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Research report

Implementing an ideology. A case study from Leicestershire, England

ABSTRACT

D. Cameron: Implementing an ideology. A case study from Leicestershire, England

In the late 1970s, we established for the county of Leicestershire in England (pop. 850,000) what was then a highly innovative service for problem drinkers. It was based upon a number of core beliefs about the nature of people with alcohol problems and about what would be helpful for them. Most notably it rejected the concept of "alcoholism" and treated the clients ("customers") at all times as being responsible and therefore able to make decisions about what would be helpful for them. It was a community based tiered service, non-abstinence oriented and client demand led.

That system of intervention generated a burgeoning referral rate and there was evidence that compared with neighbouring similar counties, the service may have had a positive impact on the long term morbidity and mortality related to alcohol use. The data available were correlational and incomplete but were encouraging.

Changes in the style of provision in the neighbouring counties and administrative and structural changes in health and social services nationally meant that it was not possible to continue the service in its comprehensive form, and tracking

Introduction

In terms of our understanding of alcohol problems, the twentieth century could be characterized as the one in which the "disease concept of alcoholism" was first accepted and then rejected. The "marketing" of the disease concept started in the first half of the century in the USA, with proponents such as E.M. Jellinek (1960) from the scientific community and lay support from the developing fellowship of Alcoholics Anonymous. It was in the latter half of the century, from the 1960s onwards, that the disease concept came under sustained attack, with possibly the first paper to question one of its underlying beliefs, that of irreversibility, being published by D.L. Davies in 1962. Following that, the disease concept's basic tenets had been placed under experimental scrutiny and found wanting. In lay language the core beliefs, that "an alcoholic was born, not made", that "one drink [led to] one drunk" and that "once an alcoholic, always an alcoholic" had been demonstrated to be at best half-truths. Not only had the nature

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changes in the indirect indicators of alcohol problems became unfeasible. The natural experiment was terminated by factors beyond our control. Nonetheless, the service still exists, though in a truncated form. Its presence played a part in the development of the template for local alcohol service provision in Britain.

■ KEY WORDS
community alcohol services, client demand led, indirect indices, partnership capital, treatment

of people with alcohol problems been redefined, but what was helpful to them by way of intervention was also being questioned. The efficacy of conventional treatment, inpatient detoxication followed by support to remain abstinent with the assistance of Alcoholics Anonymous, had been seriously questioned. This was part of a general movement in healthcare away from residential care towards less intensive community-based interventions. Spratley et al. (1977) were early proponents of the idea of primary care workers caring for their own 'problem drinkers' where they lived with the support of an accessible advisory Community Alcohol Team.

It had also been observed that a large number of people in the general population who had developed severe alcohol problems could grow out of those problems and resume problem-free drinking. So, the possibility of return to "controlled drinking" in clinical populations had been explored experimentally in a number of studies worldwide. Mary Spence and I made a small contribution to that literature by running an outpatient controlled drinking group in Dumfries, Scotland in 1974 (Cameron & Spence 1976). But these studies were experimental and small scale and usually with relatively short follow-up.

What had not been developed was a treatment system for a whole population using what might be called the emerging new paradigm. That is what we tried to do in the county of Leicestershire in England.

This case study describes what we tried to do at that time and some of its consequences. It is relevant today because it demonstrates what can happen if a service is allowed to develop away from the mainstream ideology of the time. The reassuring message is that 'nothing awful happened'.

Ideology

We expressed the new paradigm as eleven "articles of faith":

1. There is no such thing as alcoholism.
2. Alcohol dependence is unimportant.
3. People's drinking makes sense.
4. Presenters are different inasmuch as they present.
5. People present at times of crisis.
6. Rejection referral is the usual reason for specialist involvement.

7. Most conventional treatment modalities are useless.
8. Simple human caring skills are helpful.
9. Some therapists are better than others.
10. There is no generally accepted body of knowledge about alcohol problems.
11. Goals of intervention must be negotiated, appropriate, attainable and meaningful.

(Article 6 may need some explanation. Rejection referral is where the prime motivation for passing someone on to another agency is so that the referrers no longer have to deal with them themselves.)

Even now these "articles of faith" so starkly stated look quite extreme. But there was a substantial literature to support every one of them, based on the work of such people as Pattison (1966), Sobell & Sobell (1973), Heather & Robertson (1981), Shaw et al. (1978), Room (1979), Costello (1975a; 1975b), Glaser (1978), Truax &. Carkuff (1967) and Rogers (1951): all prominent names in the 1970s. When I appointed a team to start developing the Leicestershire Services I inculcated into them those beliefs and attitudes.

What would a treatment system which had those beliefs as its operating principles look like? It would not be medicalised. It would not be an inpatient unit. It would not use compulsion. But it would accept that the service users were responsible for their own behaviour. It would accept that people will go on with a behaviour (however maladaptive) while they are "getting away with it". Only when something goes wrong, such as someone complaining, trouble with the law or physical illness, are they likely to "decide" that something needs to be done and present for help. It would be fast-acting and accessible. It would be community based. It would be pragmatic and eclectic. It would be amenable to negotiation about goals and outcomes. It would allow people to come and go. It would provide a wide range of intervention options.

Implementation

What we developed was a tiered system, as illustrated in Figure 1. It was a very simple idea. People presented from the community directly to the Alcohol Advice Centre. They could be referred by a general practitioner, a probation officer, hospital staff, family members or, as was the case with more than half of the presenters, they could self-refer. There two things happened. They were assessed, using a semi-structured assessment form which was common to all parts of the service and immediately offered advice. At the heart of that assessment was a very simple question, "What do you think would be helpful?" and that was the starting point. If all that the presenter wanted was advice, then

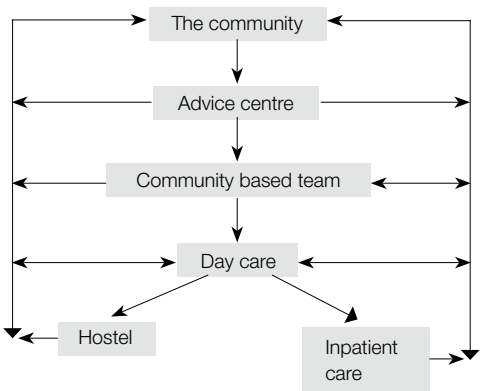

Figure 1. The Leicestershire Community Alcohol Services Model

that was all they would get. We were keen not to "contaminate" presenters with any more treatment than they were willing to accept.

But if the presenter sought something more comprehensive than simple advice, they would be referred to the Community Alcohol Team (CAT), tier two of the model. If the presenters, we called them "customers", could not manage at home, they would drop down another tier, into the day centre. There, group work, occupational therapy and some really quite structured interventions were offered. It operated from 9 to 5 on weekdays. And again, after a period of time in the day unit, the customer would pick up the threads of their lives, returning up to the community.

If even more intensive care was required, there were two residential options, a hostel and general psychiatric inpatient care. The hostel was not a dry house. It was "damp". Drinking within preset limits was negotiable. Some residents wanted to be abstinent, some did not. The hostel had strong links with local housing associations, providing public sector housing, follow-on accommodation. It also offered informal ongoing support for ex-residents. We used inpatient care very sparingly, and for only three reasons. First we offered detoxication if there was no social support at home. Second, if there was an unusual presentation, we might admit for assessment. Third, very occasionally we would use it to remove the drinker from a fraught home situation so that we could start work with the family.

Most of these resources: advice centre, day centre, hostel, hospital are present in most areas of the UK. What was different about us in Leicestershire was that we had a large Community Alcohol Team and all the components of the service operated from the same ideology. That was crucial. It did not matter which part of the service the customers were using, they heard the same core messages.

The services were developed over a period of years as resources became available, and involved collaboration between the Leicestershire Health Authority and Leicestershire County Council Social Services Department. It started in 1977 with a follow-up group for ex inpatients with alcohol problems from the general psychiatry acute admission ward. That follow-up group enlarged to become the day unit. The Hostel was opened in 1977. The Community Alcohol Team was established in 1978, the Alcohol Advice Centre in 1979. The Community Alcohol Team and the Day Unit were Health Authority funded, as was General Psychiatry Inpatient care. The Alcohol Advice Centre and the Hostel were funded by the Leicestershire Social Services Department assisted by central government: a capital grant to buy the hostel building and 'pump priming' for the Advice Centre.

The Community Alcohol Team was the culture carrier. It was multidisciplinary: psychiatrists, nurses, psychologist, social workers, occupational therapist, and normally had about ten members. The team was self-supervising. Team members worked mostly in people's homes, mostly alone, but would go wherever they were wanted. The majority of service users were maintained in the community by the provision of a wide range of interventions by team members. Crucial to the operation of the Community Alcohol Team was the allocation to each customer of a key worker who would be "theirs" for the entire period

of contact. We did our best to match up what we thought might be the needs of the customer with the skills of the therapist but often it was size of caseload which mattered most. During and after the interventions, the presenter was usually living at home and could well continue to be at work.

The key worker would undertake some interventions him/herself but would also recruit other team members for assistance as required. They might also get help from other workers in the alcohol services, or, indeed, elsewhere. What is important about the list is not really what is on it, but the diversity of it and that the choice about what we did was given over to the customer. Of course we would negotiate but we would not dictate. We were attempting to operate what was then considered very important: matching of service to client need. And the best way to determine client need was simply to ask them.

Sometimes that would lead to intervention suggestions which were, to say the least, unusual. For instance the problem reported by one customer was that after a session in the pub he would tend to wet the bed. The solution was for him to change to drinking whisky for the last few rounds of the drinking session, and for him to remain awake after getting home until emptying his bladder one more time before going to bed. That dealt with the presenting problem and he did not need to reduce his session intake.

We would try an intervention for a while to see if it worked, and if no progress was being made, we would try something else. We did not go on pursuing a treatment modality if it did not seem to be working. Table 1 shows the interventions we undertook over the years.

Table 1. Intervention packages

Detoxication
Home based
Hospital based
Abstinence training
Controlled drinking training
Education on alcohol
Time out
Day Unit
Hostel
Hospital
General support and advice
Marital counselling
Sexual counselling
Family therapy
Individual therapy
Women's group therapy
Occupational therapy
Assertion training
Relaxation training
Desensitisation/flooding
Social skills training
Leisure counselling
Job counselling
Help with accommodation
Welfare rights counselling
Medical assessment
Psychological assessment
Medication, including disulfiram (antabuse)
Follow-up
Open contact
Referral to other agencies (including AA)

What is critical to operating in this manner is a belief that the customer is sane, self willed and able to make decisions in their own best interests, including decisions about their drinking. It is the converse of the concept of victim of a disease. We found validation for that view in what the customers said to us at the time of presentation. The question was "On a scale of

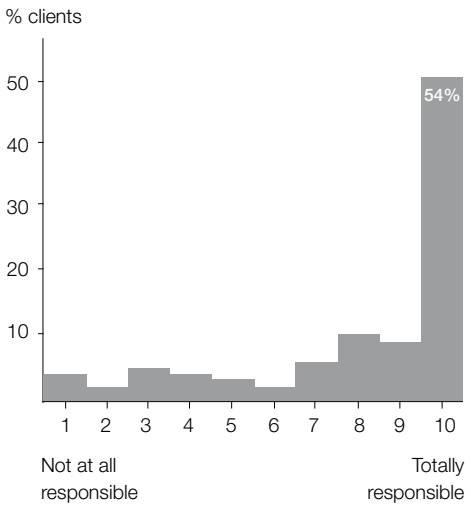

Figure 2. Responsibility for drinking

1–10 how responsible do you feel for your drinking, with 1 not at all responsible and 10 totally responsible?" This is shown as Figure 2.

Length of contact varied, obviously. The mean time in active contact for men was nine weeks, for women thirteen. However, case closure was a ragged process with the keyworker often saying "feel free to get back in touch if you want to". That was 'open contact'. And some cases remained open for years, even though contact would be trivial: a home visit every couple of months when the keyworker was in the area anyway, so-called 'coffee stop visits'. There is much validity in sustained declaration of interest as a 'relapse prevention' measure.

Impact

Although we did gather a good deal of data, we were really operating a clinical service and our outcome data tended to have the usual problems of being self-report, having a relatively short time scale and high attrition. We simply did not have the resources to conduct scrupulous individual outcome studies. As best we could determine it, six months after cessation of intensive contact a quarter of our customers reported being totally abstinent, and those still drinking reported consuming approximately half what they reported at initial assessment. (Cameron 1995) Those data are not robust but the data presented below are, although they are open to a number of possible interpretations of which the impact of our services is but one.

To understand these data, it is necessary to describe Leicestershire and the surrounding counties. Leicestershire is in the East Midlands of England. It is diamond-shaped and approximately 80 km East-West and 50 km North-South. It is semi-rural and the county town, Leicester is in the centre. There is a circle of small market towns all about 20 km from the centre. Its population was then approximately 850,000, with a third of them living in Leicester city. At the time of this work, one third of Leicester city residents were from ethnic minorities, mostly from the Indian subcontinent, many via East Africa. When these data were collected, Leicestershire County Council, which included the city of Leicester, provided Social Services. It, the Health Authority and the County Constabulary (Police Force) all shared common boundaries.

There are two neighbouring counties which are very similar to Leicestershire: Nottinghamshire and Derbyshire. They have similar size, demography, population, similar county towns, similar levels of employment mostly in light industry,

similar levels of alcohol consumption, similar deprivation scores. But when these data were collected they had very different alcohol services. Nottinghamshire had an inpatient alcohol treatment unit, a dry hostel and an advice centre. Derbyshire had two advice centres but no other specialist alcohol services. So there was the potential for a natural experiment comparing Leicestershire's comprehensive community based service with a more conventional service in Nottinghamshire and in Derbyshire effectively a control. It was possible to gather data on referral rates and indices of alcohol related harm. The data were extracted from the Annual Reports of the local Alcohol Advisory Services (which have to submit returns for national collation); from the Local Health Authority's data sets which used the Hospital Activity Analyses (HAA); from death certificates submitted to the English Registrar of Birth, Deaths and Marriages; from the records departments of the three County Constabularies. A more detailed account of this work and all these figures may be found in Cameron (1995).

Leicestershire with its heavily backed up advice centre, had a burgeoning referral rate, far outstripping the other two (Figure 3). It achieved much greater "market penetration". That would be expected, but what would not necessarily be expected would be these: Alcohol-related deaths and discharges, over the years, Leicestershire got fewer (Figure 4); Cirrhosis deaths, Leicestershire got fewer (Figure 5). Even alcohol related arrests, Leicestershire got fewer (Figure 6). These graphs demonstrate some of the more striking findings. But what they show is consistent: across a number of indirect indices of alcohol problems, some years after implementing "our" model of alcohol services, Leicestershire seemed to start showing reductions in alcohol related harms compared with similar neighbouring counties. Of course all the usual caveats about temporal correlational data need to be applied.

This was not the only study that had shown a possible treatment effect on the levels of alcohol related harm in the general population. There was a notable study in Ontario suggesting something similar (Mann et al. 1988).

It was possible that with this high "market penetration", helping a large number of people to cut down or stop their alcohol consumption, even if only in the short term, was having an impact. Of course we will never know. But we could say that our unusual form of service met and engaged with a lot of people, over 10,000 in fifteen years, and did not appear to do any harm. Indeed it might have been doing some good, not only for individuals but for the community at large.

Instability

So, what happened next? In 1979, in Britain, a Conservative Government was elected, with Margaret Thatcher as Prime Minister. She was a right wing libertarian who disapproved of powerful local government, of professions, of anything smacking of monopoly. She believed in the free market. She famously said there was no such thing as society. It did not happen instantly, but her government gradually demanded that competition be introduced into health and social care.

The Leicestershire service was a monopoly. It might have been a service which offered its customers a free choice of many

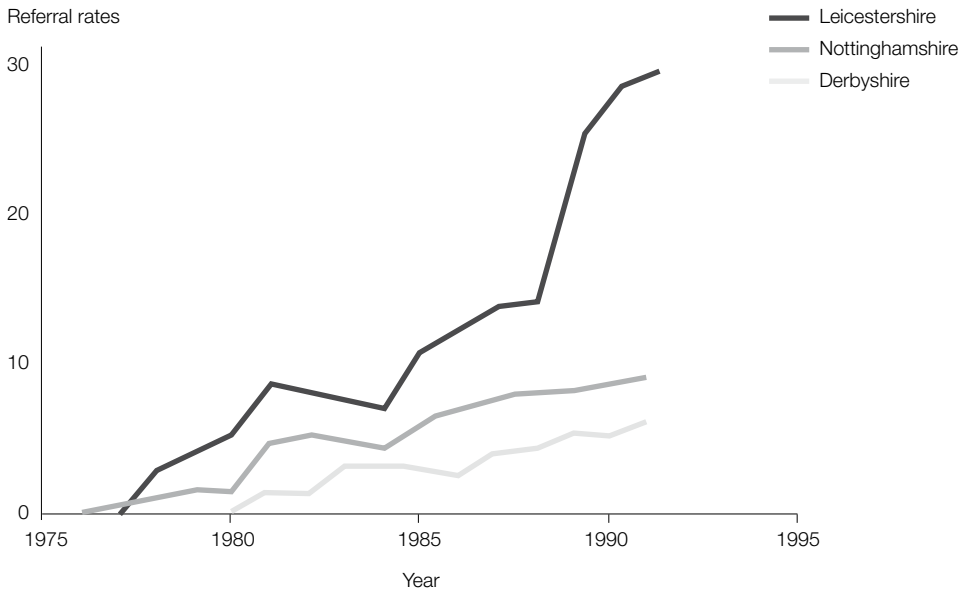

Figure 3. Rates of referral into community-based counseling services per 10,000 population

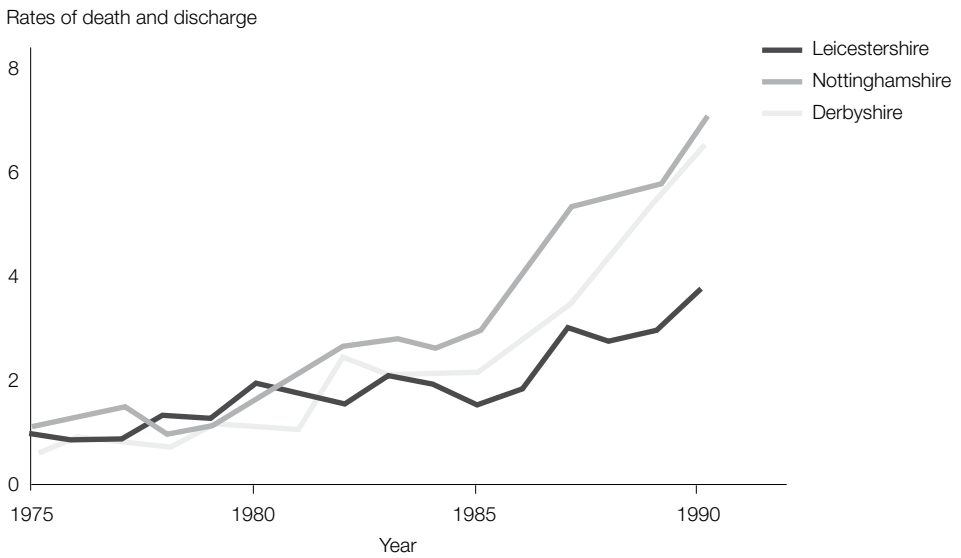

Figure 4. Rates of death and discharge from general hospitals: alcohol dependence and alcoholic psychosis per 10,000 population

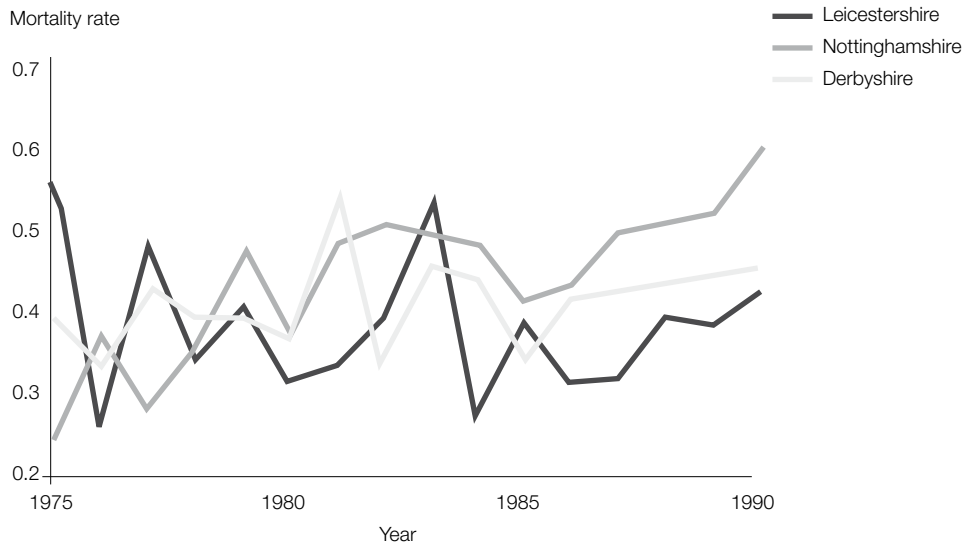

Figure 5. Mortality rate from hepatic cirrhosis and chronic liver disease per 10,000 population (ICD10 Code 571)

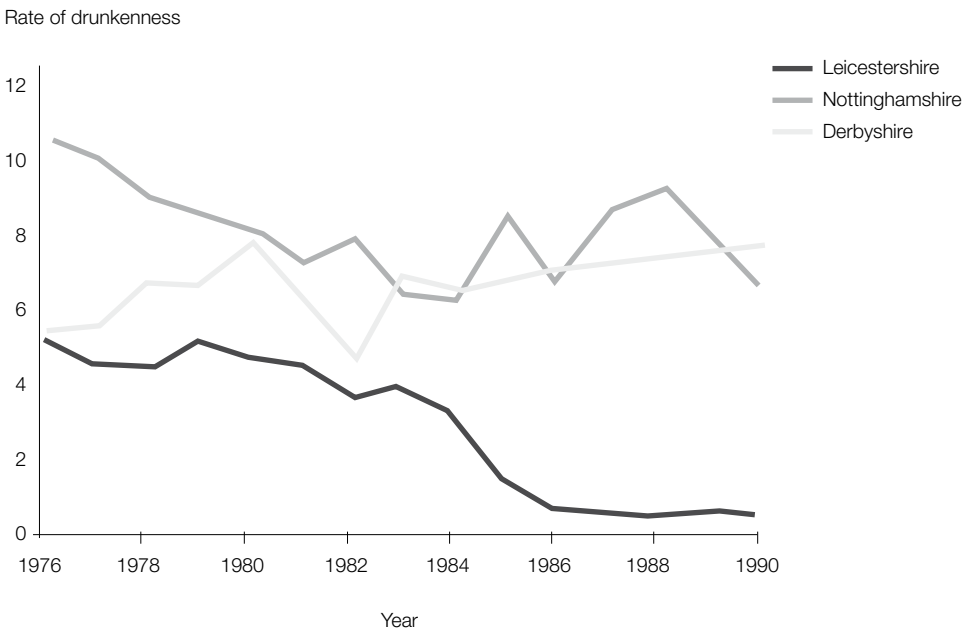

Figure 6. Rates of arrest for drunkenness (excluding drink/driving) per 10,000 population

service options but it still counted as a monopoly. So, the individual components of the service were forced to compete with each other. The informal collaboration was discouraged. And then market forces came into play. The Advice Centre was taken over by a larger NGO more interested in youth and criminal justice. It actively promoted competition between itself and the Community Alcohol Team. In healthcare, General Practitioners (GPs) who wanted them were given their own budgets to spend on secondary care. So self-referrals to the Advice Centre could only be done with GP approval which was not necessarily given. And a Minnesota Model residential clinic opened in Nottingham and started marketing itself with outrageous claims of efficacy. Our health service funders started insisting on us offering more inpatient care because otherwise they would have to pay for people to go to the Nottingham Clinic. The social services funded hostel could not compete with, to them, free residential care in hospital. Its occupancy dropped. It tried to broaden its base to include users of other substances. It became run-down and lacking in direction and was closed in 2000. The day centre was moved from the health service to social services. It was taken over in 1997 by the same organization which took over the advice centre but is no longer an integrated tier.

Another significant trend also led to fragmentation of the integrated service. In Britain, there are a number of national organizations which bid for contracts to run non-statutory services in the substance misuse field. They have departments whose function is to put together bids. Small local organizations have difficulty competing with the professional bidding styles of such bodies, which have been known to put in spuriously low bids and then come back seeking more money at a later date. Of course they appeal, initially at least, to service commissioners but what they do is "parachute" a service into a specific area without regard to what is there already. Although initially cheap, what they do not have is what Trevor McCarthy (2004) has called "partnership capital"; those links, understandings and goodwill cultivated over years of collaborative working. In Leicestershire one of these large national organizations opened a stand-alone agency in the largest of the market towns. It did not share the ideology of the existing services.

Furthermore, Leicestershire County was broken up into three: Leicester City, Rutland County to the East and the residue of the county, a strange ring round the city. The heath authority has been dismantled into three too, but the boundaries do not converge with the local authority boundaries. The data that were available for me to collect with relative ease became fragmented, with differing geographic boundaries between the data sets. We no longer can track exactly what is happening without going back to individual person data, which is all but impossible to do. We simply do not know what is happening anymore. The neighbouring counties have developed services much more like the Leicestershire model, with community alcohol teams. But they, and our Leicestershire team have become much more medicalised with a greater emphasis on detoxication, with the advice centres, allegedly, doing much more social care. The Community Alcohol Team is now

perceived primarily as providing predominantly a home detox service and not an eclectic multidisciplinary response to its presenters. General practitioner referrals now predominate, and no longer need to be assessed first at the AAC. They can be referred straight into the second tier. We had always blurred the boundaries between health and social care. That is much less easy to do now. Informal grassroots collaborations are discouraged. Separate funding streams have always existed but more rigid lines of demarcation and accountability between health and social care are now the norm.

As this article is being written all components of the old Leicestershire services are being subjected to competitive tendering. Depending upon the outcome of that process, the whole tiered system might finally be gone. So, there it is: a bold experiment that lasted for more than twenty years but was then gradually fragmented such that it became no longer a functioning system.

Implications

It is worth speculating upon what is the place of "maverick" service styles in the current climate of "evidence based medicine", and whether they have a place in generating lasting change.

The first thing to say is that, in Britain anyway, we could not now do what we did in the 1970s. Effectively at that time we could define our own service ideology and working practices and draw up our own service specification. At that time the so-called evidence base, such as it was, was about abstinence rates and the idea of allowing people to make a decision to try and moderate their consumption was a heresy. The evidence base now uses language like brief interventions for hazardous drinkers, harmful drinkers, dependent drinkers and dual diagnosis. And there are guidelines about how to treat these "conditions". In Britain anyway, you do not get funding if you try and offer unusual interventions. A top down template needs to be implemented and of course that template adheres to mainstream beliefs, the current zeitgeist. The ridiculous thing is that the current top down template looks strikingly like what the Leicestershire services looked like twenty years ago, and not what they look like now. The risks of this kind of state sponsored "top-down" dictat were highlighted over thirty years ago by Mulford (1979). So how will evolution and change happen in the future? Someone has to be brave enough or stupid enough to give it a go, and to be allowed the space to do it. But to do so was to engage in a risky venture which would not have been possible without the support of many people some of whom shared the vision and some of whom did not but were willing to let us get on with it. For us, the fellow travelers could be found in such places as The New Directions in the Study of Alcohol Group. And locally we were lucky to have a number of National Health Service and Social Services managers and voluntary management groups who believed in collaboration and were willing to trust us.

There is a fundamental conflict between enforced competition, adherence to the mores of the market, and the possibility of long-term collaborations, of developing partnership capital. As Trevor McCarthy (2004) says, "*Partnership capital* can be seen as the value a local commissioning

area gets from having integrated collaborative constellations of services in the different sectors which manage to work together for the benefit of local service users. This value is difficult to put a price on – except that you know when you aren't getting it. Competition and failure to collaborate between local service providers is hard for commissioners to manage." It might be that a comparison of the Leicestershire and Nottinghamshire services could put a price on the value of partnership capital, providing evidence that an integrated tiered whole did provide greater value than the sum of its parts.

So, looking back from the position of a retired person, what do I think our Leicestershire services achieved? At one level, they provided a service for many of the drinkers of Leicestershire who got into difficulties, and did so with enthusiasm and care. At another level, the services provided a beacon, a model service which was visited by people from many places and which was described and discussed at many conferences and other fora. It is my personal view that the presence of the Leicestershire Services helped some people to be braver in what they offered in their own workplaces, and played some part in supporting our changing beliefs about the nature of people with alcohol problems and some part in shaping a national template for alcohol service provision.

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