Public Health
England

Protecting and improving the nation's health

Alcohol prevention, treatment and recovery for adults: JSNA support pack

Good practice prompts for planning comprehensive interventions in 2015-16

About Public Health England

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339

Contents

Introduction

Alcohol consumption is the third highest risk factor for avoidable ill health in England and the harm from alcohol cuts across a range of public health priorities. In England, over nine million people (22% of the population) drink at levels that increase the risk of harm to their health. Of these, 1.6 million adults show some signs of alcohol dependence.

Alcohol is a significant contributor to some 60 health conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression. The increase in risk for these conditions is greatest among those 2.2 million people in England drinking at harmful levels (ie, in excess of 35/50 units per week, female/male). However, even increasing risk drinkers (those regularly exceeding the lower risk guidelines) are at significantly increased risk of these conditions. Binge drinking can lead to injuries, anti-social behaviour and other societal harm.

The most deprived fifth of the population suffers two to three times greater loss of life attributable to alcohol; three to five times greater mortality due to alcohol-specific causes; and two to five times more admission to hospital because of alcohol than the more affluent areas.[1]

Because this range of drinking behaviour leads to such a wide variety of harm, evidence points to an multi-faceted and integrated response, aimed at individual drinkers, at-risk groups and whole populations.

Effective local systems will be those that are coherently planned by local government, NHS and crime and justice partners to provide clear, integrated pathways through levels of intervention based on identified need.

Planning is key. To address the harm, costs and burden on public services from alcohol misuse, successful plans will take into account local needs and community assets assessments, and will reflect evidence of what is known to work in terms of: effective prevention; health improvement interventions for those at risk; treatment and recovery services for dependent drinkers; and action to reduce binge drinking and reduce the harm caused by binge drinkers.

This document outlines key principles that local areas might consider when developing plans for an integrated system. There are five principles, followed by a series of prompts to help put them into practice.

1. Commissioning principles for adult alcohol and drugs prevention, treatment and recovery

[Note the principles in this section cover the commissioning of alcohol and drug services, and are repeated in the good practice JSNA support pack for drug and the pack for alcohol prevention, treatment and recovery interventions for adults.]

Local authority public health commissioners work closely with all relevant partners to commission high-quality, evidence-led alcohol and drug services based on outcomes.

What will you see locally if you are meeting the principle?

Effective integrated commissioning of services that achieve positive outcomes for individuals, families and communities by:

- effective partnership working between local authority-led public health, the NHS (clinical commissioning groups and NHS England local area teams), mental health services, Jobcentre Plus, Work Programme providers and adult social care, children's services and criminal justice agencies

- operating transparently according to assessed need

- bringing providers and mutual aid together into cost-efficient delivery systems

- fully involving service users and local communities, including through Healthwatch

Alcohol and drug users have the best possible access to warm, safe and affordable homes, suitable for their needs in the community, those local conditions will allow.

More alcohol and drug users in treatment are supported into work by an effective partnership between the treatment and employability sectors.

An integrated support offer involving greater support around training, education, voluntary work and general improvement of skills and work experience.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

1.1. Embedding in local systems

1.1.1. Do alcohol and drugs needs assessments, the local commissioning strategy, clinical commissioning group strategy, and joint health and wellbeing strategy demonstrate an explicit link between evidence of need and service planning?

1.1.2. Does the local public health structure have mechanisms in place for reporting on alcohol and drugs to the health and wellbeing board and police and crime commissioner?

1.1.3. Has the local authority public health team responsible for commissioning alcohol and drug services, established partnership arrangements with clinical commissioning groups, local clinical networks, NHS England local area teams and criminal justice agencies?

1.1.4. Is a joint commissioning approach adopted where there is a shared responsibility for commissioning and planning (eg, local authorities/clinical commissioning groups) around hospital-based services pathways?

1.1.5. Is there a formal strategic partnership in place for alcohol and drugs involving key stakeholders and agencies (health, public health, housing, employment, social care, families and safeguarding, and criminal justice), the aim of which is to develop a fully integrated system of health improvement, treatment and recovery for alcohol and drug misusers?

1.1.6. Do the general public, service users and staff in other mainstream services have ready access to information that enables them to understand the alcohol and drug services available, the pathways between them and points of entry?

1.1.7. Are there clinical governance mechanisms for assuring the quality and safety of alcohol and drug treatment services? Are these clearly embedded in public health systems?

1.2. Needs assessment

1.2.1. Does the local needs assessment, conducted as part of the JSNA, include a comprehensive section on alcohol and drug-related harm that reflects need across the whole spectrum of harm and readily acknowledges the impact of alcohol and drug work across the public health outcomes framework and the NHS outcomes framework, resulting in partnership collaboration and support?

1.2.2. Is there a shared understanding of the local level of demand and need, based on a range of local and national data across a range of public services?

1.2.3. Is local data on alcohol and drug interventions which are provided in hospitals, primary health care, and other settings collected to inform needs assessment?

1.2.4. Do commissioners analyse the local levels of alcohol and drug-related admissions to hospital in order to target interventions?

1.2.5. Do commissioners analyse and monitor local specialist alcohol and drugs treatment data, including specific breakdown by gender, age, postcode, condition, route of admission, repeat admission, etc, in order to compare current treatment provision with need?

1.2.6. Has a mutual aid self-assessment tool[2] been completed as part of the local needs assessment?

1.2.7. Does the needs assessment take into account the availability and potential development of existing community support networks and other local assets, using a methodology such as asset-based community development?

1.2.8. Are the following fully identified:

- gaps in delivery of primary, secondary and tertiary prevention for alcohol and drugs
- the extent of drug treatment penetration and access to alcohol treatment by the estimated dependent population.
- the impact of services on health and wellbeing, public health and offending?

1.2.9. Does the local needs assessment take account of the needs of women and young girls vulnerable to alcohol and drug misuse (for example, those subject to domestic violence or sexual assault, or involved in prostitution, or with poor mental health)?

1.2.10. Does the local needs assessment take account of the needs of prisoners and continuity of care requirements for alcohol and drug misusing offenders moving between custody and the community?

1.3. Finance

1.3.1. Is investment sufficient for a range of prevention, harm reduction and treatment services commensurate with the level of identified need?

1.3.2. Can commissioners identify the total level of local investment by all partners who contribute to delivery?

1.4. Effective commissioning

1.4.1. Is commissioning based on the evidence base, such as NICE guidance, for effective interventions in tackling alcohol and drug related harm?[3,4,5,6]

1.4.2. Is there an alcohol and drugs planning document that describes how best to meet local need, which clearly identifies:

- the level of local demand
- existing strengths and ways in which services can be commissioned
- finance and resources made available?

1.4.3.   Are reliable cost effectiveness data tools used when making commissioning decisions? Is investment in alcohol and drug prevention, treatment and recovery based on an understanding of expenditure, performance and cost-effectiveness?

1.4.4.   Are there contracts in place for commissioned services that specify the outcomes to be achieved and that are regularly monitored and reviewed?

1.4.5.   Are care pathways and services geographically and socio-culturally appropriate to those for whom they are designed?

1.4.6.   Are pathways for both alcohol dependent and increasing/higher risk drinkers jointly agreed and regularly monitored and reviewed by all relevant local partners?

1.4.7.   Are service users, carers and people in recovery involved at the heart of planning and commissioning? Is this evident throughout needs assessment and key priority-setting processes both for community and prison based services?

1.4.8.   Are commissioning functions fit for purpose? Is there sufficient alcohol and drug misuse commissioning capacity and expertise, including information management?

1.4.9.   Is there a workforce strategy and improvement plan that covers the commissioning partnership itself? Does this ensure that all staff are competent to commission safe and effective services?

1.4.10. Do service specifications clearly indicate the level of professional competence required to deliver safe and effective services?

1.4.11. Do commissioners include formal evaluation of the range of alcohol and drug interventions within the commissioning strategy?

1.4.12. Do all agencies have agreed policies for monitoring the delivery of services in full compliance with the Human Rights Act and the protected characteristics within the Equality Act 2010?

1.5. Commissioning services for individuals in contact with the criminal justice system

1.5.1.   Are there clear pathways for alcohol and drug misusing offenders to access alcohol and drug treatment at every point in the criminal justice process (ie. police custody suites, courts, youth offending teams, community rehabilitation companies /National Probation Service, prisons and the children and young peoples' estate)? Are these pathways part of the local integrated offender management model?

1.5.2.   Have discussions with police and crime commissioners taken place on investment in police custody-based alcohol and drug misuse interventions or other appropriate criminal justice pathways?

1.5.3.   Has the local authority engaged with the NHS England local area team responsible for health and justice to agree a jointly owned and collaborative approach to commissioning fully integrated services that effectively support and engage individuals as they transition between custodial and community settings?

1.5.4.   Have commissioners engaged with their local National Probation Service and community rehabilitation company to agree capacity and treatment interventions required for offenders subject to statutory supervision in the community and on release from prison.

1.6.   Involvement with mutual aid significantly improves recovery from alcohol and drug dependency

1.6.1.   Is there a shared, locally developed vision of recovery where mutual aid is appropriately integrated with alcohol and drug services (including in-patient and residential treatment)?

1.6.2.   Do people in treatment have access to a range of peer-based recovery support options, including 12-step, SMART Recovery and other community recovery organisations?

1.6.3.   Are local services encouraged to support service users to engage with mutual aid groups by including specific requirements in their service specifications?

1.7.   The home environment enables people to sustain their recovery

1.7.1.   Have the housing needs of alcohol and drug users in the community, prison and residential treatment been identified and used to inform local commissioning plans for housing, homelessness and housing related services?

1.7.2.   Are the housing needs of alcohol and drug users and their families (where appropriate) assessed in a timely manner to prevent homelessness and/or to enable move-on to a suitable home? (This includes those in prison, in residential services and those living in their own home but at risk of homelessness)

1.7.3.   Is good quality housing information and advice readily available?

1.7.4.   Is there a range of suitable housing options to meet different needs including: emergency bed spaces; direct access accommodation; refuges for those fleeing domestic abuse; supported housing; floating support available to those in their own home; accommodation specifically for

women or young people, housing for people with complex needs (eg, Housing First[7])?

1.7.5. Are alcohol and drug users who are rough sleeping able to access emergency accommodation and appropriate support?

1.7.6. Do housing services support homeless alcohol and drug users to access primary care?

1.7.7. Have commissioners, service users and providers agreed a definition for a 'suitable' home? Is the definition based on the description of 'suitable' found in the Homelessness (Suitability of Accommodation) (England) Order 2012,[8] as a minimum? Is the local definition consistently applied in practice by staff working with alcohol and drug users when supporting them along the pathway? Are frontline housing staff (working in local authority services, for social landlords and housing support providers) trained in working with alcohol and drug users to meet their housing and related needs?

1.7.8. Is there a hospital discharge policy and procedure in place for homeless alcohol and drug users (and others) to enable access to a pathway to suitable housing?

1.8. Getting a job enables people to sustain their recovery

1.8.1. Are treatment commissioners and providers jointly planning with local Jobcentre Plus (JCP) and Work Programme (WP) leads how to meet the employment, training and education (ETE) needs of the alcohol and drug misusing population?

1.8.2. Are the ETE needs of alcohol and drug misusers reflected in local worklessness and employability strategies?

1.8.3. Are commissioners incorporating ETE in performance monitoring arrangements with treatment providers and providers as part of supervision for key workers?

1.8.4. Have JCP, WP and treatment providers agreed a process of joint working between agencies, including arrangements for three way meetings?

1.8.5. Are there jointly delivered training sessions between JCP, WP and treatment providers in each area focusing on structures, service offers and the mutually beneficial relationship between treatment and employment outcomes?

1.8.6. Are key ETE service directories shared across JCP, WP and treatment providers, including the sharing of promotional materials?

1.8.7. Are there local single points of contact in JCP, WP and all treatment teams and have their details been circulated?

1.8.8. Has the partnership considered establishing employment champions in treatment teams, whose role it is to liaise with JCP and WP, and to champion ETE?

1.8.9. Is data sharing effectively taking place using the TPR referral forms?

1.8.10. Has some form of co-location been considered, even if this is part time (eg treatment workers spending two days a week in WP or JCP premises and/or vice versa)? Employability sessions could also be jointly delivered.

1.8.11. Are treatment providers, JCP and WP engaging with local employers to make the case and address negative preconceptions and stigma about employing people with a history of alcohol and drug misuse?

1.8.12. Are there case studies of successful employment outcomes shared across treatment provider, JCP and WP staff?

1.8.13. Are discussions about employability introduced early on in treatment journeys, and are commissioners and treatment providers assessing the prioritisation of the ETE agenda in local recovery provision?

1.8.14. Are treatment staff encouraging clients to consider appropriate disclosure of their alcohol and drug misuse within JCP and WP?

1.8.15. Are providers actively working with JCP and WP to address low levels of skills, training, education and work experience?

1.9. Commissioning hospital-based alcohol and drug services

1.9.1. Are there services in place to meet the needs of alcohol and drug misusing hospital patients?

1.9.2. Is there a strategic understanding at health and wellbeing board level of how alcohol and drug services for people in hospital integrate into the overall local system of alcohol and drug interventions and treatment?

1.9.3. Are linkages to community alcohol and drug services offered to support patients requiring further treatment and recovery support?

1.10. Young people, children and families

1.10.1. Are effective referral pathways and joint working arrangements in place with children and family services where there are safeguarding issues and with local Troubled Families provision where alcohol or drug misuse is a factor?

1.10.2. Have local protocols between alcohol and drug systems, and children and family services been developed in line with 'Supporting information for the development of joint local protocols between alcohol and drug partnerships, children and family service'?[9]

2. There are effective population-level actions in place to reduce alcohol-related harms

What will you see locally if you are meeting the principle?

Effective population-level approaches will reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol-related harm.[10]

What questions should you ask to check you are following the evidence and best practice that supports the principle?

2.1. Are local health improvement campaigns planned and are they based on and targeted at identified needs in the local population?

2.2. Where local alcohol social marketing campaigns are employed, do they reflect and amplify, national campaign messages[11] when appropriate?

2.3. Is public health active in the licensing process?

2.4. Is local crime and health and social care data used to map the extent of alcohol-related problems as part of licensing policy?

2.5. Is hospital and ambulance data shared routinely to inform improvements in community safety activity?

2.6. Has a 'cumulative impact' policy been adopted where an area is saturated with licensed premises informing the consideration and implementation of the range of measures and conditions available to the local licensing board?

2.7. Is optimal use made of existing legislation to target the prevention of under-age sales, sales to people who are intoxicated, proxy sales to minors, non-compliance with any other alcohol licence condition and illegal imports of alcohol?

2.8. Are local arrangements brokered with industry partners to promote responsible marketing, promotion and selling of alcohol?

3. There is large scale delivery of targeted brief advice

Early interventions, aimed at individuals in at-risk groups can help make people aware of the harm they may be doing and can prevent extensive damage to health and wellbeing.

What will you see locally if you are meeting the principle?

There is large scale delivery of identification and brief advice (IBA) to those at the most risk of alcohol-related ill health.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

3.1. Does the partnership have an integrated plan which sets out the partners' agreed roles and responsibilities, including for workforce development, in rolling out IBA in a range of settings and is there a system in place to monitor activity?

3.2. Are local hospitals part of the health-promoting hospitals network[12] and, if so, do commitments include alcohol harm reduction?

3.3. Do the services that deliver IBA collect, analyse and report data to demonstrate the level of delivery?

3.4. Does local 'making every contact count' (MECC) activity include evidence-based alcohol IBA?[13]

3.5. Are there any specific interventions to raise awareness of the harms of drinking for specific at-risk groups, such as pregnant women, older people and those with existing long-term conditions?

3.6. Do the NHS Health Check[14] programme and enhanced service for alcohol misuse include evidence-based alcohol IBA in line with regulations and guidance?

3.7. Is there IBA delivery across a range of adult local authority services, criminal justice and health settings?

3.8. Are there clear pathways to specialist assessment for those who may be dependent?

4. There are specialist alcohol care services for people in hospital

Specialist alcohol teams in hospitals reduce alcohol-related hospital admissions and improve quality of care, thereby saving costs for the NHS.[15]

What will you see locally if you are meeting the principle?

All district hospitals will have specialist provision for alcohol, in stand-alone teams or as part of a team with a wider remit including drugs and/or psychiatric liaison.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

4.1 Are alcohol (and drug) services contracted and employed in all acute hospitals where they could have an impact?

4.2 Is senior medical/nursing support and leadership provided to the alcohol (and drug) service to ensure that their role and function is understood and utilised by partners in the system?

4.3 Has planning ensured that community services are accessible and available to ensure continuation of detoxification with psychosocial interventions outside of the hospital?

4.4 Is there a range of services to support and reduce frequent hospital attendances?

5. There is prompt access to effective alcohol treatment

What will you see locally if you are meeting the principle?

Packages of psycho-social, pharmacotherapeutic and recovery interventions that are accessed by the target populations and, which deliver sustained recovery from alcohol dependency.

What questions should you ask to check you are following the evidence and best practice that supports the principle?

5.1 Is the alcohol prevention and treatment system integrated and configured to meet the needs of the local population across community and prison settings?

5.2 Is a joint commissioning approach adopted where there is a shared responsibility for commissioning and planning, eg, local authorities/NHS England around prison/community services pathways?

5.3 Is there sufficient capacity in the treatment system to address the needs of the estimated local dependent population and are alcohol services being commissioned to target highest risk groups, wherever they are located in the community?

5.4 Is there an explicit information governance agreement across all services to ensure that information is shared routinely to support effective care delivery and risk management?

5.5 Are service users, carers and people in recovery involved at the heart of planning and commissioning? Is this evident throughout needs assessment and key priority-setting processes both for community and prison based services?

5.6 Do alcohol treatment services in all settings offer evidence-based, effective recovery-orientated interventions in line with NICE guidance CG115[16], CG100[17] and quality standards QS11[18] (including, where appropriate, quality statements 4, 5, 7, 8, 9, 10, 11, 13,), and, for example, service improvement tools such as clustering and packages of care tools?

5.7 Is there a range of recovery support interventions and services accessible to facilitate the recovery journey, eg, peer support, mutual aid, family/parenting support, employment, training and housing?

5.8 Do all alcohol treatment providers report data to the National Drug Treatment Monitoring System (NDTMS) and is this data analysed locally to inform improvements?

5.9 Do information systems for alcohol treatment comply with the NDTMS community minimum data set? Are there plans for investment in IT systems that meet the clinical and NDTMS needs of providers?

5.10 Do treatment providers have workforce plans that describe how specialist staff are trained and supported to ensure appropriate competence and supervision to deliver specialist interventions?

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