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Assessing the availability of and need for specialist alcohol treatment services in Scotland.

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Evidence that in 2012 Scotland's alcohol treatment caseload equated to about 1 in 4 of the country's alcohol-dependent adults, over three times the 1 in 14 ratio in England, partly a consequence of extra funding accompanying Scotland's 2009 national alcohol strategy. Evidence too of a peer-based recovery orientation taking root.

SUMMARY This research assessed the availability, demand and utilisation of specialist alcohol treatment services in Scotland following publication in 2009 of the national alcohol strategy. Additional resources accompanied the strategy, totalling £120 million over three years, an increase of over £85 million on previous funding. Primarily it was intended to improve the identification, support and treatment of problem drinkers as well as to develop the alcohol treatment workforce.

In 2011 guidance was issued on the commissioning and delivery of person-centred, recovery-orientated, outcome-focused local services. This also recommended that services and planning authorities should have robust needs assessment and equality impact assessments to ensure the needs of all groups are identified and met. Other key recommendations focused on service user involvement, outcome monitoring, staff development, and links with mutual aid organisations. To drive improvements the Scottish government set a target that 90% of people referred for alcohol treatment would wait no longer than three weeks to receive it, and that an estimated 75% of people who could benefit from an alcohol brief intervention should receive one by 2010/11.

The study assessed the impact of these measures partly by means of a survey in 2012 of specialist alcohol treatment services delivering structured, care-planned treatment to adults either on a non-residential (tier 3) or residential (tier 4) basis. Nearly 90% of the 149 services responded to the survey, of which 117 answered questions about how many drinkers they had in treatment. From these an estimate was made for all 149 services.

How many people in Scotland might need treatment was estimated from the 2012 Scottish Health Survey as the numbers scoring at least 16 (possible dependence) on the AUDIT questionnaire used to screen for risky drinking. Combining this with the numbers in treatment (see paragraph above) provided a ratio of the degree to which treatment capacity could accomodate the possible need for treatment – the service-utilisation:prevalence ratio.

The three alcohol and drug partnership areas prepared to undertake this acted as case studies and were subject to more in-depth investigation including interviews with staff and service users.

Main findings

The study identified 149 specialist alcohol treatment services which were delivering tier 3 and 4 interventions to an estimated almost 32,000 individuals (two-thirds men) across Scotland during 2012. Nearly two-thirds of the patients were in services delivering only non-residential/outpatient (tier 3) interventions. Fewer than a quarter of services provided information on service users by either age, ethnicity, offender status, homelessness, disability status, or whether asylum seekers, refugees, or gypsy/travellers. Over 8 out of 10 services also delivered drug treatment services. Half of all the services delivered only tier 3 interventions, 43% both tier 3 and tier 4, and about 1 in 14 only tier 4.

In the 2012 Scottish Health Survey about a fifth of adults aged 16 or over reported drinking behaviour consistent with an alcohol use disorder. Most scored on the AUDIT screening test as hazardous drinkers (8 to 15) but 3.1% of the population displayed signs of moderate or severe alcohol dependence (scores of 16 or more), equating to almost 138,000 individuals, twice as many of whom were men as women.

These figures can be used to calculate a service-utilisation:prevalence ratio of 1:4.3 – that is, about 1 in 4 alcohol-dependent adults accessed specialist alcohol treatment in 2012. This ratio was (as far as could be told from the limited data available) about the same for men and women. Retail sales suggest survey respondents under-estimate how much they drink. If instead of about 3%, some 6% of the adult population were potentially dependent on alcohol, the service-utilisation:prevalence ratio rises to 1:8.3 – that is, treatment service caseloads equate to about 1 in 8 of all adults possibly in need of treatment.

In response to an open-ended question about future challenges and opportunities, respondents from treatment services identified funding as the main challenge, expressing concern about anticipated future budget cuts and the impact this would have on services.

Case study areas

In the three case study areas, service commissioners, providers and users described the positive impact of the additional funding and resources that accompanied the national alcohol strategy. Extra staff helped extend support to more drinkers, reduce each worker's caseload, and increase the frequency of therapeutic contacts. The strategy had also led to more holistic assessment of support needs and more effective treatment, with an increased understanding of the importance of recovery and preventive work. The waiting time target was also seen as a factor, though some criticised the work involved in meeting associated reporting requirements.

Other developments identified by staff included convergence with drug treatment services. In many cases, specialist drug and alcohol treatment services had merged and or co-located since 2008/09. Only a handful of interviewed staff dealt solely with alcohol. Growth of the 'third' or non-statutory sector since 2008 was seen as creating greater choice and facilitating tailored pathways for service users. These services too were able to extend their capacity through volunteers – often former service users who had sustained their recovery. Another development mentioned by commissioners and service managers, staff and users, was increased resources for peer-led recovery networks, such as Self Management Addiction Recovery Training (SMART), providing venues for service-user led meetings, suggesting activities for those in recovery such as hill-walking, and raising awareness of funding available to cover costs such as transport. Staff and managers across all three areas suggested these networks provide an additional resource that could increase recovery support capacity. Also mentioned were positive relationships between service commissioners and providers and increasing service user involvement in the design of services.

There was a concern however that in some cases new services had recently been scaled back or ended due to funding issues. One of the main gaps in service reach was seen as individuals who either do not recognise their need for treatment or are reluctant to access it, as well as gaps in treatment availability, such as for people affected by alcohol-related brain damage.

Staff in four services in two of the case study areas took part in a capacity assessment exercise. Recording their activities established that direct contact with service users accounted for about a third of the time staff spent on alcohol-related activities; slightly more time was spent on activities related to service users but not involving direct contact with the patient/client.

The authors' conclusions

The study found that 149 specialist alcohol treatment services delivered tier 3 and 4 interventions across Scotland during 2012. Additional resources accompanying the national alcohol strategy enabled these services to support almost 32,000 individuals, about a quarter of those in need of help. Findings suggest that service commissioners and planners have used those resources to further the national strategy's aims to improve local service delivery and accountability, and specifically to improve the identification, support and treatment of people misusing alcohol and the building of capacity in specialist alcohol treatment and care services. Nevertheless a service-utilisation:prevalence ratio of 1:4.3 means that about three-quarters of alcohol-dependent individuals could not have accessed treatment in 2012, supporting the views expressed in the case study areas that many individuals either do not recognise their need for treatment or are reluctant to access it.

For England it is possible to calculate a roughly equivalent service-utilisation:prevalence ratio by combining records of numbers in treatment for alcohol problems in 2012/13 and receiving tier 3 and 4 services, with the results of a national survey in 2007 which included the AUDIT alcohol screening questions. In the survey, 5.8% of men and 1.9% of women scored 16 or more, equating to about 1,526,000 possibly dependent adults, while the treatment caseload was 109,675; the resulting ratio is about 1:14. From these figures is seems a higher proportion of alcohol-dependent adults in Scotland (23%) access treatment than in England (7%), and this remains the case even if the Scottish prevalence estimate is inflated to take account of possible under-reporting. The Scottish figure also compares favourably with international standards; an access ratio of 1 in 5 would be regarded as high.

Though based on returns from a minority of services, the rough equality of the service-utilisation:prevalence ratio for each sex (about 1 in 4–5) suggests men and women in need are accessing treatment at broadly similar rates. It is a concern that even fewer services were able to break down their caseloads in to the other categories (including ethnicity, age and disability) which the Equality Act 2010 requires statutory providers to record in order to identify and rectify discrimination.

Many staff said their main focus was to meet the three-week waiting time target set by government, leaving little scope for additional work to increase the reach of services. Linked to this, there was a recurring theme about the reluctance of some NHS staff to expand their roles in terms of activity related to recovery. Commissioners and service managers and staff suggested the ways services undertake assessment and planning had moved beyond the traditional model of providing services to those in treatment, towards working in partnership with individuals in recovery. Peer-led recovery initiatives are an associated development and an additional resource welcomed by many service users and staff. However, there is limited research on how these initiatives link to specialist alcohol treatment services. Sustainability may be an issue, and there are potential risks in the delivery of recovery support by peers who may not be fully trained and who may not be able to sustain continuity of service, perhaps due to relapse or ill health.

FINDINGS COMMENTARY For more on calculating the degree to which treatment systems can treat all drinkers who might need treatment, see this Findings analysis of the English report used as the basis of the featured study's assessment that a much higher proportion of possibly dependent drinkers can access treatment in Scotland. That assessment seems based – as close as can be – on a like-for-like comparison. However, the Scottish figure for numbers in treatment was derived from a survey of treatment services, which benefited from direct contact with local area coordinators to identify those services, while the equivalent English figure derived from a routine data gathering system. The Scottish figure was grossed up to take account of services which had not responded to the survey, while the English estimate was derived just from those services which submitted data to the national database.

In England results from the AUDIT questionnaire relied on in Scotland – intended to identify risky drinking – could be combined with those from a questionnaire designed to assess severity of dependence. On this basis, the UK's National Institute for Health and Clinical Excellence (NICE) calculated that 260,000 adults in England are at least moderately dependent, suggesting that numbers in treatment in England equate to over 40% of the 'really' in-need population. What such an exercise might reveal in Scotland is unclear, but certainly it would take the service-utilisation:prevalence ratio closer to the system having the capacity to treat all those who need treatment, as indicated *both* by the AUDIT screening questionnaire and by the dependence-specific questionnaire. But even if the ratio was 1:1, it would not mean that all drinkers who need treatment receive it, just that the system has the capacity to achieve this; it could still be that many seriously dependent drinkers avoid or are not identified as needing treatment, and that some treatment slots are filled by less serious cases.

Estimates both for England and Scotland based on surveys must be adjusted for the under-reporting indicated by comparing survey responses with how much drink is actually sold. There is reason to believe that the heaviest drinkers underestimate their drinking most when responding to surveys, perhaps actually drinking over twice as much as they say.

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