**Simple brief interventions** (sometimes referred to as 'minimal intervention') are usually provided by a competent practitioner in about five minutes, immediately following a screening assessment or in another 'teachable moment'. Simple advice may include:

- information about the nature and effects of alcohol and its potential for harm
- personalised feedback on risk and harm
- emphasis on the individual's personal responsibility for change
- attempts to increase the patient's confidence in being able to reduce their alcohol consumption ('self-efficacy')
- goal-setting (for example, start dates and daily or weekly targets for drinking)
- written self-help material for the individual to take away, containing more detailed information on consequences of excessive drinking and tips for cutting down (this can be in a variety of media, including electronic, such as the internet)
- signposting individuals to having a wider general health check, where indicated
- arrangements for follow-up monitoring.

**Extended brief interventions** typically take 20–30 minutes to deliver and can involve a small number of repeat sessions (between 3 and 12).

Where moderately or severely dependent drinkers and those with identified alcohol-related problems in need of more intensive care-planned treatment are identified, this group should be referred directly to specialist alcohol provision.

Commissioners and PCTs should ensure the following are in place to develop local targeted screening and brief intervention and support networks:

- simple, practical screening tools
- materials providing information and advice about the sensible use of alcohol
- arrangements for referring moderately and severely dependent drinkers to specialists
- training in the provision of screening and brief interventions with alcohol misusers.

# B2 Assessing the needs of individuals with identified alcohol problems

## B2.1 Aim

To ensure treatment decisions for individuals with alcohol-related problems are based on reliable and cost-effective assessments of their needs, within locally agreed protocols for screening and assessment.

## B2.2 Criteria

### **Criterion 7: System of Assessment for alcohol misusers at appropriate levels**

Local areas establish a system of three levels of assessment comprising screening, triage assessment and comprehensive assessment.

### **Criterion 8: Comprehensive assessment for alcohol misusers to inform care planning**

Individuals with identified alcohol problems are comprehensively assessed in sufficient detail to identify the most appropriate treatment and inform an individualised care plan to meet their needs.

## B2.3 Rationale

*MoCDM* (2002)<sup>4</sup> outlined a three-tier system of screening and assessment for implementation in each local area, depending on local configuration of services. Initial consultation with alcohol treatment stakeholders has found widespread support for this model (2004).

The three levels of assessment recommended are:

- Level 1: screening (with brief interventions) and referral
- Level 2: alcohol misuse triage assessment
- Level 3: comprehensive alcohol or substance misuse assessment.

Level 1 screening is covered in Section B1 (see page 53). In *MoCAM* it covers targeted screening and brief interventions for hazardous and harmful drinkers, as well as onward referral. Section B2 focuses on:

- the need for a local systems approach to screening, assessment and referral
- Level 2 triage and Level 3 comprehensive assessment.

## B2.4 Local systems of screening and assessment

In each area, commissioners and providers are recommended to develop local systems, which cover the three levels of screening and assessment. The levels of assessment reflect the different levels of complexity and expertise required to carry out the assessment at each stage. In this system, a broad base of personnel – who can carry out less complex screening and screening for alcohol – is required, allowing more opportunities for preventative brief interventions, more points of access to the specialist alcohol treatment system and less delay in treatment entry.

Assessment is an intervention in its own right, which can help to change the individual's perception of their problem, their expectations of help and their commitment to treatment, and can prompt a reduction in alcohol consumption. There is evidence to suggest that excessive drinkers will reduce their drinking to sensible or less risky levels following a short assessment of their alcohol consumption and related problems.

The levels of screening and assessment should map onto the four tiers (see Section 2.2.1 on page 20) in that:

- Level 1 screening and referral (and simple brief intervention) is essentially a Tier 1 provision, although it may also be a Tier 2 provision if the brief intervention is extended
- Level 2 triage assessment is essentially a Tier 2 provision and is, in essence, a filtering process to establish what type of alcohol treatment is likely to be required, to assess the level of risk and to refer to the most appropriate specialist alcohol treatment provider
- Level 3 comprehensive assessment is essentially a Tier 3 and Tier 4 provision, though may be undertaken by some practitioners providing mainly Tier 2 interventions if they are trained and competent in comprehensive alcohol assessments. This level of assessment covers various domains, may need to be multidisciplinary and should inform the development of the care plan. There is a basic alcohol-specialist level of knowledge and skills needed to complete a Level 3 comprehensive assessment. More specialised practitioners will, in addition, carry out further and more specialised alcohol assessment (for example psychometric or psychiatric assessments) as part of their comprehensive assessment of such service users when appropriate.

However, the effectiveness of such a system depends on standardisation of approach. Specifically, commissioners should ensure the following elements are present in each locality:

- clear and standardised screening and assessment procedures and processes used across all agencies
- clear criteria for referral and eligibility for entry to each part of the alcohol treatment system
- clear local alcohol treatment pathways
- a local directory of services for alcohol misusers
- clear criteria for priority treatment entry and accelerated access
- adequate training of personnel carrying out screening and assessment at each level
- protocols for sharing appropriate information between agencies in the alcohol treatment system
- monitoring, auditing and reviewing of the screening and assessment system.

Different levels of assessment require different levels of competence in assessors. Commissioners and providers should ensure that local training in screening, triage and comprehensive assessment is available, following the development of locally agreed processes, criteria, information-sharing protocols and monitoring.

The system should minimise the potential burden of multiple assessments of an individual service user. Sharing relevant information between agencies following assessment should be encouraged, to avoid repeated assessment of service users without action and to manage risk to the service user and others. Commissioners should encourage locally agreed policies across different agencies on information sharing, including informed service user consent. Information-sharing protocols should be sensitive to service user confidentiality, while facilitating referral to treatment options required by the service user.

Assessment and care planning needs to be an inclusive process, in which service users and assessors work in partnership to identify needs and plan care appropriately. The assessment should achieve sufficient agreement between service user and assessor on the needs to be addressed by treatment and the most appropriate course of action. Without a sufficient level of consensus, future referral and effective engagement in treatment may be compromised, or at worst may fail. Similarly, issues of diversity and the development of services sensitive to

a range of service user needs are crucial – these are essential ingredients of effective treatment systems. Evidence from other areas of healthcare – in particular mental health – shows a need for assessment procedures and tools that take into account the cultural diversity of local populations.

### **B2.5 Triage assessment**

Triage assessment should identify the seriousness of alcohol-related problems, the urgency with which they require treatment, any immediate risk of harm to service users or key people with whom they are in contact, and should refer the individual to the most appropriate local alcohol treatment provider.

Triage assessment usually covers:

- alcohol consumption
- alcohol dependence
- alcohol-related problems
- co-existing health conditions, including co-existing drug and/or mental health problems
- risk of harm to self and others
- urgency for treatment
- motivation and readiness to change
- socio-demographic data.

For further information on screening and assessment tools, refer to the *Review of the effectiveness of treatment for alcohol problems*.<sup>1</sup>

### **B2.6 Comprehensive assessment**

The purpose of comprehensive substance misuse assessment is to determine the precise nature of the alcohol problems, including co-existing health conditions or social problems, to enable an individualised care plan to be prepared. This process may also begin the building of a helping alliance between the therapist or service and the individual service user.

The comprehensive substance misuse assessment provides full data to inform the development of an individualised care plan. It will normally involve assessment of a range of domains, including:

- alcohol consumption, dependence and alcohol-related problems
- co-existing health conditions, including co-existing drug and mental health problems
- cognitive functioning
- risk of harm to self and others
- urgency for treatment
- motivation and readiness to change
- socio-demographic data
- family relationships and social network functioning.

There are many validated assessment tools for alcohol dependence and assessments. It may be helpful for local area providers to use the same assessment tool or, as a minimum, to agree common elements of local assessment tools. It is important to recognise the roles and competence of different professionals in multidisciplinary assessments. Particular aspects of assessment may be the specific remits of certain groups, for example: doctors and independent nurse prescribers, in the prescribing of medication; detailed psychometric assessments by psychologists; psychiatric assessment by addiction psychiatrists; and occupational therapy assessments.

### **B2.7 Impact of alcohol misuse on significant others**

Alcohol misuse and withdrawal can have a wide range of negative impacts on those close to the problem drinker. These include a greater propensity for involvement in domestic abuse (as perpetrator or victim), domestic and road traffic accidents, negative impact on partners and on parenting capacity, lack of funds to pay for essentials such as food, housing, heating and clothing, and damage to unborn children of pregnant drinkers. In extreme cases, it may lead to hospitalisation, imprisonment or death of the problem drinker and potentially to serious harm to those associated with them. Assessment processes should be sensitive enough to cover key areas of risk and impact on others, particularly children.

A large proportion of alcohol misusers have responsibility for the care of children. Alcohol (or other substance) misuse does not necessarily lead to problems or poor parenting, neglect or abuse of children. However, it is important to consider the impact of parental alcohol misuse on the welfare of children in their care. If a professional has concerns about the welfare or safety of the children of alcohol misusers, from assessment or indeed at any point during treatment, they should follow local joint working arrangements as agreed by the local safeguarding children boards (formerly area child protection committees). This would normally mean involving social services. Some local areas have now developed specific policies for working with drug and alcohol misusers, agreed by the boards.

Partners, carers and others affected by someone else's drinking behaviour should receive the protection and support of the police, social services and a wide range of voluntary agencies and mutual support groups. Alcohol treatment services also have a role to play in the provision of services to those affected by someone else's drinking, both in identification of risk and problems and initiating appropriate action and referral, and in providing services, whether directly or in partnership.

# B3 Care planning to meet the assessed needs of individuals with alcohol problems

## B3.1 Aim

Following comprehensive assessment, structured alcohol treatment is delivered in the context of a care plan with clear and agreed goals and review processes. The accepted core principles and key elements of practice in care planning for substance misuse treatment are described in the *Care planning practice guidance*.<sup>25</sup>

## B3.2 Criteria

### Criterion 9: Individualised care planning

Following assessment, individuals with alcohol dependence have an individualised care plan, which is agreed with the service user.

The care plan states the treatment goals, the treatment interventions and services to be provided, and the responsibilities of professionals, the individuals, their carers and others in the co-ordination and delivery of treatment in the care plan.

The care plan is effectively co-ordinated and reviewed on a regular basis with the service user and other relevant professionals by the keyworker who is the dedicated and named practitioner responsible for ensuring the client's care plan is delivered and reviewed.

'Keyworking' is a process undertaken by the keyworker to ensure the delivery and ongoing review of the care plan. This would normally involve regular meetings between the keyworker and the client where progress against the care plan would be discussed and goals revised, as appropriate. The keyworker should have a therapeutic relationship with the client and would normally be a member of the multidisciplinary team responsible for delivering most of the client's care and usually, but not necessarily, the main therapist.

## B3.3 Rationale

Those with alcohol problems may have a number of needs and treatment goals involving more than one individual or agency to assist achievement of these goals. They may have multiple needs in a variety of domains, including alcohol dependence, co-existing physical health needs, co-existing mental health needs, drug misuse, issues relating to social functioning, housing, education, training and employment, and risk of harm to self and others.

Identifying such needs and goals in dependent drinkers requires a comprehensive alcohol misuse assessment and the development of an individualised care plan. This should be agreed with the service user and should have clear treatment goals. It may also need to identify different professionals who may need to be involved to meet multiple needs, and to be shared with a range of services to meet the individual's needs in a coherent way.

### **B3.4 Care planning**

Commissioners should ensure that structured alcohol treatment employs a care-planned approach. The assessment of the alcohol misuser should result in a written care plan. A care plan is a structured, often multidisciplinary, task-oriented individual treatment plan, which details the essential steps in the care of an alcohol misuser and describes the alcohol misuser's expected treatment and care course. The care plan involves the translation of the needs, strengths and risks identified by the assessment into a service response. A care plan is a tool to monitor any changes in the situation of the alcohol and drug misuser and to keep other relevant professionals aware of these changes. It is ideally a paper document that is available to the client and service providers. A care plan should be brief and readily understood by all parties involved and should be a shared exercise between the client and service. It should document and enable routine review of client needs, subsequent goals and progress across the key domains of comprehensive assessment.

The care plan should:

- set the goals of treatment and milestones to be achieved (taking into account the views and treatment goals of the alcohol and drug misuser and developed with their active participation)
- indicate the interventions planned and the agencies and professionals responsible for carrying out the interventions
- make explicit reference to risk management and identify the risk management plan and contingency plans
- identify information sharing (what information will be given to other professionals and agencies and under what circumstances)
- identify the engagement plan to be adopted with alcohol misusers who are difficult to engage in the treatment system
- identify the review date (the date of the next review meeting is set and recorded at each meeting)

- reflect the cultural and ethnic background of the drug and alcohol misuser, as well as their gender, sexuality and preferences in terms of service delivery
- make clear who is the named keyworker who has agreed to be responsible for drawing up the care plan with the service user, involving any others as appropriate, and who will monitor the care plan and ensure its review.

Service users with multiple needs may receive care from a range of providers of care. This will require the keyworker to co-ordinate elements of the care plan to ensure that the service user receives appropriate interventions and that providers work together effectively.

A care plan should be reviewed and evaluated at regular intervals and at the request of a member of the care team, the service user or their carer. The date of the next review meeting is set and recorded at each meeting. In reviewing the care plan, the following is assessed:

- the relevance of the care plan
- the effectiveness of care plans and outcomes
- any unmet needs
- the service user's satisfaction with the care.

Over time, the care planning process should also reflect the expected service user treatment journey. It should have a clear beginning to treatment, which maximises initial retention and service user motivation. The subsequent stage of treatment is where the bulk of the therapeutic work is undertaken and, when appropriate, there should be a clear exit strategy from treatment which may include the development of post-treatment support mechanisms, open access, therapeutic support, housing and education or employment opportunities. A small number of service users may require ongoing care.

Many problem drinkers will relapse and require more than one cycle of interventions before they achieve their goal (abstinence, harm-free drinking and associated improvements in health and well-being). However, each relapse offers the problem drinker a potential learning experience that may improve the chance of a successful outcome in future. Successful treatment interventions may not eliminate all future risk and harm, but may ameliorate them to a level acceptable to the service user and others affected by their behaviour.

Responsibility for co-ordination of the individual's care plan should clearly rest with one person, the keyworker, who would normally be the person responsible for the

delivery of the bulk of the alcohol treatment – the service user's main therapist. In this instance, care planning and effective co-ordination of care will involve liaison with professionals involved with the service user, to check that interventions and treatments are delivered in accordance with the care plan. This will usually involve having review meetings of progress with the service user, and others as appropriate, towards the goals in the care plan, and making amendments to the care plan where necessary. This role also may involve keeping relevant parties informed of change or progress in the care plan and of any changes in roles and responsibilities, in accordance with agreed information-sharing protocols.

#### *Care planning in groups with externally co-ordinated care*

Some groups of individuals require particular co-ordination of care with other agencies. For individuals with severe mental health problems, the lead organisation in co-ordinating their care will be the relevant mental health services (see *Dual diagnosis good practice guide*<sup>14</sup>). Care will be co-ordinated under the care programme approach (CPA) by a named mental healthcare co-ordinator. Service users receiving community care funding, for example to pay for residential rehabilitation treatment, will typically have a community care manager responsible for their treatment. In these, and other similar instances, the structured alcohol treatment providers will liaise and work collaboratively with the other agencies involved. The development of detailed local alcohol treatment pathways will facilitate this process.

# B4 Providing a range of structured treatment interventions to meet the needs of alcohol misusers

## B4.1 Aim

Provide a range of structured community-based and inpatient alcohol treatment interventions, to meet a range of needs of individuals with alcohol problems.

## B4.2 Criteria

### Criterion 10: Care-planned treatment for alcohol misusers

Local alcohol treatment systems should provide a range of community-based and inpatient structured alcohol treatment interventions, to meet a range of local needs.

## B4.3 Rationale

Structured alcohol treatment interventions, comprising a single intervention or a combination of interventions or therapies delivered in the appropriate sequence, can be effective in helping individuals with alcohol problems either abstain from drinking or achieve a return to controlled, less risky drinking and maintain this pattern of behaviour over an extended period.

Section 2 outlined the range of structured alcohol treatment interventions that should be commissioned and provided for residents of each local area. These should be provided by those with competence in provision of specialist alcohol treatment and commissioned at Tier 3 and Tier 4.

## B4.4 Key factors influencing successful alcohol treatment

Many alcohol therapies have been shown to be effective in treating dependent drinkers. Among effective therapies, no single therapy stands out as being more effective in all circumstances than others.

Key components in effective treatment appear to be:

- a supportive and empathetic therapeutic relationship (helping alliance)
- the expertise of the therapist
- the level of motivation (readiness for change) of the alcohol misuser

- the cognitive ability of the alcohol misuser
- the presence of a social network that is supportive of the chosen drinking goal.

However, any effective care plan for an alcohol misuser is likely to contain a number of the components described below.

#### **B4.5 Therapeutic relationship**

The quality of the relationship between the alcohol misuser and the professional working with them is one of the most powerful determinants of successful outcomes of alcohol treatment, accounting for up to 40 per cent of the outcome variances in randomised controlled trials. The most effective therapists are characterised as:

- empathetic
- supportive
- goal-directed
- helping and understanding
- encouraging service user autonomy
- effective at helping service users access external resources.

A confrontational approach has been found to be far less effective than a supportive one. Ensuring competence of staff in alcohol treatment provision is key to providing effective alcohol treatment.

#### **B4.6 Psychosocial therapies**

Most treatment for alcohol dependence and alcohol-related problems includes some form of therapy to support the individual's psychological and social development.

As well as brief support for behaviour change discussed in Section 2, the *Review of the effectiveness of treatment for alcohol problems*<sup>1)</sup> identifies a wide range of treatments shown to be effective in research studies, including cognitive-behavioural therapy, motivational enhancement therapy, 12-step facilitation therapy, coping and social skills training, a community reinforcement approach, social behaviour and network therapy, behavioural self-control training, and cognitive-behavioural marital therapy.

In practice, the delivery of psychosocial therapies is not necessarily discrete. Different therapies often share common components and, indeed, they are all designed to help alcohol misusers change their behaviour in some way. They also often help alcohol misusers develop new skills, allowing them to handle high-risk drinking situations without relapsing in the future.

Commissioners need to ensure the availability of a range of psychosocial therapies to meet the needs of the local population, including targeted interventions for discrete groups, and services competent to respond to specific cultural and gender issues and issues of sexuality.

#### **B4.7 Pharmacological therapies**

Pharmacological therapies are most effective when used as enhancements to psychosocial therapies as part of an integrated programme of care. The *Review of the effectiveness of treatment for alcohol problems*<sup>1</sup> identifies three classes of pharmacotherapy that are effective in the treatment of alcohol misusers:

- medications for treating patients with withdrawal symptoms during medically assisted alcohol withdrawal
- medications to promote abstinence or prevent relapse, including sensitising agents
- nutritional supplements, including vitamin supplements as a harm reduction measure for heavy drinkers and high-dose parenteral thiamin for the treatment of individuals with Wernicke's encephalopathy and its prevention.

Psychosocial approaches may be delivered through individual counselling, group work or within the context of structured residential or outpatient programmes. Psychosocial and pharmacological therapies should be delivered in the context of structured care-planned treatment, and commissioners will determine the range of appropriate settings to meet local needs in consultation with service providers.

Staff competence is a key factor in the successful delivery of alcohol treatment, together with continuing supervision and professional development.

Whatever delivery mechanism and settings are chosen to meet local needs, local commissioners and providers should ensure evidence-based practice is underpinned by good clinical governance and audit mechanisms (or equivalent).

## B4.8 Delivering a range of alcohol treatments in a care-planned approach

Each alcohol misuser with an individualised care plan will have a unique combination and schedule of treatments and services to meet their particular needs. However, the overall model of care will be largely similar.

In line with a 'stepped care' model of intervention for alcohol misusers, introduced in the *Review of the effectiveness of treatment for alcohol problems*,<sup>1</sup> moderately or severely dependent drinkers will usually be offered the least intensive treatments appropriate for their assessed needs. If this fails to deliver a positive outcome, they should be offered more intensive or prolonged treatment until their treatment goals have been achieved. Because alcohol dependence is a relapsing condition, individuals' progress must continue to be monitored after the formal end of care-planned treatment and should at least be followed up after all structured intervention has ended.

Care-planned alcohol treatment can be delivered in a variety of settings, including the home, workplace, general and psychiatric hospitals, primary care, hostels and community-based treatment agencies. The selection of setting will depend on a number of factors, including individual choice, safety, opportunism, accessibility, availability of treatment and cost.

Community settings are preferred for the treatment of the majority of alcohol misusers, both because individuals need to learn how to change their drinking behaviour in their normal social environment and because it is cost-effective. Those individuals who are unable to leave the home or who would have difficulties attending a specialist agency – for example older people, disabled people and parents with childcare responsibilities – may need specialist alcohol treatment in their own homes or other community settings. However, some individuals will require treatment in hospital or in supported residential accommodation.

Dependent drinkers who have difficulty in achieving abstinence through treatment in community settings may require inpatient treatment. Criteria for inpatient admission may include:

- severe dependence
- a history of withdrawal complicated by seizures or Delerium Tremens (DTs)
- poor physical or psychological health
- a risk of suicide
- other drug misuse.

Homeless people, those who lack social support or those who have had previous unsuccessful attempts at withdrawal in the community may also require inpatient treatment. Inpatient prescribing will be available to those who require stabilisation in a controlled environment.

Inpatient assisted withdrawal should lead seamlessly into structured care-planned treatment and support, whether delivered in the community or in residential rehabilitation services. For further guidance relating to the use of specialist inpatient substance misuse provision, see *Scan consensus project 1: Inpatient Treatment of Drug and Alcohol Misusers*.<sup>26</sup>

Inpatient and residential rehabilitation services may have capacity to offer services in more than one area. Commissioners can explore opportunities for collaborative commissioning arrangements with other areas to optimise the efficient use of resources dedicated to these components of their local treatment systems.

# B5 Helping individuals maintain the gains they have made from alcohol treatment

## B5.1 Aim

To prevent individuals relapsing after participating in alcohol treatment.

## B5.2 Criteria

### Criterion 11: Maintaining gains from alcohol treatment

Individuals who have participated in alcohol treatment receive information, advice and continuing support to help them maintain improvements in their health and social well-being and reductions in their alcohol consumption.

## B5.3 Rationale

Alcohol dependence is, for some people, a relapsing condition. Individuals can quickly return to their previous drinking habits and their health and well-being gains can rapidly be eroded if they are not provided with information, advice and continuing support to address the social, environmental and financial factors associated with their substance misuse.

While they are undergoing alcohol treatment and afterwards, individuals may need help to:

- maintain their personal commitment to their drinking goals
- avoid the company of heavy drinkers
- find housing
- find employment
- access training and education to develop employment and life skills
- manage their personal finances
- achieve lasting changes in their lifestyle.

The relevance and importance of these factors need to be identified as part of the comprehensive substance misuse assessment (see Section 2) and the strategy for addressing these issues developed as part of the individualised care plan.

Relapse prevention is best viewed not as a separate activity, but as integral to the care plan. It may involve:

- **psychosocial therapies**, as identified in Section 2, especially those that help individuals avoid or cope with high-risk drinking situations
- **social support to make lifestyle changes**, such as housing, employment, family and social relationships
- **pharmacological therapies** as an adjunct to psychosocial interventions – not as stand-alone treatments
- **a structured programme of activities**, at set intervals following the initial achievement of the individual's drinking goals, designed to monitor the individual's progress, build on their successes, identify problems and ways of overcoming these, reinforce skills and behaviour changes and prevent a lapse turning into a full relapse.

Psychosocial factors that may lead to relapse are identified as part of the comprehensive substance misuse assessment. Action to address these is included in the individualised care plan, which will also identify the nature of rehabilitation and continuing care required. A range of other services to prevent relapse (such as support with housing, employment, family and social relationships) may be provided in parallel with the core treatment interventions for alcohol problems.

Once the individual's drinking goal has been achieved, they may need a period of supported rehabilitation to maintain their treatment gains. For some this may take the form of structured interventions (such as forms of structured counselling or structured day services) to help individuals restructure their lives; for others a more supportive and closely monitored approach in a residential facility may be required. Local needs assessment will inform commissioners about the level of demand for community and residential rehabilitation required.

Because of the relapsing nature of alcohol dependence, all alcohol misusers who have been treated should be monitored and followed up in a structured way. Continuing care, with appointments on an individual or group basis at regular intervals after the completion of treatment, can:

- enable the early detection of a relapse and attempt to limit its negative consequences
- help prevent a minor lapse from turning into a full relapse

- provide an opportunity to evaluate the usefulness of new skills and behaviours that individuals have been trying to put into effect, including lifestyle changes, and discuss any problems that may have arisen
- provide specific booster sessions for skills and behavioural changes that need strengthening
- provide the means of monitoring and recording progress and of reinforcing individuals' success.

Rehabilitation and continuing care form a continuum of a range of activities, initially provided in a more structured way based on the individual's assessed needs, but later delivered in response to the individual's ongoing requirements.

Mutual aid and self-help groups are often a useful local resource, particularly for aftercare. Alcoholics Anonymous (AA) offers a model of support and continuing care for alcohol misusers, using the 12-step approach, and has the benefit of being available nationally. Other complementary mutual aid services may need to be specifically commissioned in each area to offer choice and an appropriate range of provision.

# B6 Managing alcohol treatment services

## B6.1 Aim

To ensure organisations providing alcohol treatment deliver quality services that meet the needs of service users and the requirements of service level agreements.

## B6.2 Criteria

### Criterion 12: Managing alcohol treatment services

Organisations providing alcohol treatment services are managed to meet the requirements of service level agreements, ensure staff competence, deliver evidence-based practice, undertake regular reviews of performance based on service user monitoring data, and have good relationships with commissioners and other providers.

## B6.3 Rationale

Like all organisations, alcohol services can only be fully effective if they are properly managed. This means:

- being clear about the strategic aims and objectives of the organisation, how it fits into the wider alcohol treatment system, the services it offers and those it does not offer
- proactively involving service users in the planning, design, delivery, monitoring and evaluation of services
- agreeing with commissioners the type and level of services to be provided to which groups of users and the quality, time and cost parameters around these
- developing and adhering to an operational policy and planning the delivery of services
- providing an environment that is safe and conducive to the effective delivery of services
- recruiting, supervising, developing and retaining a workforce with the required mix of competences for delivering services
- maintaining complete, accurate and accessible records and keeping these secure within agreed confidentiality protocols

- establishing and maintaining effective processes for communication and joint working between workers within the organisation and with other organisations
- using data from routine service user monitoring to review practice regularly
- undertaking regular service audits or clinical guidance reviews
- assuring the quality of services and promoting continuous improvement in treatments, processes and outcomes
- monitoring performance and reporting to commissioners and statutory bodies as required.

It is the responsibility of service managers to ensure that services are accessible and provided equitably to all users in their defined target groups.

#### **B6.4 Quality standards**

The standard of performance required of individual managers within alcohol services is described in Key Area B 'Management of Services' of the Drugs and Alcohol National Occupational Standards (DANOS).<sup>17</sup>

*Quality in Alcohol and Drug Services (QuADS) Organisational Standards for Alcohol and Drug Treatment Services*<sup>21</sup> remains a relevant, nationally agreed quality framework for alcohol treatment and represents good practice.

# Annex A

## Links to other commissioning initiatives

*Models of care for alcohol misusers* has not been developed in isolation. It has been developed with reference to *Models of care for the treatment of adult drug misusers*<sup>4</sup> and complements the forthcoming *Models of care for the treatment of adult drug misusers: Update 2006*.

Alcohol brief interventions and treatment are integral to NHS and social care commissioning and should be provided in line with the Department of Health's *National standards, local action: Health and social care standards and planning framework 2005/06–2007/08*<sup>15</sup> and *Alcohol misuse interventions: Guidance on developing a local programme of improvement*.<sup>5</sup>

## Standards for organisations commissioning and delivering alcohol services

Other commissioning guidance that can contribute to understanding the commissioning process includes:

### Commissioning standards for drug and alcohol treatment and care

Commissioning standards for drug and alcohol treatment and care<sup>22</sup> were developed by the Substance Misuse Advisory Service in 1999 as a tool for commissioners of treatment and care.

The standards were designed to develop firm mechanisms for health and local authority treatment commissioning and to ensure that all treatment programmes accord with a nationally accepted standard. The standards provide guidance on the commissioning of comprehensive and evidence-based alcohol and drug treatment and care systems.

### Quality in Alcohol and Drug Services (QuADS)

QuADS<sup>21</sup> was developed jointly by Alcohol Concern and DrugScope and is still widely used by alcohol and drug treatment services throughout England, as the set of quality standards for organisations in the sector. Organisations use the standards for self-assessment and also for peer review.

QuADS is particularly relevant when considering the management and quality assurance of alcohol treatment services. It is therefore referenced in Section B6 Managing alcohol treatment services in Chapter 3 Criteria for commissioning and provision of local treatment systems for alcohol misusers.

### **National minimum standards for care homes for younger adults**

National minimum standards for care homes for younger adults are issued by the Secretary of State for Health under section 23(1) of the Care Standards Act 2000. They came into effect on 1 April 2002.

It is the responsibility of the Commission for Social Care Inspection (CSCI) to apply them to the circumstances of individual establishments, agencies and institutions through regulation.

The standards apply to homes for which registration as care homes is required, including currently registered residential care and nursing homes, small homes, new facilities, local authority homes and establishments that were exempt under the Registered Homes Act 1984 (for example charter homes). The standards specifically apply to care homes for people with alcohol or substance misuse problems. The standards cover: choice of home; individual needs and choices; lifestyle; personal and healthcare support; concerns, complaints and protection; environment; staffing; and conduct and management of the home.

### **Other quality frameworks and standards**

Other quality improvement frameworks, standards or accreditation systems may also be relevant to alcohol intervention and treatment systems. These may include clinical governance mechanisms in NHS providers, Investors in People, criminal justice accredited programmes and standards and registration for independent hospital provision.

Commissioners and providers should be clear about the requirement around individual quality initiatives and how they contribute to demonstrating the quality of local provision. Commissioners should minimise duplication of effort for providers in monitoring and reporting requirements where possible.

# Annex B

## Wider policy context

### Creating a patient-led NHS

The NHS now has the capacity and the capability to move on from being an organisation that simply delivers services to people to being one that is totally patient led – responding to their needs and wishes.

Every aspect of the new system is designed to create a service that is patient led, where:

- people have a far greater range of choices, and information and help to make choices
- there are stronger standards and safeguards for patients
- NHS organisations are better at understanding patients and their needs, use new and different methodologies to do so and have better and more regular sources of information about preferences and satisfaction.

In order to be patient led, the NHS will develop new service models which build on current experience and innovation to:

- give patients more choice and control wherever possible
- offer integrated networks for emergency, urgent and specialist care to ensure that everyone throughout the country has access to safe, high-quality care
- make sure that all services and all parts of the NHS contribute to health promotion, protection and improvement.

The NHS will also develop the way it secures services for its patients:

- It will promote more choice in acute care:
  - Primary care trusts (PCTs) will be responsible for making sure that from 2006 they offer choices to patients
  - PCTs will not need to direct patients to particular providers but will offer a choice of four or five local NHS providers, together with all NHS foundation trusts and nationally procured independent sector treatment centres

- All other independent sector providers may apply to be on the list of choices for patients, if they are able to operate to NHS standards and at the NHS tariff
- Primary and community services will be encouraged to develop new services and new practices
- Existing networks for emergency, urgent and specialist services will be strengthened, with PCTs and strategic health authorities (SHAs) having explicit responsibility to review and develop them
- Current practice in shared commissioning will be developed with the aim of creating a far simpler contract management and administration system, which can be professionally managed and provide better analysis while leaving practices and PCTs in control of decision making
- There will be greater focus on health improvement and developing local patient pathways and services.
- The NHS needs a change of culture as well as systems to become truly patient led, where:
  - everything is measured by its impact on patients
  - the NHS is as concerned with health promotion and prevention – looking after the whole person – as with sickness and injury
  - the staff directly looking after patients have more authority and autonomy, supporting the patient better. This will require:
    - action to tackle the barriers that create rigidity and inflexibility in the system
    - shared values and codes of conduct, enshrining the desired changes in culture
    - greater support of front-line staff and clinical leadership
    - continuous learning, supported by the new NHS Institute for Innovation and Improvement
    - a new model for managing change suitable for the new environment
    - clearer leadership at all levels, integrated nationally through the new National Leadership Network for Health and Social Care.

- A patient-led NHS needs effective organisations and incentives, with:
  - a new development programme to help NHS trusts become NHS foundation trusts
  - a similar structured programme to support PCTs in their development
  - further development of Payment by Results to provide appropriate financial incentives for all services
  - greater integration of all the financial and quality incentives
  - full utilisation of the new human resources and IT programmes.
- Change on this scale involves uncertainty, and all organisations need to plan to manage the risks with some national support to:
  - strengthen the role of the NHS Bank
  - improve the way the NHS handles service and organisational failures
  - improve the way that service change and reconfiguration is managed.

### **Alcohol harm reduction strategy**

The *Alcohol harm reduction strategy for England*<sup>2</sup> has four themes:

- improved education and communication
- better identification and treatment
- alcohol-related crime and disorder
- supply and industry responsibilities.

### **Choosing Health White Paper**

*Choosing Health: Making healthy choices easier*<sup>3</sup> highlights action on reducing alcohol-related harm and encouraging sensible drinking as one of its six priorities, and places alcohol firmly in the realm of public health practice.

*Choosing Health* emphasises and builds on the recommendations in the *Alcohol harm reduction strategy for England*.<sup>2</sup> It proposes:

- a national information campaign to tackle the problems of binge drinking
- a social responsibility scheme
- training for professionals

- piloting screening and brief interventions in primary and secondary health settings, including accident and emergency
- similar pilots in criminal justice settings
- a programme of improvements for treatment services
- additional funding will be available from April 2007.

### **Crime and Disorder Act 1998**

PCTs in England became 'responsible authorities' under the Crime and Disorder Act 1998 (as amended by the Police Reform Act 2002) on 30 April 2004. This means that PCTs now have a statutory responsibility to work in partnership with other responsible authorities, namely the police, fire services, local authorities and co-operating bodies to tackle crime, disorder and the misuse of drugs.

Over a three-year cycle, the Act places a duty on PCTs to:

- participate in an audit of crime and disorder, anti-social behaviour and drug misuse for the crime and disorder reduction partnership (CDRP) area or areas in which they fall
- contribute to the development of local strategies that effectively deal with the issues which are identified.

The first audit in which PCTs participated was completed by the end of September 2004 and, after consultation with local communities, the local CDRP was required to publish their strategy by April 2005. The strategy will last for three years.

The extent to which the PCT is involved in the delivery of the strategy is not specified. In practice, this will be determined through local negotiation and it is likely to be greatest in areas where the delivery of action on drugs, alcohol and crime and disorder makes a significant contribution to the PCT's own national or local priorities.

Action in support of local crime and disorder strategies may impact positively on a range of national NHS priorities, including:

- reducing health inequalities
- positive patient satisfaction surveys
- positive staff satisfaction surveys
- improvement in the life chances of children

- increasing the participation of problem drug users in treatment
- implementation of the National Service Framework for mental health
- reductions in waiting times.

The Tackling Violent Crime Programme (TVCP), launched by the Home Office in November 2004, is one of the programmes funded and delivered through crime and drugs partnerships. TVCP targets the highest violent crime areas only and focuses on domestic violence and alcohol-related violence. (The British Crime Survey shows that 47 per cent of victims described their assailant as being under the influence of alcohol.)

Local crime and drugs partnerships work to deliver the young people's substance misuse prevention agenda, and local authorities hold the young people's partnership grant on behalf of the partnership. There is a particular emphasis on targeting young people in high-focus areas (HFAs).

The Licensing Act 2003 is intended to provide:

- a clear focus on the prevention of crime and disorder
- a clear focus on public safety
- the prevention of public nuisance
- the protection of children from harm.

PCTs are not responsible authorities under this Act and local licensing committees are not required to consult with PCTs when granting licences. Licensing committees are required to consult with crime and drugs partnerships, and PCTs can make their views and recommendations known through their crime and drugs partnership.

### **The Respect Action Plan**

The Government's proposals to deliver on the 'respect' drive were set out in the Respect Action Plan. The aim of the respect drive is to ensure that all local areas tackle unacceptable behaviour and its causes to improve quality of life for residents – particularly those in the most disadvantaged communities.

Commissioners can ensure that alcohol treatment services inform and contribute to the provision of services to address the needs of those whose alcohol-related behaviour causes harm to the wider community.

## **Every Child Matters**

This White Paper focuses on supporting all children, particularly those in vulnerable groups, to have better outcomes as adults. Substance misuse, including alcohol, is an important element of this.

## **Local strategic partnerships (LSPs)**

In the interests of strong multi-agency working, a PCT will commonly agree its shared objectives with local authorities and other partners through LSPs.

## **Local area agreements (LAAs)**

LAAs are an important new planning process that brings health inequalities and health outcomes to the forefront of local community planning. LAAs are negotiated and agreed by regional Government Offices (GOs) on behalf of the Government, with SHAs responsible for agreeing PCT contributions to the LAA and informing GOs that they are acceptable. Regional directors of public health will support SHAs and represent the Department of Health in this process.

Outcomes are negotiated between local authorities (and their partners) and GOs on behalf of central departments. LAAs reflect both local and national priorities. PCTs are responsible for leading the development and delivery of the health elements of LAAs, with the support and encouragement of SHAs.

- The health and social care input in phase two LAAs (from April 2006) is focused on public health and on services to adults at the interface between health and social care agencies
- For phase two LAAs, there is a need to ensure that LAAs' proposals are consistent and aligned with already agreed local delivery plans (LDPs), through local targets or agreed contributions to national priorities
- There should be scope for the LAA to build on the LDP, for example by identifying joint action to tackle the wider determinants of health such as the reducing alcohol harm priority identified in *Choosing Health*.<sup>3</sup>

Spearhead PCTs have been set particularly challenging targets to reduce health inequalities in their area. Through the LAA process, PCTs can engage the local authority and other local partners in the co-delivery role described in *Choosing Health*.<sup>3</sup>

# Annex C

## Associated documents

### List of referenced documents

- <sup>1</sup> *Review of the effectiveness of treatment for alcohol problems* (National Treatment Agency for Substance Misuse, 2006)
- <sup>2</sup> *Alcohol harm reduction strategy for England* (Prime Minister's Strategy Unit, 2004)
- <sup>3</sup> *Choosing Health: Making healthy choices easier* (Department of Health, 2004)
- <sup>4</sup> *Models of care for the treatment of adult drug misusers (MoCDM)* (National Treatment Agency for Substance Misuse, 2002)
- <sup>5</sup> *Alcohol misuse interventions: guidance on developing a local programme of improvement* (Department of Health, 2005)
- <sup>6</sup> *Alcohol treatment pathways: guidance for developing local integrated care pathways for alcohol* (National Treatment Agency for Substance Misuse, 2006)
- <sup>7</sup> *The Alcohol Needs Assessment Research Project (ANARP)* (Department of Health, 2005)
- <sup>8</sup> *Office for National Statistics general household survey* (Office for National Statistics, 2001)
- <sup>9</sup> *Interim analytical report* (Prime Minister's Strategy Unit, 2003)
- <sup>10</sup> *World Health Organization lexicon of alcohol and drug terms* (World Health Organization, 1994)
- <sup>11</sup> *WHO International Classification of Diseases: The ICD-10 Classification of Mental and Behavioural Disorders* (World Health Organization, 1992) (ICD-10) (World Health Organization, 1994)
- <sup>12</sup> *Standards for better health* (Department of Health, 2004)
- <sup>13</sup> *National Treatment Outcome Research Study (NTORS)*, 2001)
- <sup>14</sup> *Dual diagnosis good practice guide* (Department of Health, 2002)
- <sup>15</sup> *National standards, local action: Health and social care standards and planning framework 2005/06–2007/08* (Department of Health, 2004)
- <sup>16</sup> *Models of care for the treatment of adult drug misusers: update 2006* (National Treatment Agency for Substance Misuse, 2006)
- <sup>17</sup> *Drugs and Alcohol National Occupational Standards (DANOS)* (Skills for Health, 2002)

- <sup>18</sup> *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers* (Royal College of General Practitioners and Royal College of Psychiatrists, 2005)
- <sup>19</sup> *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers*, NTA briefing document (National Treatment Agency for Substance Misuse, 2005)
- <sup>20</sup> *The NHS Improvement Plan: Putting people at the heart of public service* (Department of Health, 2004)
- <sup>21</sup> *Quality in Alcohol and Drug Services (QuADS) – Organisational Standards for Alcohol and Drug Treatment Services* (Alcohol Concern/DrugScope, 1999)
- <sup>22</sup> *Commissioning Standards – Drug and Alcohol Treatment and Care* (Substance Misuse Advisory Service, 1999)
- <sup>23</sup> *The New NHS White Paper* (Department of Health, 1997)
- <sup>24</sup> *Choosing Health Planning and Performance Toolkit for PCTs and their Partners* (Department of Health, 2005)
- <sup>25</sup> *Care planning practice guidance* (National Treatment Agency for Substance Misuse, 2006)
- <sup>26</sup> *Scan Consensus Project 1: Inpatient Treatment of Drug and Alcohol Misusers* (Specialist Clinical Addiction Network, 2006)

## National Treatment Agency

- *Promoting safer drinking: A briefing paper for drug workers* (2004)

## Department of Health

- *NTORS after five years (National Treatment Outcome Research Study): Changes in substance use, health and criminal behaviour in the five years after intake* (2001)
- *Tackling health inequalities: A programme for action*
- *The NHS cancer plan: A plan for investment, a plan for reform*
- *National Service Framework for coronary heart disease*
- *Guidance for partnerships and primary care trusts (PCTs): Commencement of PCTs as responsible authorities from 30 April 2004*
- [www.dh.gov.uk/alcohol](http://www.dh.gov.uk/alcohol) – alcohol misuse website

## Home Office

- Crime and Disorder Act 1998 and Police Reform Act 2002
- The respect agenda
- *Crime and disorder reduction partnerships*
- *Alcohol-related crime*
- *Drinking responsibly*
- *Violent crime (including domestic violence)*
- Violent Crime Reduction Bill

## Department for Culture, Media and Sport

- Licensing Act 2003

## Office of the Deputy Prime Minister (now Department for Communities and Local Government)

- [www.odpm.gov.uk](http://www.odpm.gov.uk)
- *'How to' guide* on engagement for integrated partnerships in respect of crime, alcohol and drugs
- Local strategic partnerships
- Local area agreements guidance

## Department for Education and Skills

- *Every Child Matters*

## Health and Safety Executive

- Guides to alcohol and employment

## Alcohol Concern

- *Local alcohol strategy toolkit* – [www.localalcoholstrategies.org.uk](http://www.localalcoholstrategies.org.uk)

## UKATT Research Team

- UKATT Research Team (2005) Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). *British Medical Journal*: 2005 331 (download from [www.bmj.com](http://www.bmj.com))
- UKATT Research Team (2005) Cost-effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). *British Medical Journal*: 2005 331 (download from [www.bmj.com](http://www.bmj.com))





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