Public Accounts Committee – Inquiry on alcohol treatment services: WithYou response

About WithYou

WithYou is a charity that offers free, confidential support and treatment to people in England and Scotland who have issues with drugs, alcohol or mental health. We give people support in a way that's right for them, either face to face in their local service, community or online. We are one of the largest providers of treatment and support services in the UK, helping more than 75,000 people last year, currently working in over 80 locations across the UK.

Summary

- Despite increasing rates of alcohol-related harm and alcohol deaths, too many people are not accessing alcohol treatment and support.
- The long term disinvestment to the public health grant has significantly impacted local authority budgets, having a direct impact on the outcomes of alcohol service provision, impacting the size and quality of the workforce, and the diversity of specialist servico-occces that can be provided.
- Despite these funding challenges, there are important strengths to situating commissioning responsibility with local authorities who are best placed to understand the specific needs of local communities and where resources should be targeted for maximum impact.
- There are several barriers to more people accessing alcohol services. Though services are addressing them, ultimately they continue to be constrained in what they can do by the financial landscape within which they operate.
- We support calls for the Government to commission an independent review on alcohol harm to inform a new national alcohol strategy. This should look beyond just commissioning models or treatment pathways, but take a detailed examination of all areas of the alcohol policy and treatment system, as well as looking at our models prevention, access to services, primary care, and the role

of marketing, labelling and affordability.

Trends in consumption and treatment

1. Current estimates show that only 18% of dependent drinkers are in treatment.[1] The number of people being treated solely for alcohol issues is also decreasing. According to the latest OHID data, there were just under 85,000 people treated for alcohol in 2021-22, and though this was an increase of 10% from the previous year, this is still less than the peak of more than 91,600 in 2013-14.

2. People being treated for alcohol alone makes up 29% of all adults in drug and alcohol treatment, second to those in treatment for opiate use at 49%. However, among the general population, there are an estimated 10 million adults in England who drink above the UK Chief Medical Officers' low risk guidelines. More than two million drink at higher risk and an estimated 602,391 who are dependent on alcohol.[2] Alcohol-related harm and deaths are also increasing across the UK. There were almost 10,000 alcohol-related deaths in 2021, increasing by 27% between 2019-2021.[3] The ONS estimates that this only accounts for a third of all alcohol related deaths.

3. Where these harms and deaths occur is heavily influenced by socioeconomic inequality. The death rate from alcohol in the most deprived proportion of the population is double the rate of deaths in the least deprived.[4] The North East of England has double the rate of alcohol specific mortality compared to London.

4. The pandemic has also had a significant impact on trends in consumption and treatment. More people drank at harmful levels during the pandemic with recent data showing 17.5% of people drinking at increasing-risk and higher-risk levels in March 2022 compared to 12.4% in February 2020.[5] Alcohol specific deaths increased by 20% during the pandemic year of 2020.[6]

5. Our own internal and external data also showed significant variance in consumption patterns across the UK and Scotland. While the general trend showed that alcohol consumption increased among problematic drinkers, both our adult and young persons services saw a drop in alcohol referrals during the pandemic, a consequence of the main referral routes into service being closed. As a result, we saw a significant increase in alcohol-related engagement via our

[1] PHE (2021). Available at: Public Health Dashboard - OHID
[2] Ibid.
[3] ONS (2022) Alcohol-specific deaths in the UK: registered in 2021
[4] OHID (2021) Local Alcohol Profiles for England: short statistical commentary, December 2021 - GOV.UK
[5] University College London, Alcohol Toolkit Study
[6] LGA (2021) LGA responds to PHE report on alcohol consumption and harm during COVID-19 | Local Government Association

web-chat services and over the phone. As expected, alcohol referrals into treatment have increased post pandemic.

6. Lastly, we remain particularly concerned around alcohol consumption among older drinkers. Alcohol harm is increasing more in the over 55s than in any other age group. 55-64 year olds drink more on average than any other age group and are the most likely to exceed the UK drinking guidelines. Alcohol-related deaths in the UK are also the highest in this age group and have increased significantly in the over 65s in recent years.

Commissioning

7. Since 2012 local authorities have been responsible for commissioning drug and alcohol services. The vast majority of investment from central Government into alcohol treatment comes through the local authority public health grant, about a fifth of which is spent on alcohol and drugs treatment.[7] However, the public health grant has been cut by approximately 24% on a real-terms per capita basis since 2015/16. This has not only had a direct impact on the budgets for commissioning (drug and) alcohol specific services, but has also had a significant impact on local authorities being able to invest in other services that will reduce ill health, health inequalities and support a sustainable and well functioning health and social care system.

8. The long-term disinvestment from austerity, from 2010 onwards, has been significant. This has not just impacted local authority budgets, but has had a direct knock-on impact on the outcomes of alcohol service provision, impacting the size and quality of the workforce, and the diversity of specialist services that can be provided (like inpatient detox and residential rehabilitation).[8] Studies show increases in the number of alcohol-related hospital admissions are directly linked with the decreases in funding for alcohol services.[9] Research shows that decreasing funding does not result in money saved but simply displaced costs to other parts of the system, such as the NHS, social care, criminal justice and the benefits system. However, despite being faced with these challenges, (drug and) alcohol treatment outcomes have managed to remain relatively stable when taking into account the cuts commissioned service have had to absorb.

9. Despite these funding challenges, there are important strengths to situating

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[7] LGA (2021) LGA briefing: Alcohol harm. House of Commons
[8] DHSC (2021) Review of drugs part two: prevention, treatment, and recovery - GOV.UK
[9] Roberts, Hotopf, & Drummond (2021) The relationship between alcohol-related hospital admission and specialist alcohol treatment provision across local authorities in England since passage of the Health and Social Care Act 2012 | The British Journal of Psychiatry

commissioning responsibility with local authorities. Local authorities have a unique understanding of their locality, being best placed to understand the specific needs of local communities and where resources should be targeted for maximum impact. The treatment system includes various different stakeholders, from smaller charities, to culturally sensitive services, to large NHS trusts. An effective system requires all these different parts of the system to work together at a local/community level, and this is something that local authorities are far better equipped to do than in a more centralised system.

10. Though there are commissioning practices that can be improved to enhance the quality of alcohol treatment provision (such as longer contracts, greater contract flexibility etc), the main challenge isn't the commissioning model for alcohol treatment, but rather the sustainability of its funding. The main driver for a more effective (commissioning and) alcohol treatment system is longer term, sustainable funding. Without additional increases in the public health grant from central Government, the ability for service providers to substantially improve the quality of alcohol treatment and recovery services is significantly constrained. Evidence shows that for every £1 spent on alcohol treatment, there is a social return of £3.[10] Short term funding of a few years limits the ability of local authorities and their treatment providers to planning, service development and innovation, things that we know are essential to improve engagement, retention and outcomes. Evidence shows that the increase in alcohol-related hospital admissions is in part likely to be fueled by a reduction in expenditure for specialist alcohol treatment,[11] and local authority areas where alcohol dependence and deprivation is most acute, should be prioritised to receive targeted increased funding.

Access to services

11. Access to alcohol treatment and support is a significant issue that needs more attention. The number of people accessing services for alcohol support and treatment continues to trend downwards. Current estimates show that only 18% of dependent drinkers are in treatment.[12]

12. There are a number of reasons why access to alcohol services has decreased.[13] People who require support and treatment for alcohol have been found to be less likely to access integrated drug and alcohol services because of their own

[10] PHE (2018) Alcohol and drug prevention, treatment and recovery: why invest? - GOV.UK
[11] Roberts, Hotopf, & Drummond (2021) The relationship between alcohol-related hospital admission and specialist alcohol treatment provision across local authorities in England since passage of the Health and Social Care Act 2012 | The British Journal of Psychiatry
[12] PHE (2021) Public Health Dashboard - OHID
[13] PHE (2018) PHE inquiry into the fall in numbers of people in alcohol treatment: findings - GOV.UK

attitudes and the characteristics of the service. This includes a fear of stigma, preconceptions about drug users and a sense that their treatment needs were different to what the services offered. Long term disinvestment has also led to a loss of alcohol treatment expertise among staff, reduction in satellite sites and in-reach services with partners in the community.

13. We also know that drug and alcohol services with male-dominated, service user populations can be daunting and intimidating places for some, and sometimes in locations that have a reputation for antisocial behaviour.[14] Making integrated services more welcoming and flexible is essential to increasing access and retention. Many services are now addressing these barriers through more visually engaging branding, making their physical spaces more welcoming and engaging, and adopting a more mixed model of service delivery, including both digital and in-person treatment to offer greater choice in how people engage. However, service providers continue to be constrained in what they can do by the financial landscape within which they operate.

14. Our own research has shown that for some demographic groups, specialist alcohol services are far more successful in engaging and retaining service users and in improving outcomes.[15] Evidence from our Drink Wise, Age Well programme highlights that the alcohol treatment system is often poorly aligned with the needs of older adults.[16] The evidence from the 5-year programme found that many alcohol treatment providers often fail to provide appropriate support to older adults.[17] There appears to be a lot of variation between the quality of alcohol services and practitioners, and many older adults find that the services are unsuitable for their needs.

15. We found bespoke older adults' treatment and support services were often the ideal model of care for older adults, particularly if their alcohol use is caused by an age-related issue (eg grief, loneliness, boredom, retirement), they have age-related barriers to accessing or engaging with alcohol services (eg frailty, poor mobility, cognitive impairment, sensory limitations, comorbidity) or they are likely to feel intimidated in a mixed-age service.

16. Where people have co-occurring mental health and alcohol dependency, there is also inconsistency between national policy and local practice when it comes to accessing care. Our research as part of the Suicide Prevention Consortium has shown that people may be afraid to disclose their alcohol use when seeking

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[14] With You (2021) A system designed for women?
[15] Drink Wise, Age Well (2021). Evaluation of the Drink Wise Age Well programme 2015-2020
[16] https://www.drinkwiseagewell.org.uk/
[17] Drink Wise, Age Well (2021). Evaluation of the Drink Wise Age Well programme 2015-2020

mental health support fearing they could be deemed ineligible for mental health treatment, and/or because they don't feel 'safe' to do so[18]. We know many people cannot access appropriate support due to strict eligibility criteria, often at a local level, excluding people from the help they need. Their co-occurring needs around alcohol and mental health weren't treated as a shared responsibility for different services.

17. Improved specialist and integrated care is essential, along with a better understanding among professionals that there is 'no wrong door' for people with co-occurring mental health and alcohol conditions who want to access services.[19] The indications are that national guidance is often poorly implemented, or misinterpreted locally, and access to services remains inadequate in some areas.

18. Despite the challenges presented by the pandemic, WithYou and other third sector providers were able to continue to carry out successful remote interventions. The ability to shift our models of service delivery at a rapid pace highlighted one of the key flexibility benefits of commissioning third sector providers to deliver alcohol treatment and support services. Third sector providers were shown to be able in shifting service delivery models to ensure the safety of those we work with, but also quickly launching new technologies and remote support options that can easily be expanded outreach in the future if adequately resourced.

19. The main source of referrals into our services are through self-referral, GP's, hospital, courts, prisons and other services, family and friends, or through our web-chat services. People referred to us are often at more advanced stages of alcohol dependence, often with significant physical health problems. It is critical they are appropriately linked in with the right healthcare professionals at the right time. The process of referral involves a comprehensive assessment by a recovery worker who completes a unit calculation and audit score, then the level of risk and treatment pathway will be determined by these scores. Those who require a detoxification programme are provided a combined approach of medical management and tailored psychosocial interventions in order to give clients the best chance of continued abstinence.

20. Our experience of working with people who have more advanced alcohol dependence has shown that there needs to be more advice and support for

[18] Samaritans (2021) Insights from experience: alcohol and suicide
[19] PHE (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions: a guide for commissioners and service providers

lower level drinkers. Many people will not know that alcohol services are available to provide support to people no matter how developed, or heavy their dependence is.

Alcohol strategy

21. It has been over 10 years since the Government produced an alcohol strategy. The aims of the 2012 alcohol strategy have not been met and it is clear alcohol policy and addressing alcohol-related harm has not been given the appropriate focus it needs.

22. We support calls for the Government to commission an independent review on alcohol harm to inform a new national alcohol strategy, to complement the Black Review which informed the Government's 10-year Drug Strategy. It is clear there needs to be a whole system review of our approach to alcohol policy and treatment. This must look beyond assessing just commissioning models or treatment pathways, but take a detailed examination of all areas of the alcohol policy and treatment system, as well as looking at our models prevention, access to services, workforce expertise, primary care, and the role of marketing, labelling and affordability. This is a complex, wide-ranging issue, where the whole system needs examining before any structural changes are proposed. This requires long-term thinking, not short-term solutions.