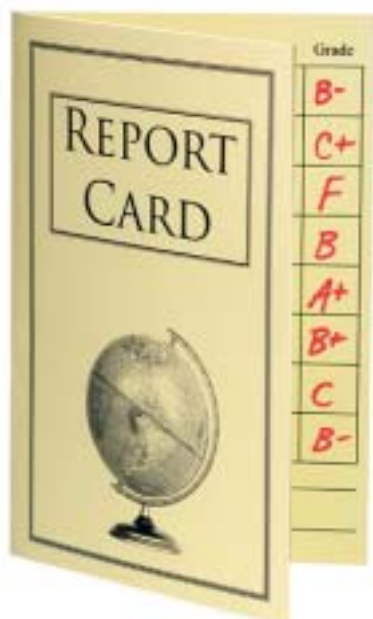


# Does MoCAM pass or fail?



Models of care for alcohol misusers was launched by government at the end of June, following a lengthy consultation process and much anticipation. Does it pave the way for more effective and integrated alcohol treatment services? DDN asked two alcohol experts for their verdict.

describing individual assessment systems; and describes care planning equally well to take into account both treatment journeys and integrated care pathways.

**‘Another missed opportunity’, says Don Shenker, director of policy and services at Alcohol Concern.**

## The good...

MoCAM does some things well. It sets out the key criteria for commissioning by itemising core standards as defined by the Department of Health’s *Standards for Better Health* (2004), and gives armour to services that argue that access to treatment remains inequitable, because services locally are patchy and demand heavily outstrips supply.

MoCAM successfully covers the need for implementing screening and brief interventions to identify problem drinkers at the hazardous or harmful stage, before patterns of dependency occur. It provides a good basis for

## The bad...

MoCAM lets alcohol treatment services down badly. After months of consultation and various drafts, it now reads more like an introductory guide to alcohol misuse and treatment, rather than a principle of effective commissioning. Commissioners who really care about stemming the growing tide of alcohol related deaths must be sick to the teeth about another government document that fails to answer the basic question of how to reduce alcohol harm without releasing extra funds.

In fairness, MoCAM was never going to promise any extra cash for additional

alcohol treatment, but very little has been provided about how to make the most of local health systems that are already stretched to the maximum. Worse still, the focus of ‘treatment’ is still seen within a strict mono-cultural, individualistic and bureaucratic top-down model, passing only scant reference to the needs of Black, Asian and other ethnic groups; women (including survivors of domestic abuse); children and families; and crucially, the voice of service users themselves.

Nothing is mentioned about how integrated care pathways are going to be mapped and how to close the real-world gaps between statutory and voluntary services as they currently exist. There are often gaps in referral protocols, communication and policies locally – between alcohol services and community mental health teams, social services, housing probation and prison services, where clients frequently fall through the net.

An added essential criterion that Local Alcohol Planning groups are set up within DA/AT and PCT commissioning structures would have been extremely useful, comprising commissioners, senior managers of statutory services, alcohol service providers and users, and reporting to PCT Boards.

Very little is offered to persuade local strategic planning groups to ensure alcohol treatment is on their agenda as equally as drugs. It is assumed commissioners will do this in isolation. Equally, MoCAM assumes that implementing screening and brief interventions (SBI) will occur happily without any discussion on how to engage with, and provide incentives for, primary care or other tier 1 staff. In fact no mention is made of the possibility of targeted screening across all statutory services, including the criminal justice system or housing.

There is no discussion of where treatment funds should actually come from to commission local systems of alcohol intervention and treatment. Assuming that commissioners will simply use existing funding streams lacks imagination – especially when some commissioners have had success with a variety of streams, including community safety monies, local area agreement budgets, local enhanced service budgets (PCT), area probation funds, policing budgets, domestic violence budgets and Connexions funding.

It is also not made clear what planning processes will involve and what actual involvement service users and providers will have. Planning on the basis of ANARP will be limited, as figures are regional and not local. It would have been better to point to planning guidance already provided in the Local Alcohol Strategies Toolkit, which uses expert practitioner, management and service user groups to plan a local strategy based on knowledge from the ground. Alternatively, consultancy could have been suggested to carry out a detailed local needs assessment.

In terms of monitoring, there is no consideration of the plethora of monitoring requirements already in place, or how these could be married together to form a unified and efficient system. Alcohol services need to consider what additional resources would be needed to allow them to monitor outcomes.

One of the biggest problems providers will see with MoCAM is the lack of attention paid to the needs of women and non-white service users. No examples, suggestions or guidelines are given on how to engage with diverse community groups to help plan, develop and run discrete and

specialist services for those who need them. It is a great disservice to all those that took part in the consultation process that after so much energetic and useful feedback, the published document fails to take these issues seriously.

Although there is a small section on the needs of family members, much more could have been provided on setting up services for the whole family to safeguard children. MoCAM provides no discussion on the need for statutory children and families services, schools, parenting teams and alcohol services to meet regularly, carry out joint training, and establish local protocols and referral systems. Neither is there any guidance for commissioners to encourage alcohol or children's teams to work jointly by sharing staff or developing new unified services.

Other points that worried me include the fact that the criteria for residential care appear very tight, excluding those who (after assessment), simply need a break from their high relapse-risk environment in a safe setting in order to achieve abstinence; and the omission of any apparent link between residential and community services in the 'treatment journey'.

Ultimately I found reading MoCAM a grave disappointment and couldn't quite see how it might benefit alcohol treatment services or commissioners. Until we resolve the primary issue of resources, most commissioners will rightly argue that no matter how crippling alcohol misuse is in their locality, their hands are tied. To improve access and equity in relation to alcohol treatment they will need more than just a model of care, however good it is.

**'MoCAM is a muddle', says Mary Longley, non-executive director of Broxtowe & Hucknall PCT and director of SASSI Direct Ltd.**

## The good...

What do I like about MoCAM? Long awaited and consulted over, it promises to locate services in a comprehensible framework and to help end the 'planning blight' doldrums in which alcohol services have long drifted.

Its categorisation of drinkers into hazardous, harmful, moderate and severe dependence is useful in terms of triage and care planning decisions – although I should have liked consistent adherence to WHO definitions, which would help the standardisation of assessments that MoCAM aims to effect.

There is excellent encouragement to develop local protocols for screening, assessment and triage, and for the sharing of information and protection of confidentiality within and between different service providers. It points the way to an unbeatable equality of access and choice of treatment method.

Importantly, it gives a solid basis to arguments in favour of joined-up aftercare services, psychosocial interventions which sustain abstinence, the provision of new peer groups and intelligent housing support.

## The bad...

Compared with the previously issued draft version, the final MoCAM offers much greater coherence in terms of terminology and conceptual analysis, but here and there the old inconsistencies resurface, provoking the suspicion of multi- and disparate authorship. Lack of clarity, fence-sitting and fear of creating offence sabotage what might have illuminated many a client journey: some clear guidance on goal setting.

For instance, whereas in section 1.3.9 we read 'alcohol treatment... should always be designed to meet needs and reduce risks', section 2.4's 'stepped care model to assist commissioning' contains the unquestioned assumption that what a service user 'wants' should determine interventional goal. Certainly the word 'appropriate' seems to be missing from all this. Clearly there is often a distance between 'wants' and 'needs', in which professional ethics would seem to demand some action on the part of the alcohol worker in terms of providing mainstream research-based evidence, motivational therapies, self-efficacy support and outlining of consequences for the self and others, if inappropriate goals are adopted.

Uncontroversially (it would appear), brief interventions are recommended as a means to achieve both a reduction in drinking and a reduction in harm. There is even a shy but unarticulated

implication that they are not suitable for people with 'moderate to severe levels of alcohol dependence', where 'abstinence will be the preferred goal for many problem drinkers...' although I have to question the word 'preferred' here. Preferred by whom, I wonder? Not so easily perhaps by those still wrestling with their internal ambivalence, not by those who are unable to recognise the problematic nature of their usage, not by those who are frightened to acknowledge that they might have lost their internal locus of control over the drug alcohol.

But worse follows: '...abstinence will be the preferred goal for many problem drinkers... 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.'

So now, as if a classification of dependence were not enough to recommend an abstinence-based goal, not only is the 'double whammy' of dependence with organic damage called on, but a further category of dependence in 'those who have previously attempted to moderate their drinking without success'. Not only can this group not be an additional sub-set of dependent drinkers, but the thesis is dangerously misleading. Permanent organic damage is a sufficient justification for abstinence on its own, whether or not the drinker is dependent!

Consultant hepatologists around the UK are constantly wringing their hands at the numbers of young women in their 20s and early 30s who have developed cirrhosis within two or three years of regularly drinking marginally above sensible limits. Indeed, one of the risks of delivering brief interventions with a reduced drinking goal to non-dependent drinkers is that anyone who does so without first ruling out the possibility of permanent liver damage may be liable to be sued for professional negligence, whether or not they are medically qualified. Brief Interventions have no more automatic equation with reduced drinking goals, than does reduced drinking with 'harm minimisation'; if a person has cirrhosis, any level of continued drinking will lead to an exponential rate of increase in damage.

And still MoCAM digs itself in deeper. The overlapping categories of 'low to moderate' and 'moderate to severe' dependence show no real

understanding of the difference between dependent and non-dependent drinking, no recognition of the research evidence highlighting the discrete and distant categories they represent (in adults at least), and no articulation of the rationale for goal-setting which flows from that difference.

Last but not least, we are advised that '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'. Conversely, of course, it could be considered unprofessional to endorse a goal which is by (mainstream evidence-based) definition unobtainable for a given client, and to fail to do everything in one's power to encourage a client towards an appropriate one. Will an increasingly litigious society come back to haunt therapists who are drawn into colluding with a client's self-deception or into setting them up to fail?

## And the plainly bizarre..?

There are three mentions of Alcoholics Anonymous in MoCAM; all of them rather curious. Locating it in the schema of interventions at all seems questionable, but it appears particularly out of place at tier 2. It is true that it has 'open meetings' which anyone can attend, but it also has closed meetings, where custom and practice requires a self-assessment of severe dependency as the criterion for admission. AA does not offer brief interventions, reduced drinking goals, or assessment and referral for care planned treatment.

Finally, MoCAM suggests that AA and other complementary mutual aid services may need to be specifically encouraged or commissioned in each area, to offer choice and an appropriate range of provision. Difficult to envisage with the former, given its fierce financial and ideological independence; with the latter this sounds like an expensive Utopian vision whose success might be measured in interecine wars!

*MoCAM can be viewed online as a pdf document. Visit [www.dh.gov.uk/assetRoot/04/13/68/09/04136809.pdf](http://www.dh.gov.uk/assetRoot/04/13/68/09/04136809.pdf)*