

**COMMENTS ON CONSULTATION DOCUMENT**

National Alcohol Reduction Strategy

## **SERVICE BACKGROUND**

The CNWL Mental Health NHS Trust currently provides drug and alcohol services for six boroughs: Westminster, Kensington & Chelsea, Hammersmith & Fulham, Ealing, Harrow and Hounslow.

These services consist of the following units (descriptions are brief synopsis):

Central Assessment Primary Services (CAPS) South – K&C and H&F first point of contact at drop in and also GP liaison.

CAPS North, now named Westminster SMS Assessment Team – first contact at drop in or A&E liaison, also GP liaison.

Soho Square Alcohol Team – relapse prevention for Westminster and K&C, plus some hospital liaison.

Wolverton Gardens Alcohol Team – relapse prevention for H&F, plus some hospital liaison.

Gatehouse alcohol Team – first point of contact for Ealing by appointment, also relapse prevention support, plus some hospital liaison.

Hounslow CDAS – has alcohol workers, first point of contact for referral to in-patient unit at the Max Glatt Unit.

Harrow – has community alcohol liaison and hospital liaison, first point of contact for referral and onward referral for in-patient detox.

The Max Glatt Unit - CNWL SMS inpatient drug and alcohol detox unit. Based at St Bernards Hospital, Ealing, but takes referrals from all of the above except K&C and Westminster.

Although there has been a considerable expansion in service provision for drug users over the years, it has proved very difficult to develop alcohol services due to lack of funding availability, especially in the health sector.

Despite this challenge, our service has developed alcohol services in each sector, offering a range of multidisciplinary interventions based on best evidence available.

Based on the total funding for our service (£10,330,535), the proportion of money spent on alcohol services is around 15%. This does not allow for the alcohol work that goes on at the drug treatment centres, secondary to opiate use, nor does it include GP liaison work, but it does account for services that see both drugs and alcohol clients.

Based on activity at CNWL services for 2000 to 2002 (in Hammersmith & Fulham, Ealing, Kensington & Chelsea and Westminster sectors only), around 40% of new admissions were alcohol assessments. During 2001/2002, 19% of all alcohol clients (n=1445) were one off advice and information sessions, against 5% of all opiate clients (n= 2591).

## **CURRENT SERVICES: TIER STRUCTURE**

The service has concentrated on developing tier 2, tier 3 and tier four services to address the needs of clients presenting with significant alcohol problems usually in the context of significant physical social and psychological consequences. Currently the service has agreed guidelines for the management of alcohol problems within the service that is to provide evidence based practice. These guidelines are reviewed periodically within the clinical governance structures within the service.

Tier 0: Little or no development in any of the borough covered by the service. Urgent need for PCT to address public health initiatives needed. One borough (Hammersmith & Fulham) has employed an alcohol co-ordinator to address the borough's alcohol policy, but is limited what this post can achieve without additional funding. However this is a useful post to be able to co-ordinate alcohol provision in the locality.

Tier1: Liaison with hospitals has been the main focus for the service including liaison with A&E. This has been an important target for the service to reduce readmission rates and access those clients presenting with health consequences. There is current need to expand this to make significant impact. It is our recommendation that every general hospital should have a liaison nurse/ health specialist to be available for training and support non-specialist on screening and brief interventions as well as offering specialist assessment, engagement and referral on to specialist service.

Tier 2: There has been no access to funding for liaison with primary care. As a service we have not been able to access funding to develop support and liaison with GP's as funding has only been available for the voluntary sector. We feel that we have a role to play in supporting primary care teams in particular on the management of for example prescribing in general practice. As part of the shared care schemes we offer for opiate users, we often have demands from GP's to provide support and interventions for patients in their care and this is an identified gap.

We currently offer open access drop-in services (Tier2/Tier3) with brief assessment as well as offering tier three interventions for those identified for example requiring access to out-patient detoxification. This is delivered in assessment teams for drug and alcohol users, and combining this function for both drugs and alcohol has been effective use of resources. Separating this assessment function from longer-term interventions for alcohol users has been a useful model for some part of the service. This has meant that we have developed teams specialising in brief assessment/ treatment prioritisation (triage) which is based on assessment of client risks.

Tier3: Each sector has alcohol teams that offer appointment base services for problem drinkers and their families/ significant other, and the emphasis has been on developing multidisciplinary interventions that share and understanding of biopsychosocial model of addiction. This includes specialist

nurses, occupational therapists, psychiatrist, psychologists and family therapists.

In addition we have developed interventions to target specific populations:

These has included developing partnership for the provision of the following

Women's service

Gay men's group

Ethnic minority services (in particular Asian)

Young people

These initiatives have taken part in different part of the service reflecting local population needs. However there is a priority commitment to have women only drop-in sessions which have impacted on positive engagement of women in service. Again providing women's session for both drug and alcohol users have been essential in the development of these services. Currently there is a need to develop interventions that take into account of the effect on children of those currently in treatment and the development of for example parenting services will need to be addressed.

There is currently an urgent need to develop services for under 16 but current funding structures prevents development of services for example across sectors, and their needs to be national directives joint working arrangements with local CHAMS services.

Dual diagnosis post have been developed in the service with the aim of providing training and liaison to CMHTS, Currently the service has written a dual diagnosis strategy, which gives direction and recommendation for this service

Tier 4: The service currently provides an in-patient detoxification service for Ealing Hammersmith and Hounslow and this unit offers detoxification for drug and alcohol clients. It has been useful to combine resources for drugs and alcohol in the provision of this service, which can take clients with complex and poly-drug use.

A tier 4 service is provided by the private sector with medical input from our service in Kensington Chelsea and Westminster. It has been part of the service strategy to develop an in-patient detoxification service, which can provide a comprehensive service across all boroughs, and can work within our currently agreed clinical guidelines.

The main challenges we have faced as service has been the lack of agreed standards and national guidelines. Due to changing commissioning structures it has been difficult to provide equity of service across all boroughs and some areas alcohol has been historically neglected. Lack of resources together with a critical approach from commissioners to health providers has made any developments difficult to realise. Currently despite good achievements some commissioner are reluctant to invest in the development of health based alcohol specialist, against some of the overwhelming evidence available in the contrary.

There is a need for some governance of commissioning as this is having major impact on service development.

## COMMENTS FOR THE STRATEGY

As a service we selected the section on “Health: prevention, treatment and impact on the NHS” for comments, as this section from the consultation document relates most to our experience of service provision.

The following is summary of our comments gathered from the five alcohol teams and the senior clinicians for the service, which reflect our current practice.

Questions:

### 1. How do you define harmful drinking? What factors do you take into account in deciding whether heavy drinking has become problematic drinking?

- *Thorley (1) described three types of alcohol problems in an attempt to move away from thinking that alcohol related problems belong only to “alcoholics” who are all too readily seen as a minority and deviant group. These three types of alcohol problems (problems of intoxication, problems of dependence and problems of excessive use) have been an important distinction to make when identifying interventions for different problems drinker presenting in different settings. Within this identifying biological sociological and psychological factors in presentation has been the basis of multidisciplinary assessments.*
- *To be able to define alcohol dependence is an important therapeutic task, as it will often dictate treatment options and treatment modality. It is important to be able to distinguish dependent use from say harmful use, so those clients requiring detoxification for example can be identified.*  
*The ICD-10 (2) offers internationally agreed criteria for the diagnosis of dependence syndrome as well as well as defining related substance misuse patterns e.g. harmful use. This has been the agreed criterion within mental health settings.*
- *As a service we make use of different diagnostic tools to assess the nature of alcohol problems in different settings. These are:*  
*\*The Severity of Alcohol Dependence Questionnaire (SADQ) is a useful as clinical and research tool to assist clinicians in measuring degree of dependence be completed by the presenting client to aid assessment (3).*  
*\*There are many screening tools available for the detection of alcohol problems in general population. Two of these questionnaires are currently recommended by the service*  
*The AUDIT (4) is a 10- item questionnaire that is used as a screening instrument for hazardous or harmful alcohol consumption. It aims to screen people experiencing alcohol problems who may benefit from further assessment and intervention. This is a simple questionnaire that can be used to screen patients presenting in general settings i.e. General practice or in-patient admissions.*  
*The PAT (5) was developed at St Mary’s A&E department to enable medical staff to identify alcohol problems for referral to the specialist liaison service we offer in A&E for further screening and assessment. This was developed to be simple and quick, taking an average of one minute to complete, which was more realistic for this stressful and demanding setting.*
- *Some of current challenges are those of defining/ measuring binge drinking and developing consensus and an evidence base for the most effective treatments that should be targeted for this group.*
  1. Thorley, A. “ Medical responses to problem drinking”, Medicine ( 3<sup>d</sup> series) 35 (1980)pp.1816-22
  2. World Health Organisation (1992). *The ICD-10 Classification of mental and behavioural Disorders: Clinical Descriptions and Diagnostic guidelines*. Geneva: World Health Organisation.

3. Stockwell, T., Hodgson, R., Edwards, G., Taylor, C. & Rankin, H. (1979). The development of a questionnaire to measure alcohol dependence. *British Journal of Addiction* **74**, 79-87.
4. Babor, T.F., De la Fuente, J.R., Saunders, J. & Grant, M. (1989). *AUDIT, The Alcohol Use Disorder Identification Test: Guidelines for use in Primary health care*. Geneva: World health Organisation.
5. Smith, S.G.T, Touquet, R. Wright, S, Des Gupta, N. " *Detection of alcohol misusing patients in accident & emergency department : The Paddington Alcohol Test (PAT)*". *Journal of Accident and Emergency Medicine* 1996;13: pp308-312

## 2. What are the costs to the NHS both directly and indirectly due to alcohol?

- *Excessive alcohol use is a common cause of admission to hospital, as studies have shown that up to 25% of patients in hospital are found to be heavy drinkers (1). Usually only those patients with chronic alcohol problems are detected and referred to specialist services and the great majority of early stage problem drinkers who may benefit from simple advice and information go undetected. This percentage rises in mental health settings where up to 50% patients may be experiencing alcohol problems.*
- *Direct costs of alcohol related liver and gastrointestinal, cardiovascular, neurological/ musculo- skeletal, endocrine as well as mental health problems ( depression ,anxiety) and those relating to cognitive impairment (Korsakoff and dementia). Attendance in A&E and burden on A&E staff of dealing with intoxication in particular at weekend.*
- *Indirect costs: patients who drink excessively attend GP surgeries more frequently ( up to 5 times). High levels of DNA rates to appointments and even cancelled operations may be contributed by alcohol. Costs to workforce, and alcohol related problems for the workforce have not been studied ( estimated 10% doctors alcohol dependent by BMA) Workplace alcohol policies are patchy within the NHS and very little assistance is offered to staff when problem is identified.*
- *There needs to be a focus in research of alcohol related deaths in particular with young people which far outweighs that of drugs*
  1. A.B.C of Alcohol, British Medical Association (BMA) Publishing Group, 1982 London

## 3. What are the most appropriate means of prevention of alcohol dependence and serious misuse? What form of training are most appropriate for professionals in health and social care, as well as other fields, who play a role in prevention?

- *Large evidence base for brief interventions in general settings for those who may be drinking hazardously but not dependent clearly shows effectiveness. Alcohol is a public health issue and screening for problems should be part of every health and social care professional. For this to happen, alcohol assessment and interventions should be an integral part of professional academic programmes. Currently the approach is patchy and often depends on academic champions rather than agreed national standards. Investment in education is the key for better screening and early treatment of alcohol problems. For example some universities have alcohol or substance misuse specialist teaching staff but not others.*
- *Investing hospital liaison services is essential in the ongoing professional development and support as well as for providing a link between general and specialist settings. Our service provides a limited liaison service due to lack of resources, but this is an area that has been identified across sectors as one needing investment that can yield great benefits. NHS alcohol teams have the knowledge and expertise to be able to take on not only direct patient contact but alcohol to provide specialist education training and consultation which is needed with constantly changing workforce in hospital settings.*
- *Liaison with GP services is also an essential role of health care professionals. NHS based alcohol teams have not been able to develop these services as funding has only been made available to the voluntary sector. We would argue that it is essential to include health care specialist in the development of GP liaison services to train and*

support primary care staff in the management of alcohol problems in primary care and the development of treatment pathways.

**4. Brief interventions, How they work and how they might work better?**

- As stated above good evidence for brief interventions. However current limited alcohol resources have been targeted to those with significant alcohol problems as they cause the most costs to NHS. There needs to be investment in brief interventions in general settings for impact to be significant.
- Further research is needed in focusing on brief interventions for minority groups, and in particular women as the evidence appears less effective
- Training and support of non-specialist in the delivery of brief interventions is essential part of the development needed.
- It is important the where brief interventions are offered there needs to be support from specialist services to be able to offer more intensive treatment for those people identified with significant alcohol problems

**5. Do current treatments work? Need for guidance to commissioners? How should individuals access?**

- There is increasing evidence for the fact that treatment works and that there needs to be range of treatment options available which incorporates existing evidence.
- Our service has developed out patient treatment options which incorporates a range of interventions:
  - Important for clients to have a choice of goal reduction, controlled drinking and abstinence.
  - Out-patient detoxification effective alternative were no significant health risks are identified with access to in-patient for those requiring this
  - Motivational interviewing as a counselling approach to direct clients towards change has been found to be effective.
  - Use of acamprosate and disulfiram to assist in abstinence as an adjunct to counselling has been found to improve outcomes for some clients and this needs to be made available and supported
  - Case management is an important component for co-ordination of interventions over time
  - Relapse prevention/ skills training is also essential aspect of alcohol treatment that is supported by the evidence.
  - Couple therapy/ family interventions can significantly improve outcomes.
- Adopting a stepped care approach has been essential in the delivery of service, These clients with hazardous but non-dependent drinking may benefit from brief advice and intervention but those with more significant problem may require more intensive interventions,( out-patient, day programme and in-patient). This requires the service to work closely with social service for community care provision and to provide on-going case management and follow up to promote relapse management. The service has developed a model of supporting client less intensively over a longer period of time.
- Development of a women's service has also been an area of development for the service as there has needed to be improved access to service for women. Having women only access point has had a significant impact on women engaging with the service as they encounter more barriers in accessing treatment. Women only drop-ins should be recommended for improving access.
- Needs to be understanding that for women and some ethnic minorities, for example some Asian group are more likely to develop serious health sequale form alcohol, such as cirrhosis and interventions to target these groups earlier need to be developed.

**6. What can be learned from drugs prevention and treatment?**

- National strategy with funding attached has made significant changes in drug treatment which is required by alcohol services
- Appointment of regional alcohol co-ordinators in the late 1980's was unable to make impact on service provision, as there was no funding to support any initiatives.

- *A public health model needs to be applied to alcohol, which cut across primary secondary and tertiary care given the much bigger prevalence compared to drugs.*
- *Needs to be many more funding initiatives that ensure that health social care and voluntary sector work in partnership by identifying clear pathways between them. There needs to be an acknowledgement that a range of treatment options available and these should be delivered in partnership*
- *Integration of health and social care is needed for effective working*

**7. What can minimise and prevent injuries that present to A&E?**

- *Importance for the use of safety glass. Recent trend of serving bottle rather than glass. Need to promote plastic bottles??*
- *Important to stop trend of encouraging binge drinking by reducing drinks promotions “happy hours”*

**8. Links between alcohol misuse and mental health? How can these service be co-ordinated?**

- *Prevalence of co-morbidity is particularly significant for alcohol with depression and anxiety disorders .*
- *There needs to be joint working between mental health and substance misuses service. The creation of liaison posts in crucial for ensuring there is haring of expertise and joint working. These liaisons posts need to be accompanied by a training strategy to target prevention and early intervention.*
- *Such initiatives need to be co-ordinated via PCT as separate funding structures can often deter development of services*
- *Models of intervention for co-morbidity mainly developed in the USA and difficult to assess if such initiatives can be applied here. Important to evaluate the UK experience to make recommendations about the kind of service to offer client with complex needs. Currently the service has developed a dual-diagnosis strategy which is currently under consultation*