NATIONAL ALCOHOL HARM REDUCTION STRATEGY

Response to the Consultation Document

Health: prevention, treatment and the impact on the NHS

The affects of alcohol misuse cost the NHS money. There are direct costs both to the NHS and in social care in treating those with alcohol dependence. And there are a host of indirect costs through alcohol-related illnesses and accidents; through violence fuelled by alcohol; and through mental illness and depression associated with alcohol misuse; and through the mixing of alcohol with illicit drugs. But there is also some evidence that moderate alcohol use for some groups can be beneficial to health.

Questions

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

‘Drinking to the extent which causes physical, psychological, or social problems for the drinker and/or other people.’

The factors taken into account relate to the physical, psychological and social well being of the drinker and/or other people affected by someone else’s drinking.

Please note that ‘problematic drinking’ does not necessarily require someone to be drinking heavily. For some people one or two drinks can be problematic, e.g. when mixed with prescribed medication, other drugs, for people experiencing mental health problems, for somebody living within an abstinence based community, etc.

15. How clear is the evidence both for the health costs and the health benefits of alcohol? Are there key pieces of research of which we should be aware? Where are the gaps in the evidence?

I would refer you here to documents published by Alcohol Concern. Also to Dr Christine Godfrey, Centre for Health Economics, University of York.

16. What are the costs for the NHS both directly and indirectly due to alcohol? We will be examining evidence on this but would welcome your views and any evidence you think we should be aware of

Again, I would refer you to the economists mentioned above. Direct costs include those incurred through the provision of treatment services, A & E departments, Maxillo Facial Injuries units, assaults on staff, NHS staff absenteeism due to their own alcohol misuse, cost to acute wards eg liver.

Indirectly, alcohol is know to exacerbate many health conditions including those outlined in the NSF’s of Coronary Heart Disease, Diabetes, Elderly and Mental Health.

Costs to community services such as Podiatry should not be overlooked. Neither should the cost of treating people whose physical, psychological and social well being is affected by someone else's drinking.

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

Within the NHS, I would suggest that training for health and social care professionals include basic alcohol awareness training (units, daily/weekly limits, the impact of drinking on the physical, psychological and social well being of the drinker or others affected by someone else's drinking). Also skills in screening for alcohol misuse and early/brief interventions, and access to services. Interactive 'forms' of training are most appropriate for health professionals.

Cascading training can ensure widespread dissemination of information and skills development. For example, the Royal College of General Practitioners (RCGP) recently embarked upon training for health care professionals centrally with an expectation that the training would be cascaded to peers in their locality. Where this includes local specialist services we can ensure a 'joined up' approach. For example in Manchester the Community Alcohol Team (CAT) is facilitating training for midwives and district nurses in collaboration with the Alcohol and Drugs Specialist Midwifery Department recently trained by RCGP.

The CAT has also established provision for this type of training to be available for GP's and practice staff through 'Protected Learning Time' (PLT) events. South Manchester PCT has already scheduled a PLT event, North and Central Manchester PCTs are currently being approached to do so.

18. "Brief interventions" can be offered to patients who have been identified as at risk from alcohol misuse. They may consist of a short session with a doctor or nurse to discuss a patient's drinking and to offer help and support to cut down on alcohol intake, if the patient wishes to do this. How effectively do you think those at risk are identified? How well have you found brief interventions to work and how might they work better?

The effectiveness of identifying these at risk will depend on the screening tool used to identify those at risk from alcohol misuse, how routinely screening tools are used and the quality of training received by those using the tools.

The specificity and sensitivity of screening tools such as Audit and Fast have been documented, including the comparable time/cost taken to administer such tools.

Currently the CAT is involved in a nationally funded Randomised Controlled Trial (RCT) for screening and brief interventions being undertaken at the Maxillo Facial Injuries Unit at the Manchester Royal Infirmary. Also an Alcohol Arrest Referral Programme with Greater Manchester Police has been established. The results of these will continue to inform locally how best to improve the effectiveness of brief interventions in non-alcohol specialist settings.

In General Practice it is not always possible to screen the total practice population for alcohol misuse, it may therefore be necessary to embark upon 'selective screening' for specific populations. E.g. people with high blood pressure, smokers, pregnant women, elderly, specific cultural groups, individuals experiencing symptoms such as anxiety, depression and insomnia.

The potential for screening and brief interventions should not be overlooked for implementation in non-alcohol specialist services such as podiatry and for those working in the NSFs listed earlier.

19. Do current treatments for alcohol dependence and hazardous drinking work? Are they sufficiently tailored to meet differing individual needs? Are there other forms of treatment we should be aware of? Is there a need for guidance for the commissioners of local treatment services? How should individuals best access treatment services?

Current treatments for alcohol dependence and hazardous drinking do work. In Manchester we have The Manchester Alcohol Service (MAS). MAS is a partnership of four providers; Primary Care Trust CAT, Turning Point's Smithfield Project, Social Services Alcohol Care Managers, and The Brian Hore Unit provided through the Mental Health and Social Care Trust. MAS offers a single point of entry into a comprehensive range of sevices from advice to post detox rehabilitation. The Commission for Health Improvement (CHI) recently commended the CAT's approach to true multi agency partnership working thereby offering a seamless service a a model of practice transferable to other parts of England.

The MAS partnership extends to working with non alcohol specialist agencies such as Greater Manchester Police, The Lesbian and Gay Foundation, Maxillo Facial Injuries Unit., Domestic Violence agencies………………….

The CAT has also embarked upon a mainstream 'Divesrity Programme' to systematically ensure that the service is appropriate and accessible for Manchester's culturally diverse population.

Guidance for commissioners is required, particularly with minority ethnic communities, Hyare I.S. in ' The Development of Alcohol Services for the South Asian Communities: Models of Good Practice' developed an Expected Alcohol Problem ratio and formula. This ratio and formula allows for the identification of the proportion of clients from different communities that might be expected at an alcohol service taking into account demographic variations around ethnicity and differing levels of alcohol consumption between communities.

Whilst the evidence base for the use of complimentary therapies is yet to be fully established, research indicates that the provision of such therapies alongside conventional psychological therapies attracts people into a service and reduces drop out rates (see Southall AAS case study in the document identified above by Hyare I.S.).

There appears to be little clarity around commissioning services for young people and adults where there is a considerable age range overlap, for example, 16 – 25 year olds fall between young people and adult categories.

20. What can we learn from drugs prevention and treatment?

That they have a lot more resources and serious investment needs to be made for alcohol services. It is not simply that current resources can be used more effectively via reconfiguration.

21. How, in your experience, can we minimise and prevent the injuries that are presented to A & E departments as a result of alcohol related assaults (often with glasses and bottles) or home and workplace alcohol-related accidents?

City Centre Safe Manchester (includes public information campaigns, late night transport, CCTV, server training.) CAT - arrest referral and Maxillo Facial projects. Details of these have previously been made available to the members of Strategy Unit during their recent visit to Manchester.

The Criminal Justice Pathway (CJP) needs to be mapped. We are currently preparing a bid to submit to Invest to Save plotting the intervention points needed along the CJP together with some preliminary cost/ benefit analysis.

Workplaces should have policies and procedures to identify and respond to any employee experiencing difficulties with their alcohol use. They need to work in partnership with local alcohol services.

22. What are the links between alcohol misuse and mental health problems, including depression and suicide? How are services —both those aimed at prevention and treatment – best co-ordinated?

Here I would refer you to Slade Carter project manager for Alcohol and Mental Health, Alcohol Concern London.

In Manchester, the MAS is working alongside Mental Health Services, and the Clinical Nurse Specialist for Dual Diagnosis whose responsibility is to co-ordinate and implement a city wide dual diagnosis strategy.

Joint assessment protocols are yet to be established. There may be a tension in wishing to work concurrently between alcohol and mental health services with those people identified as having a concurrent alcohol and mental health problem. The tension exists were waiting times to access services differ significantly. It may be consecutive working will be necessary until mental health services can bring their waiting times in line with alcohol services.

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