



National Audit Office

DEPARTMENT OF HEALTH

Reducing Alcohol Harm: health services in England for alcohol misuse

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in England for alcohol misuse

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SUMMARY

1 For a significant and growing number of people in England, alcohol consumption is a major cause of ill-health. More than 10 million people (31 per cent of men and 20 per cent of women) are now regularly drinking above the guidelines set by Government, and many of these are likely to suffer ill-health or injury as a result. Hospital admissions for the three main alcohol-specific conditions (alcohol-related liver disease, mental health disorders linked to alcohol and acute intoxication) more than doubled in the 11 years between 1995-96 and 2006-07 from 93,459 to 207,788, although this is in the context of a general rise in admissions of about a third over the same period. There were 8,758 deaths from alcohol-related causes in the UK in 2006, twice as many as there were 15 years before.

2 The Department of Health (**the Department**) estimated in July 2008 that alcohol misuse costs the health service in the order of £2.7 billion per year. Such misuse also imposes wider costs on society, such as crime and disorder, social and family breakdown and sickness absence. The total annual cost of alcohol misuse to the UK economy has been calculated by the Cabinet Office at up to £25.1 billion.

3 The World Health Organization has identified four levels of alcohol misuse, which the Department uses in its alcohol strategies and guidance. These range from 'hazardous' drinking (above recommended limits), through to 'severely dependent' alcohol misuse, which requires intensive specialist treatment (**Figure 1**).

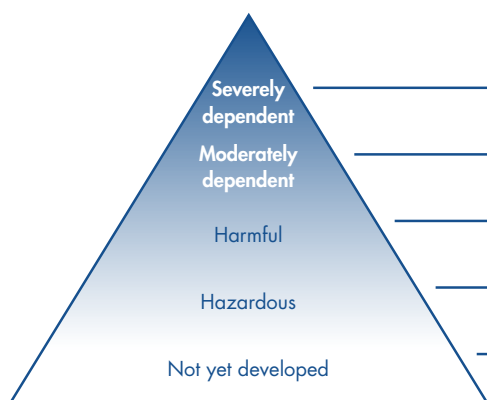
In England, it is estimated that 18 per cent of the adult population (7.6 million) are drinking at 'hazardous' levels; another seven per cent (2.9 million) are showing evidence of harm to their own physical and mental health, including approximately 1.1 million people who have a level of alcohol addiction (dependency). The health service offers different types of services for these groups, ranging from simple measures to provide information and raise awareness to acute clinical or mental health interventions for severe cases.

4 Dependent drinking can have many causes, including family history, psychological factors such as anxiety or depression, the addictive pharmacology of alcohol, and the environment in which people live. For others who drink alcohol above the guidelines, at 'hazardous' and 'harmful' levels, alcohol misuse may be due to habit, lifestyle, lack of awareness of the health effects and an absence of obvious symptoms.

5 The Department has in recent years emphasised the importance of prevention and public health measures, particularly in the *Choosing Health* White Paper (2004) and in Lord Darzi's review of the future of the NHS, *High Quality Care for All* (June 2008). In keeping with that aim, there has been a National Alcohol Strategy in place since 2004, aiming to encourage a more sensible drinking culture and reduce the burden of alcohol harm on society and the economy. In 2007 Government reviewed progress and set out the next stage of its National Alcohol Strategy in the report *Safe. Sensible. Social*, led jointly by the Department and the Home Office. The Strategy emphasises the importance of early interventions such as 'brief advice' (see box), which have been shown to reduce alcohol consumption by people who are drinking more than sensible amounts, but have not developed a dependency on alcohol.

1 The range of alcohol treatments and interventions

Level of alcohol problem



Treatments and interventions (examples)

Intensive specialist treatment (e.g. detoxification in hospital, combined with residential rehabilitation)

Specialist treatment in generalist or specialist settings (e.g. detoxification at home, with counselling)

An extended period of medical advice ('extended brief advice') in mainstream health or other settings

Short (5–10 minutes) medical advice ('brief advice') in mainstream health or other, non-health settings (e.g. by a GP)

Public health education programmes

Source: Adapted from *Broadening the Base of Treatment for Alcohol Problems*, Institute of Medicine, 1990

NOTES

Individual drinkers may move between categories of alcohol problem over time and the boundaries between categories are not clear-cut. Likewise, the treatments are indicative and may, in some circumstances, be appropriate for the other categories of alcohol problem.

Severely dependent: may have withdrawal fits (delirium tremens: e.g. confusion or hallucinations usually starting between two or three days after the last drink); may drink to escape from or avoid these symptoms.

Moderately dependent: likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking.

Harmful: showing clear evidence of alcohol-related problems.

Hazardous: drinking applies to anyone drinking over the limits recommended by the Department.

Not yet developed: people who currently have no level of alcohol misuse.

Brief advice

'Brief advice' is the term used for short, structured advisory interviews, provided when questions about a patient's drinking habits have identified that there is misuse. The advice is provided by a 'competent practitioner' such as a GP, nurse or trained non-medical professional, in about five to ten minutes. Typically, the advice given includes the risks a patient is running by drinking too much, setting goals to reduce alcohol consumption, and providing written materials such as advice leaflets. Brief advice has been shown to be effective in reducing hazardous and harmful drinking, as well as being cost-effective. In September 2008 a new Directed Enhanced Service was announced, providing an additional incentive of £8 million for GPs to undertake identification and brief advice with newly-registered patients. This will begin in April 2009.

6 Beyond the immediate health benefits to individual citizens, a greater focus on prevention also means that the costs of later, often more complex treatment are avoided, providing important savings to the NHS. By supporting early interventions on alcohol misuse, such as 'brief advice', the Department and the National Health Service (NHS) may avoid or reduce the costs of later, more intensive and specialist support for people who develop dependency or suffer from an alcohol-related illness.

7 In April 2008, for the first time, alcohol misuse became the subject of a cross-departmental Public Service Agreement (PSA), with the Department of Health a partner in delivering the new PSA 25 on alcohol and illegal drugs, led by the Home Office. The PSA will be monitored annually until 2011 and includes a performance indicator for the Department to bring down the rate of increase of alcohol-related hospital admissions. In turn, the Department is encouraging the local NHS commissioning bodies, Primary Care Trusts (PCTs), to include this indicator in their operational plans.

8 In this context, the National Audit Office has undertaken a study to evaluate:

- the arrangements for planning and commissioning health services for alcohol misuse (Part 2);
- measures to prevent alcohol misuse, and to identify misusers and provide them with simple advice and help (Part 3);
- specialist services to treat misusers who are dependent on alcohol, including those who have a serious or longstanding dependence on alcohol (Part 4).

9 The report focuses on alcohol misuse and on health services, based on data gathered in early 2008. It concentrates on the role played by the NHS and its partners in delivering on the hospital admissions indicator of the PSA. The report excludes other influences and policy areas which impact on the PSA, such as those that affect the availability of alcohol (such as pricing and promotion, taxation and licensing) or which deal with crime, disorder and other social effects.

10 The report focuses on England. The administrations in Scotland, Wales and Northern Ireland are separately responsible for health issues, and have responded in different ways to the differing patterns of alcohol harm in their countries (Appendix 3). In Scotland, where alcohol-related harm is higher than in England, there are plans to invest approximately £120 million in tackling alcohol misuse over the three financial years from 2008-09. In Wales, a new strategy for tackling substance misuse, including alcohol, was launched on 1 October 2008. A Northern Ireland alcohol strategy was published in 2000 and a further strategy document covering alcohol and drugs was published in 2006.

Main findings

The current state of services

11 PCTs are now responsible for setting their own local health priorities, but our survey found that a quarter had not accurately assessed the alcohol problems in their area. Without such assessments, PCTs cannot know what services they should be providing, and cannot assess whether the services they commission are sufficient or cost-effective. All PCTs have ready access to the data held in the Local Alcohol Profiles for England, which are generally acknowledged to be the most reliable data available on local need, but around 20 per cent of PCTs do not make use of them, and around a quarter of PCTs surveyed for this report had not carried out their own local needs assessment for alcohol in the last few years. Since April 2008, however, PCTs are required to undertake together with local authorities a formal assessment (Joint Strategic Needs Assessment) of the future health and wellbeing needs of the local population as the basis for planning future services.

The role of Primary Care Trusts in addressing alcohol harm

PCTs are responsible for determining local health priorities and have control of the majority of NHS spending. PCTs are free to decide for themselves how much to spend on services to address alcohol harm. They have no specific requirement to provide any alcohol-specific services, but since April 2008 they have been able to choose to include an indicator for alcohol-related hospital admissions in their operating plans. PCTs and other local bodies, in particular Drug and Alcohol Action Teams, may commission a range of treatments and services to address alcohol harm from various providers, including GPs, hospitals and mental health trusts, voluntary and private organisations.

Drug and Alcohol Action Teams

These Teams are local partnerships of professionals from local authorities and other public bodies such as PCTs, the police, probation service, and from private and voluntary sector providers. Their role is to address drug and alcohol problems in the local area and they plan treatments and commission services from a range of providers in all sectors. Drug and Alcohol Action Teams are accountable primarily to the local partnerships of which they are part and evolved from Drug Action Teams. There are 149 Drug Action Teams and Drug and Alcohol Action Teams in England. In many areas Drug and Alcohol Action Teams have merged or work closely with community safety or crime reduction partnerships.

12 Many PCTs do not have a strategy for alcohol harm, or a clear picture of their spending on services to address it. Some 58 per cent of the PCTs responding to our survey had an alcohol strategy and 69 per cent were able to provide details of their expenditure on alcohol services. Where spending was known, it showed PCTs spent an average of £600,000 on commissioning alcohol services in 2006-07 (including, for example, the provision of brief advice from GPs, weekly alcohol clinics, or more involved specialist treatments). This expenditure represents a little over 0.1 per cent of a typical PCT's total annual expenditure of around £460 million. The wider general cost to the NHS of dealing with the consequences of alcohol misuse, ranging from the cost of ambulance services to acute surgical procedures such as liver transplants, is estimated by the Department to be in the order of £2.7 billion annually.

13 PCTs have often looked to their local Drug and Alcohol Action Teams to take the lead in commissioning services to tackle alcohol harm, but these bodies focus primarily on specialist services for dependent users of illegal drugs and alcohol. They are not equipped to meet the needs of the much larger groups of 'hazardous' and 'harmful' alcohol misusers. The 2004 National Alcohol Strategy recommended that local Drug Action Teams should be encouraged, but not required, to extend their remit for commissioning and delivering treatment services to cover alcohol misuse for adults as well as drugs misuse (which includes under-age alcohol misuse). In 2004, around half of Drug Action Teams offered both drug and alcohol services. That figure has since increased to 81 per cent. Illegal substance use, however, remains Teams' overriding concern with their main source of funding (a budget of £385 million in 2006-07) ring-fenced for that purpose. Furthermore, many Drug and Alcohol Action Teams do not have the direct links with or experience in primary or acute (hospital) care to commission effective alcohol interventions in these areas.

14 Local provision of specialist services is not based on a good understanding of communities' needs and there are wide variations between localities. There is also much scope for better integration of hospital services with follow-on and support services, such as psychiatry or self-help groups, to improve recovery rates and prevent patients relapsing into their previous drinking patterns.

On the costs and benefits of programmes to address alcohol harm

15 The available evidence suggests that simple, often early interventions such as identification and brief advice can bring substantial savings by reducing the need for more intensive treatment later. Locally, however, opportunities to identify and advise people who are drinking above sensible levels are not being fully exploited. Alcohol screening questionnaires and the provision of brief advice offer a quick and effective means of identifying and engaging with those who are drinking above the guidelines but who may not realise the damage they are doing to their health. There is evidence indicating the cost-effectiveness of such interventions (Appendix 6). However, identification and brief advice is only sporadically provided by GPs and health workers, and rarely used in other parts of the health service, such as accident and emergency (A&E) departments where those suffering from the consequences of alcohol misuse are often present.

16 More specialist treatments, even though the cost is higher than for brief advice, have also been shown to be cost-effective, since they can also reduce the high costs of treating serious alcohol-related diseases. For example, specialist counselling and detoxification can reduce alcohol consumption, and may prevent liver damage worsening to the point where a liver transplant, typically costing £80,000, is needed. The Department recently commissioned an online system to collate details of local alcohol-related initiatives throughout England, known as the 'Hub of Commissioned Alcohol Projects & Policies' (HubCAPP). However, the programme is still in its infancy and its details have still to be communicated widely.

17 Since 2006, the Department has sought both to clarify its guidance on sensible drinking and to promote public health, through a series of new publicity campaigns. Research showed that the Department's guidelines are not fully understood by consumers, who tend to underestimate the amount of alcohol that their drinks contain. In response, the Department has funded a further campaign to raise public awareness of alcohol units in drinks, which started in May 2008. The public health campaigns ('Know Your Limits'), which were initially aimed at binge drinking and will cost the Department more than £6 million in 2008-09, have followed good practice guidance for such publicity work. The Department did not set measurable goals for the intended impact of these campaigns but aims to continue to track reported consumer awareness and behaviour change.

The new Public Service Agreement

18 The new PSA performance indicator on alcohol-related hospital admissions gives PCTs an incentive to address alcohol harm, but it has limitations and carries risks. While the indicator will measure alcohol harm and its consequences for the health service, it may not act as a clear incentive to PCTs to provide, for example, brief advice. Evidence suggests that the indicator will be responsive to provision of specialist services and early interventions (although it is also sensitive to other policies such as programmes to restrict availability and to reduce alcohol-related crime and disorder, which are not covered by this report).

19 While the majority of PCTs have chosen to include the new alcohol-related performance indicator in their operating plans, or in a Local Area Agreement, more than a third have not. In areas with relatively low levels of alcohol harm and more pressing health priorities it may be appropriate for PCTs not to adopt the indicator, but such decisions need to be based on sound evidence. PCTs' operating plans and Local Area Agreements are the direct means by which the Department can influence action locally on alcohol services and secure progress towards the PSA. As a positive development, almost all (46 of 50) of the PCTs showing the highest rate of alcohol-related hospital admissions, have included the new indicator in their operating plan and for many of these (32), the indicator is also included in the corresponding Local Area Agreement. Where Local Area Agreements do not include the alcohol indicator even though it is in the PCT's operating plan, PCTs will have to work harder to gain local partners' support for work such as the promotion of sensible drinking.

20 Regional oversight of the NHS's response to alcohol misuse has to date been limited. The creation of a new network of Regional Alcohol Offices in autumn 2008 aims to strengthen the influencing role of Strategic Health Authorities and Regional Directors of Public Health and to provide opportunities for sharing best practice between PCTs. The Department has committed £2.7 million per year for three years from 2008-09 for Regional Alcohol Offices with dedicated Regional Alcohol Managers, to support commissioners in delivering the PSA. Regional Directors of Public Health will assess whether planned activity is both realistic and reflects local need, and will check performance by PCTs against local targets annually.

Conclusion on value for money

21 Where they could provide a figure in response to the NAO survey, PCTs reported spending on average approximately £600,000 on services directly intended to address and reduce alcohol harm. Some PCT expenditure will be on services such as brief advice, which are judged generally to be cost-effective; although PCT expenditure on alcohol services as a whole cannot be comprehensively demonstrated to be so. Overall, therefore, there is scope to secure better value for money from PCT expenditure on alcohol services, which is not usually based on a clear picture of need or of the likely results. Our survey found that local strategies are lacking, or inadequate, in many areas and service delivery is fragmented, with resources allocated based on an incomplete picture of need. Service provision has, as a consequence, varied widely, both in type and degree of provision.

22 The new PSA indicator on alcohol is a way of encouraging local NHS organisations to focus on alcohol harm. The adoption of the indicator locally is, however, optional. Therefore, the indicator has no direct accompanying sanctions or rewards for PCTs. However, the Department does plan to publish benchmarking information on all PCT performance indicators, including the alcohol indicator, annually.

23 There is evidence, however, that well-planned and targeted services can produce results which are good value for money. With an increased emphasis placed by the Department on the promotion of public health, NHS trusts need to understand how to translate this wider objective into practical, well-evidenced resourcing decisions. The evidence base on cost-effectiveness will be strengthened by forthcoming studies, including a study of brief interventions – the Screening and Intervention Programme for Sensible drinking – commissioned by the Department, and the National Institute for Health and Clinical Excellence (NICE) review of prevention, early identification and clinical guidelines for the management of alcohol misuse. The resulting recommendations are due to be published in 2009 and 2010 respectively, providing the NHS with additional tools to understand the relative cost-effectiveness of different services to reduce and prevent health harm from alcohol misuse.

Recommendations

- a** **The contribution of the NHS and its partner organisations to measurable progress relies primarily on the actions of PCTs. Our evidence suggests that, to date, PCTs' planning and commissioning of health services to reduce alcohol harm have not been tailored to local needs.** In 2009, at the end of the first year of the new PSA, Strategic Health Authorities should assess the progress made by PCTs in each region towards the PSA alcohol indicator, taking local action if agreed progress has not been made.
- b** **While national systems collect detailed data on local patterns of alcohol misuse, some PCTs do not use these sources, and few PCTs collect information from their local partners to supplement these national datasets.** The Department should provide a framework to allow PCTs to assess alcohol misuse within a PCT area; thus enabling regular reviews of performance by Strategic Health Authorities and Regional Directors of Public Health, and allowing PCTs themselves to compare their provision of alcohol services against peer PCTs with similar patterns of alcohol misuse.
- c** **The new PSA indicator on alcohol needs to act as an incentive for PCTs to address effectively the alcohol misuse problems in their local area.** To strengthen the rigour of PCTs' local prioritisation and commissioning decisions concerning alcohol, the Department should deepen and develop the evidence available to PCTs on the causes and forecast trends of alcohol-related hospital admissions and alcohol health costs. It also needs to develop further evidence for the link between the PSA alcohol indicator and early interventions.
- d** **Historically, primary care data have not given a clear picture of alcohol misuse due to confusing 'codes' for recording diagnoses and interventions resulting in inconsistent recording of activity in primary care.** New codes for identification, screening and brief advice were issued in May and October 2008, and the Department should set a review point to assess how effectively these codes are operating to generate accurate and comparable information.
- e** **Currently there is no consistency in how the level and cost of alcohol services is recorded locally.** To secure greater consistency, the Department should emphasise to PCTs the importance of following the guidance set out in the NHS costing manual. Strategic Health Authorities will be able to use this standard method to compare provision across their PCTs as part of their performance management of PCTs.
- f** **Money spent on identification and brief advice can be cost effective, helping to pre-empt the need for more expensive services to treat longer-term alcohol harm, but currently such services are sporadic.** The Department should explore the feasibility of providing PCTs with a toolkit to assess locally the relative costs and benefits of different services to tackle alcohol harm, particularly those that focus on early prevention. The toolkit should aim to show the effect that such preventive measures can have in reducing the need for specialist treatment in the future, based on existing guidance and the best available estimates of cost effectiveness.

g PCTs have often seen Drug and Alcohol Action Teams as the bodies primarily responsible for commissioning services to tackle alcohol harm. These Teams, however, focus on specialist treatment of illegal substance misuse. PCTs need to be clear about the purpose of funding they provide to Drug and Alcohol Action Teams, for example in commissioning specialist services. The majority of specialist alcohol treatments are provided by combined drug and alcohol services and so there is a risk that, without a clear specification, alcohol treatment could be overlooked. At a national level, the Department, working with the Home Office, needs to undertake a consultation with representatives of local commissioners in order to provide clear guidance on the remit and local accountability of Drug and Alcohol Action Teams in relation to alcohol, including how this fits within the Teams' existing accountabilities for illegal substance misuse. PCTs should also promote the commissioning of brief advice for the large body of hazardous and harmful drinkers, whether provided in general practice, A&E departments or other parts of the public sector.

h Where PCTs do commission services, they rarely assess the quality of what is delivered. Regional Directors of Public Health and Strategic Health Authorities need to get PCTs to assess the quality of the services they commission against the Department's commissioning guidance, including *Models of Care for Alcohol Misuse, MoCAM* (2006) and criteria set out in the Department's World Class Commissioning programme.

i Our survey of PCTs showed that not all are working well with other public bodies – such as the police, prison and probation staff, and social services – to identify and help people who are misusing alcohol and whose health may be at risk. Such organisations are often well placed to identify alcohol misuse within those sections of the community that do not come into regular contact with the health service. PCTs should help educate and train NHS staff and agree with local partners outside the health service how they can be supported in developing skills to identify alcohol misuse.

j Currently there is no systematic means of promoting good evidence-based practice on alcohol harm across PCTs. Regional Directors of Public Health should develop a professional network of PCTs, Drug and Alcohol Action Teams and health care professionals with an interest in exploring and promoting new ways to tackle alcohol misuse. These networks should record details and outcomes of local alcohol-related interventions and treatments using the existing online database of alcohol initiatives (HubCAPP).



Introduction

1.1 This report evaluates work by the Department of Health (**the Department**) and the National Health Service (**NHS**) to address the health effects of alcohol misuse. In April 2008 the Department became a partner in a new joint Public Service Agreement (**PSA**) led by the Home Office to reduce the harm caused by alcohol and drugs. This Part of our report describes the background to the introduction of the new PSA and outlines the scope of our research. With a new PSA, and in recognition of the Government's aim for an increased focus on public health issues generally, this report evaluates:

- the arrangements for planning and commissioning health services for alcohol misuse (Part 2);
- measures to prevent alcohol misuse, to identify those who may have an alcohol problem, and to advise and help them (Part 3);
- specialist services to treat misusers who have a serious or longstanding dependence on alcohol (Part 4).

Alcohol misuse and public health

1.2 Alcohol misuse causes or contributes to a wide range of serious health problems and accidents that require health care. These health problems include high blood pressure, heart disease, liver and kidney disorders and a number of cancers. Misuse can be fatal, contributing to sudden deaths through acute alcoholic poisoning or accidents while people are intoxicated, as well as deaths due to long-term abuse of alcohol.

Health effects of alcohol

Some alcohol-related conditions such as liver disease and high blood pressure may not show any symptoms causing the patient to seek treatment, until serious damage has already occurred.

In 2006-07, there were 811,443 NHS hospital admissions in England with either a primary or secondary diagnosis wholly or partly related to alcohol, including alcoholic liver disease, the toxic effects of alcohol or mental or behavioural disorders due to alcohol. This figure accounts for six per cent of all hospital admissions and has increased by almost three-quarters (71 per cent) from 473,529 in 2002-03, although some of the reported increase will be due to more detailed recording of diagnoses and to more people being admitted to hospital for any reason. Nearly three-quarters of all attendances at hospital accident and emergency (A&E) departments between 12 and 5am on weekend nights are alcohol-related, often lead to disruptive behaviour, and place a heavy burden on A&E resources and capacity to meet government targets on waiting times.

More than 6,500 people died of alcohol-related causes in England and Wales in 2005. Evidence suggests that rates of disease associated with alcohol are increasing: the most common alcohol-related cause of death, alcoholic liver disease, killed 4,160 people in 2005, an increase of 20 per cent (from 3,464) since 2001.

The brain adapts to heavy alcohol use and dependent drinkers who suddenly stop drinking may suffer serious withdrawal effects, such as seizures and delirium. These symptoms can be minimised with medication and medical supervision.

Note: Alcohol-related fatality figures count only deaths for which specific alcohol-related conditions were recorded as the underlying cause (including mental and behavioural disorder due to use of alcohol, alcoholic liver disease and poisoning by exposure to alcohol).

Source: The Information Centre, *Statistics on Alcohol: England 2007*; and Department of Health *Safe, Sensible, Social – Consultation on further action* (2008)

1.3 The reasons for an individual's drinking patterns leading to alcohol misuse are complex and varied. Researchers have only limited understanding of how and why people's drinking habits develop and change over time. Factors contributing to alcohol misuse include habit and family history, psychological factors such as anxiety or depression, the addictive pharmacology of alcohol, lifestyle issues and the environment in which people live. Some researchers believe that some people may have a genetic predisposition to alcohol misuse, but the evidence is not conclusive. The availability and price of alcohol are also important factors.

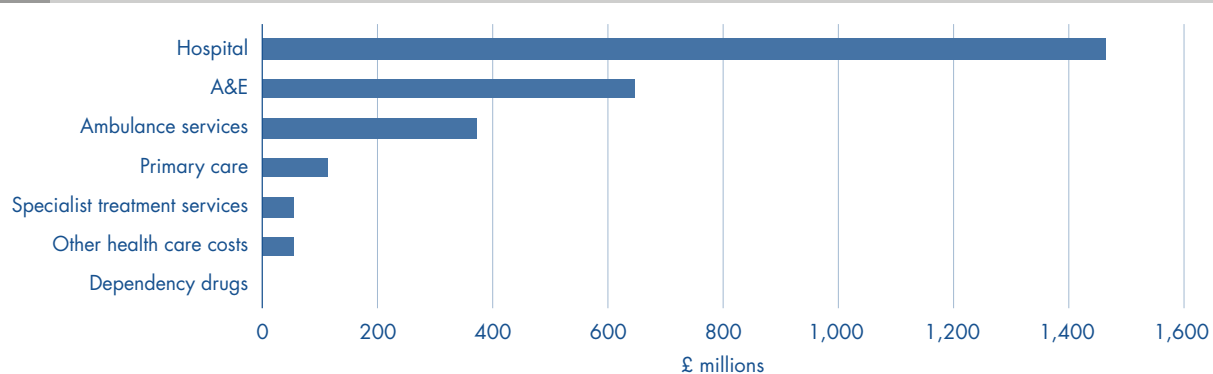
1.4 Alcohol misuse results in significant costs to the NHS, estimated by the Department as being in the order of £2.7 billion^{1,2} in 2006-07. Most of these costs are borne by the front-line and mainstream NHS. Ambulance services and accident and emergency services, taken together, bear almost a third (30 per cent) of these estimated costs, while hospital services account for over a half (56 per cent) of the total (Figure 2). Specialist alcohol treatment services, provided by non-NHS organisations, account for only two per cent of the total estimated costs. The total costs of alcohol misuse to the UK economy, including health effects and other aspects such as crime, have been estimated by the Cabinet Office at up to £25.1 billion.

Patterns of alcohol misuse

1.5 The 2007 National Alcohol Strategy³ and Department's guidance⁴ identifies four main categories of alcohol misusers who may benefit from some kind of intervention or treatment:

- **hazardous drinkers** who are drinking at levels over the sensible drinking limits, either regularly or through less frequent sessions of heavy drinking, but have so far avoided significant alcohol-related problems;
- **harmful drinkers** are drinking above sensible levels, usually more than hazardous drinkers and show clear evidence of some alcohol-related health problems;
- **moderately dependent drinkers** are likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking. They may recognise they have a problem with drinking but do not have severe dependence;

2 Annual estimated costs of alcohol harm to the NHS, 2006-07



Source: Department of Health Improvement Analytical Team report, *The cost of alcohol harm to the NHS in England: An update to the Cabinet Office (2003) study*. July 2008.

NOTES

'Hospital' includes inpatient visits (both directly and partly attributable to alcohol misuse) and outpatient attendances. 'Other health care costs' include alcohol-related counselling, community psychiatric nurse visits and health visits.

The expenditure on Dependency Drugs is estimated to be at least £2.14 million per annum.

1 Department of Health: Improvement Analytical Team, *The cost of alcohol harm to the NHS in England: An update to the Cabinet Office (2003) study* (July 2008).
 2 The estimated cost to the health service of £2.7 billion for alcohol misuse is based upon a wide definition of alcohol-related issues and a number of assumptions which are then applied to an average cost. Therefore, the actual cost is likely to be subject to variation each year. The Department's view is that this estimate should only be used as a broad indication of cost to the NHS.
 3 Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport, *Safe. Sensible. Social. The next steps in the National Alcohol Strategy* (June 2007).
 4 e.g. Department of Health, *Models of care for alcohol misusers (MoCAM)* (June 2006). The description of types of drinker used here is adapted from MoCAM guidance.

- **severely dependent drinkers** may have withdrawal fits (delirium tremens: e.g. confusion or hallucinations usually starting between two or three days after the last drink); and may drink to escape from or avoid these symptoms.

1.6 Patterns of drinking vary according to gender, age and other factors such as lifestyle and income. For example, men are more likely than women to drink more than ‘sensible’ amounts, while young people aged 16-24 are more likely than older people to ‘binge drink’.

Helping people reduce their drinking and restore their health

1.7 There is a range of interventions and treatments for people who are misusing alcohol (see [Figure 3 overleaf](#)), suitable for different types of alcohol misuse. Structured ‘brief advice’ from a trained professional is appropriate as a first-stage intervention, particularly for people who are drinking too much but who are not dependent. Other, more complex treatments such as detoxification (‘drying-out’) under medical supervision and rehabilitation and psychosocial counselling services are used to treat dependency on alcohol. Interventions and treatments may be provided in primary care (e.g. GP practices and health centres), secondary care (acute hospitals), specialist tertiary care (mental health services or residential rehabilitation) and at home. People who are dependent on alcohol often need psychological and social treatments such as counselling, group therapy and support for their families.

1.8 There is evidence that interventions and treatments can be effective and justify their cost; the evidence available to date is discussed in Appendix 6. Many such interventions have been shown to be cost-effective, whereby the costs of providing them are outweighed by the overall savings in the ‘full social cost’ which will result from reduced alcohol consumption, such as the reduced costs to the criminal justice system due to a fall in alcohol-related crime and disorder. A study in 2005 found, for example, that net savings of £5 to the public sector could result from every £1 spent on some specialist treatment services.⁵ There are local examples of innovative services which have demonstrated their cost-effectiveness. A specialist alcohol health worker service at St Mary’s Hospital, Paddington, has reduced re-attendance rates at the accident and emergency department⁶ [Case Example 2, p25].

The public service response to alcohol harm

1.9 The Department is responsible for the health aspects of alcohol policy in England, as set out in *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*, produced jointly by the Department, the Home Office, the Department for Education and Skills, and the Department for Culture, Media and Sport (DCMS) in 2007. The Department’s responsibilities, as set out in the 2007 National Alcohol Strategy and a previous Strategy published in 2004⁷, include:

- conducting and disseminating research on alcohol services;
- providing guidance to local commissioners of health services, primarily PCTs, on developing and implementing strategies and programmes to reduce alcohol harm;
- improving medical and nurse training on alcohol;
- increasing the public’s awareness of the risks associated with excessive consumption of alcohol and how to get help, where the Department works with the alcohol industry.

Further details of the Department’s specific commitments and the actions designed to meet them are given in Appendix 1. The respective roles of the Department, Regional Directors of Public Health (in the regional Government Offices and Strategic Health Authorities) and of Primary Care Trusts are shown in [Figure 4 on page 15](#). [Figure 5 on page 16](#) shows the Department’s influence on local provision of health services for alcohol misuse, which takes two main forms:

- providing guidance to PCTs, directly, via Strategic Health Authorities and Regional Directors of Public Health, or via the National Treatment Agency for Substance Misuse (NTA) for specialist treatment;
- overseeing Strategic Health Authorities’ review of PCT operating plans.

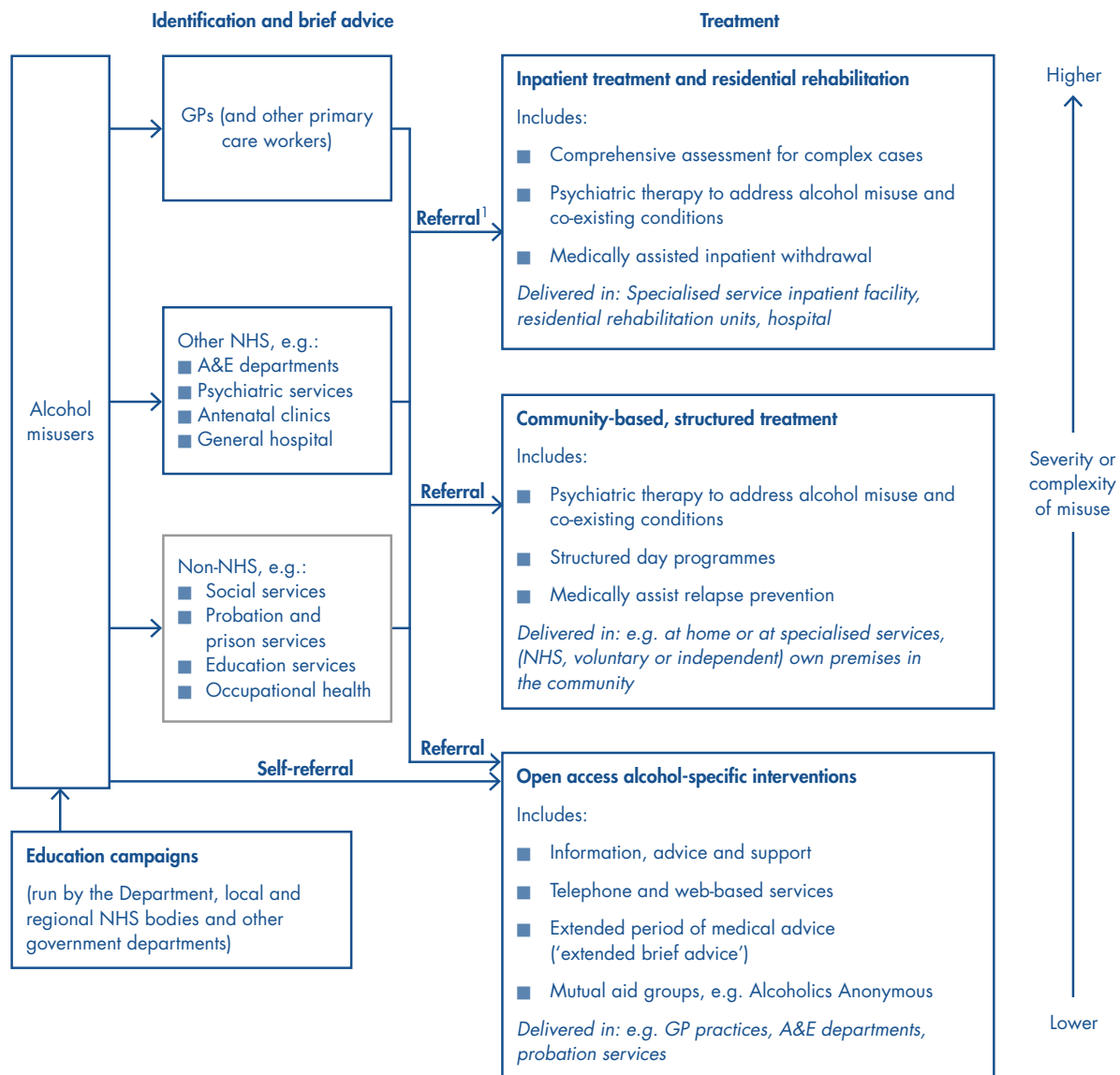
1.10 Most recently, the Department was made a partner with the Home Office in a new PSA on alcohol and illegal drug misuse. The Agreement, which came into effect in April 2008, will be monitored annually until 2011. It includes two new indicators that relate to alcohol, one of which will measure the number of alcohol-related hospital admissions. The new PSA is described in Appendix 4 of this report and its local implications are explained in paragraph 2.19.

5 UKATT Research Team (2005). *Cost-effectiveness of treatment for alcohol problems: Findings of the UK Alcohol Treatment Trial*. *British Medical Journal*, 331: 544–547.

6 Barrett, B., Byford, S., Crawford, M., Patton, R., Drummond, C., Henry, J., Touquet, R. (2006) *Cost-effectiveness of screening and referral to an alcohol health worker in alcohol misusing patients attending an accident and emergency department: A decision-making approach*. *Drug and Alcohol Dependence*, 81, 47–54.

7 Prime Minister’s Strategy Unit, *Alcohol Harm Reduction Strategy for England* (March 2004).

3 The delivery of services for education, identification and treatment of alcohol misusers



Source: National Audit Office, based on Department of Health (2006) 'Models of care for alcohol misuse (MoCAM)'

NOTE

¹ Referral occurs in various forms, such as a formal referral of a patient by a GP directly to an NHS service or an A&E worker identifying an alcohol misuser and providing them with the contact details for an alcohol treatment service.

4 Central, regional and local health service roles on alcohol harm

Body	Role
Central Department of Health	Sets the overall priorities for the NHS through the Operating Framework and accompanying Vital Signs performance framework. Sets national strategy for the NHS's response to alcohol harm, working with other government departments, and influences local delivery e.g. through World Class Commissioning, the National Institute for Clinical Excellence (NICE) and working with medical schools to improve training and providing guidance and advice. On a national level, runs campaigns, works with the industry and undertakes research and development.
Regional Regional Government Office Strategic Health Authority	Joint role of the Regional Director of Public Health: <ul style="list-style-type: none"> ■ in Strategic Health Authority, reviews and challenges Primary Care Trusts' operating plans (including the use of the alcohol PSA indicator, described below); ■ in regional Government Office, acts as the Department's representative in the region, working on alcohol as a public health issue with regional representatives of other government departments and influencing local authorities.
Local Primary Care Trust (PCT)	Commissions – involving planning, funding and performance managing – local health services to prevent and treat alcohol harm.

Source: National Audit Office

UK alcohol consumption

1.11 The UK market in alcoholic drinks is worth more than £30 billion per annum, and generates annual tax revenues of over £13 billion. Globally, alcohol consumption causes 1.8 million premature deaths each year (3.2 per cent of the total)⁸ and is the third leading preventable cause of ill-health in Europe, after smoking and high blood pressure. In England, harmful alcohol use is a public health and social issue which has a significant impact right across society. For example, there has been a large increase in NHS alcohol-related hospital admissions among the 35–49 age group and the rate of admissions increases with age. Deprived areas suffer higher levels of alcohol-related mortality, hospital admissions, crime, absence from work, school exclusions, teenage pregnancy and road traffic accidents linked to greater levels of alcohol consumption.

1.12 Patterns of alcohol misuse in other countries are often different from those in the UK, reflecting social and cultural influences. Direct comparisons are complicated by different ways of measuring alcohol consumption and different guidelines on sensible drinking. On the most recent figures, for 2004, average levels of alcohol consumption in the UK are slightly higher than those for Germany, the Netherlands and Finland, but lower than for France and Luxembourg. However, one recent survey found that UK binge drinking rates were only exceeded

in Europe by Ireland and Finland. Most Western countries have a similar overall burden of disease attributable to alcohol, though the prevalence of particular alcohol-related conditions varies. Overall, certain types of heart disease such as angina and heart attacks are the most important cause of death from alcohol misuse, accounting for 112 deaths per 100,000 population in both the UK and the US (Appendix 2 and see Appendix 3 for a UK comparison).

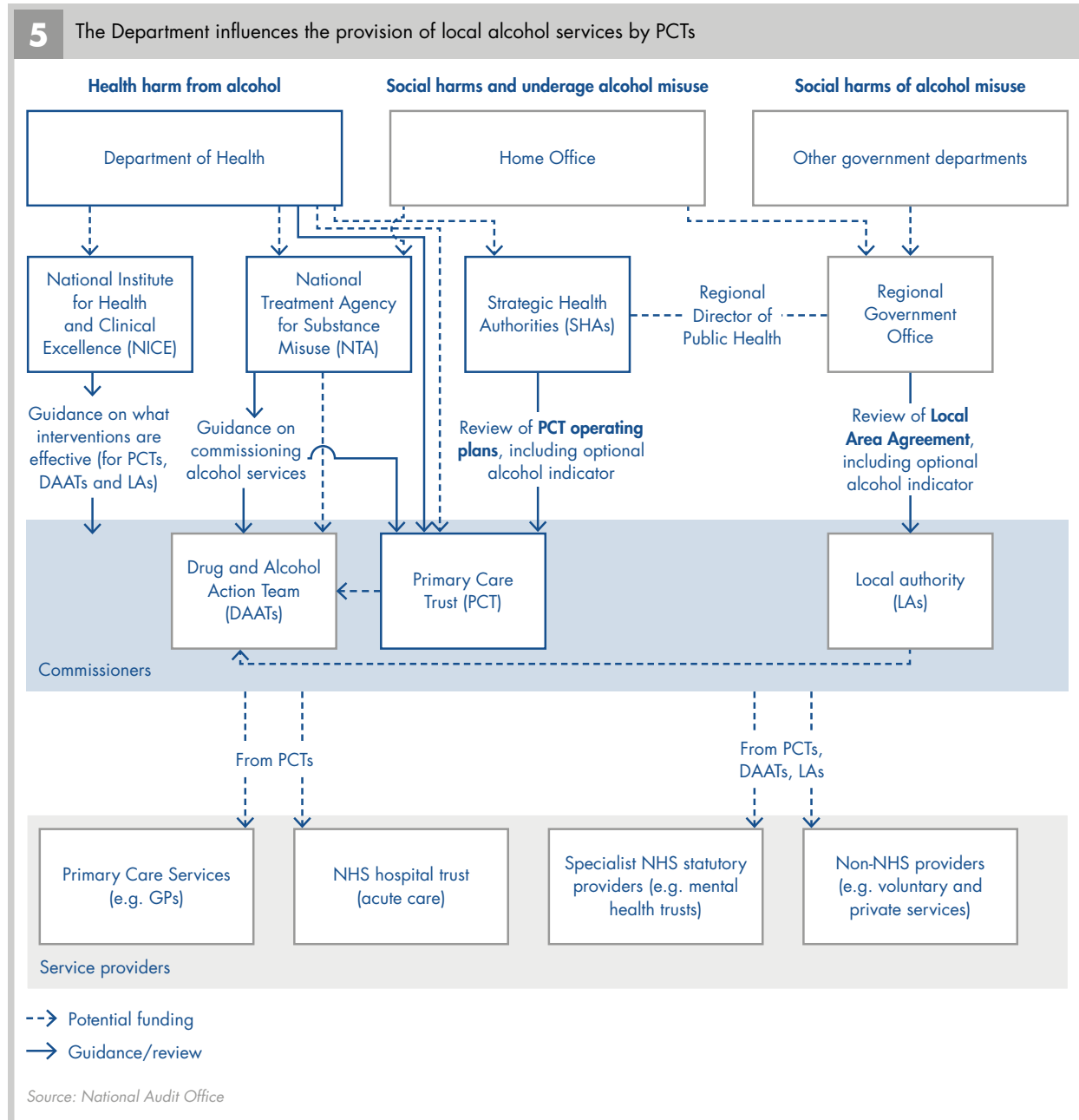
1.13 Developed economies have adopted a range of policies to tackle alcohol harm, beyond immediate health service interventions. Measures adopted, (such as restricting the availability of alcohol through taxation or licensing, stringent laws on drink-driving and minimum legal drinking ages) have been shown to be effective. Research in the US, for example, shows that the minimum legal drinking age of 21 in all states has been the most effective of a range of measures to reduce alcohol consumption and harm among high school and college students. Health interventions to reduce alcohol harm have been broadly similar in other countries to those in the UK and have faced the same barriers that we identify in the remainder of this report, such as a lack of incentives for healthcare professionals to screen patients for alcohol misuse and advise them on its health effects. Since genetic and historical cultural factors may contribute to a person's alcohol dependency, different countries may require different solutions to reduce their individual alcohol-related problems.

8 World Health Organisation. Alcohol: Facts and Figures (http://www.who.int/substance_abuse/facts/alcohol/en/index.html, accessed 01/09/2008).

Methodologies

1.14 To support our findings we carried out fieldwork from November 2007 to June 2008 comprising: a survey of all Primary Care Trusts and Drug Action Teams; a survey of some 1,450 GPs; analyses of the available quantitative data on alcohol harm and its effects on the NHS; a review

of existing literature and documentation; interviews and focus groups with alcohol misusers and their families; case study visits; international comparisons research; an expert panel meeting; and interviews with key stakeholders. A more detailed description of the methodologies used is at Appendix 5.





Planning and commissioning of services to reduce alcohol harm

2.1 This Part of the report examines the planning, commissioning and oversight of services to reduce alcohol harm. Local PCTs, which control the majority of NHS spending, can directly commission services to reduce alcohol harm. Such services range from straightforward education and advice from GPs, to more specialist treatment provided in hospitals or mental health trusts, or by private or voluntary organisations. PCTs can also work with local Drug and Alcohol Action Teams to commission specialist treatment services for dependent drug and alcohol users.

Primary Care Trusts (PCTs) and alcohol misuse

2.2 The 2004 and 2007 National Alcohol Strategies set out the Government's current and proposed initiatives on alcohol misuse and highlighted both existing guidance and examples of good practice for healthcare organisations. In 2007, the Department published general commissioning guidance for PCTs⁹ but did not clarify their responsibilities in relation to other local public bodies, particularly with reference to alcohol services. More recently, the Department has prepared *'Supplementary guidance: Alcohol'* to assist PCTs in implementing the guidance for alcohol misuse, which will be published in autumn 2008. Before April 2008, there were no centrally defined measures of local PCT performance in reducing alcohol harm. The operating framework which applied to all PCTs for the three financial years 2005-06 to 2007-08 included 36 national targets on health issues such as cardiovascular (heart) disease, cancer, smoking and sexual health, but made no specific reference to alcohol.

2.3 PCTs found it difficult to provide us with details of their spending on services to reduce alcohol harm. Most PCTs in our survey (71 per cent) could provide an overall estimate, but had difficulty providing details of expenditure for any particular type of services or setting. Nearly a third (29 per cent) could not estimate their total spending figure for such services. PCTs told us that there were various reasons why they could not give spending details, including difficulty estimating the proportion of alcohol-related spending within services catering for both alcohol and drug misuse, and for large contracts with mental health trusts.

2.4 Per capita spending on alcohol services is markedly less than on services for users of illegal drugs. Where PCTs were able to provide spending figures in response to our survey, they reported spending an average of £600,000 in 2006-07 on alcohol services. Research for the Department published in 2004 estimated that in 2002-03 a total of £217 million was spent by PCTs and Drug and Alcohol Action Teams on specialist alcohol treatment services, approximately £197 for each of the 1.1 million dependent drinkers, although the authors suggested that the expenditure figure was likely to be an overestimate. For the estimated 250,000 dependent drug users, the total amount of central and local funding spent on drug treatment in the same period was £436 million, or £1,744 per head. The 2004 National Alcohol Strategy concluded from this that there had been a lack of focus on alcohol treatment, especially in contrast to drugs services. This view was echoed, in research commissioned for the Department, by people working in alcohol-specific services.¹⁰

⁹ Department of Health, *Commissioning framework for health and well-being* (March 2007).

¹⁰ Department of Health, *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (November 2005).

2.5 From the financial year 2006-07 onwards, the Department has provided an additional £15 million annually for alcohol services to PCTs' budget allocations, under the Choosing Health programme. PCTs were not required to spend the allocation on alcohol services however, our own survey covering the second year (2007-08) indicated that PCTs had spent at least £11 million of this money on alcohol services. Nevertheless, over half of the PCTs (58 per cent) reported spending some of this money (a total of around £4 million) on services other than alcohol.

The relationship between spending and need

2.6 Our survey showed little correlation between PCTs' spending on alcohol services and the extent of alcohol problems in their local population (Figure 6). Although patterns of alcohol misuse and health effects vary a great deal in different parts of England and alcohol problems are generally much higher in more deprived locations than in

more affluent parts of the country, PCTs' spending does not reflect the pattern of need. The maps in Figure 7 show the geographical distribution of need and spending patterns.

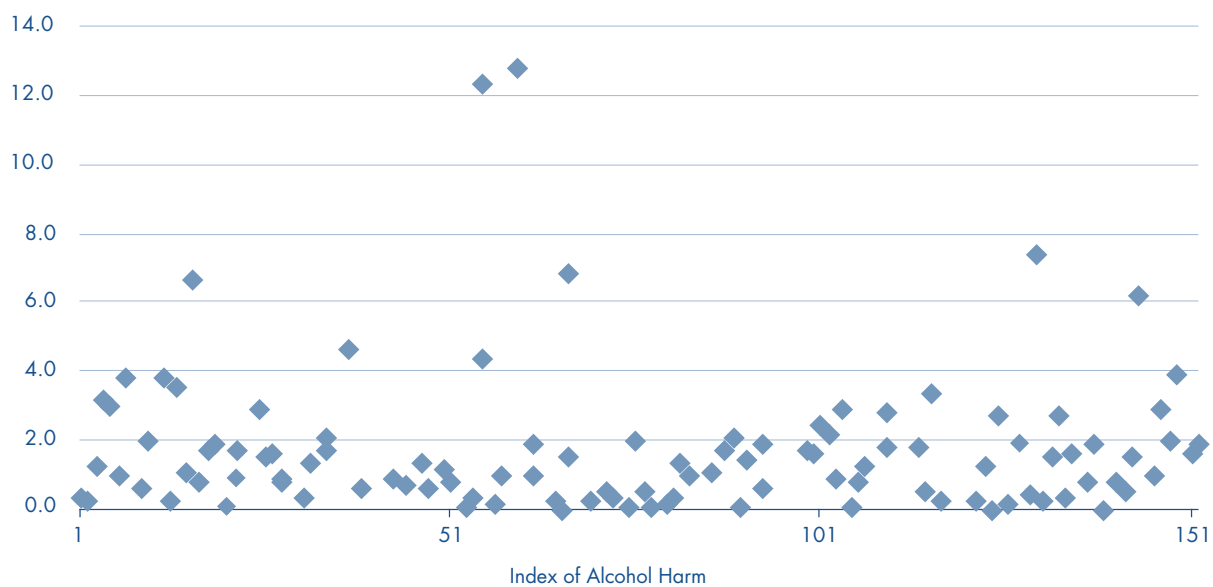
2.7 We found various reasons for these local variations in spending, including allocations based on the patterns of previous years rather than on a recent evaluation of need. Where spending had been significantly increased, this was often due to a local 'champion' such as an NHS doctor or manager with a particular interest in the health effects of alcohol, who had managed to secure extra resources.

2.8 Spending data is complex and we would neither expect nor recommend an exact correlation between 'need', however measured, and PCTs' spending patterns, for the following reasons:

- Figures provided by PCTs are unlikely to be directly comparable, since PCTs have various different ways of recording and presenting data on alcohol services and there is no standardised return required by the Department;

6 PCT expenditure patterns for services to reduce alcohol harm

PCT expenditure on alcohol services per capita, £



Source: National Audit Office

NOTES

- 1 The PCT expenditure figure includes dedicated alcohol-specific funding from PCTs to Drug and Alcohol Action Teams.
- 2 The Index of Alcohol Harm, developed for the National Audit Office by the North West Public Health Observatory (NWPHO) which compiles the Local Alcohol Profiles for England, combines a number of indicators of alcohol harm. A score of 1 indicates the lowest level of alcohol harm and 152 the highest (see Appendix 4).

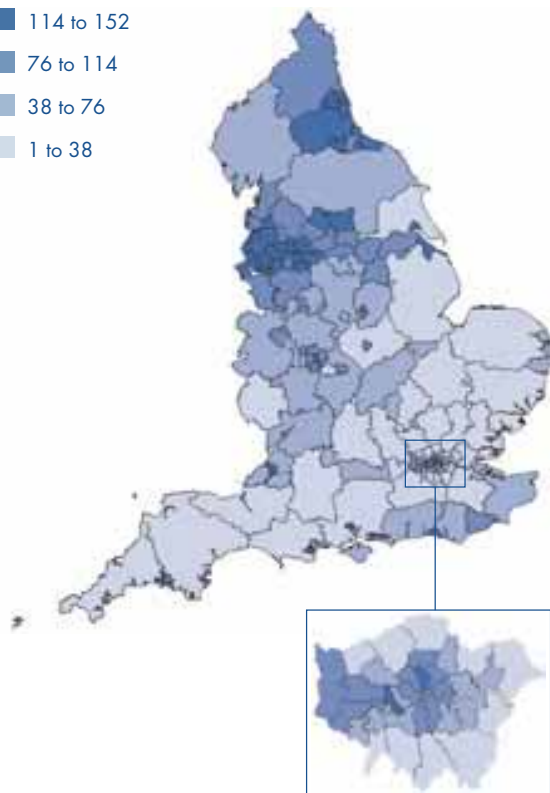
- PCTs which spend more on alcohol services may have effectively reduced levels of misuse and therefore reduced the need;
- High spending should not necessarily imply effective commissioning; and
- An area with a high level of need for alcohol services compared to other PCTs may well also have greater need for other health services, because of the clear link between economic deprivation and ill-health, including alcohol-related conditions. PCTs in such areas have difficult decisions to make on how best to allocate their resources and may not choose to make alcohol a priority issue.

2.9 However, the lack of any relationship between local need and local spending, shown in Figures 6 and 7, does suggest that there is no consistency in the criteria which PCTs use to plan services to reduce alcohol harm. PCTs have access to a variety of data to help them understand alcohol misuse in their local area. In particular, 82 per cent of PCTs in our survey reported using evidence from Local Alcohol Profiles for England (see box), which estimate the number of alcohol misusers within each area. The profiles were made available to PCTs in October 2007.

7 There is little correlation between the number of alcohol misusers and the amount spent on specialist alcohol services across PCTs

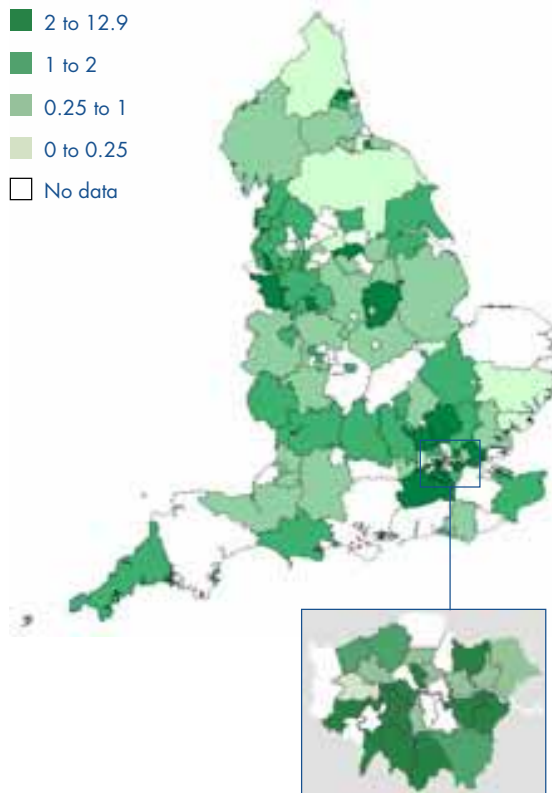
Index of alcohol harm

- 114 to 152
- 76 to 114
- 38 to 76
- 1 to 38



Spending per head on alcohol services

- 2 to 12.9
- 1 to 2
- 0.25 to 1
- 0 to 0.25
- No data



Source: National Audit Office

NOTES

Dark blue indicates higher level of alcohol harm and dark green indicates higher reported levels of PCT expenditure on alcohol services. Areas with relatively low levels of harm (lighter blue) should not necessarily be spending less on alcohol services (lighter green) since there is no exact desired relationship between levels of harm and expenditure.

The specific details and source for the Index of Alcohol Harm is outlined in the methodology appendix.

Local Alcohol Profiles for England (LAPE)

Published on the internet, the Local Alcohol Profiles measure alcohol misuse in each of 150 local authority areas in England using 23 separate indicators, including, for example, months of life lost due to alcohol misuse, alcohol-related violent crimes and rates of binge drinking. The indicators are based on national data sources such as the Hospital Episode Statistics produced by the NHS and mortality data produced by the Office for National Statistics (ONS), with an estimation factor for each local area applied where appropriate. The resulting profiles compare each authority's ratings to the national average and highlight indicators which are significantly better or significantly worse than average.

The profiles are prepared by the North West Public Health Observatory (NWPHO), based at John Moore's University in Liverpool, and are supported by the Department.

2.10 Although PCTs are aware of this data, many have not used them to assess local need. Research by the charity Alcohol Concern undertaken between November 2007 and February 2008 found that 52 per cent of PCTs surveyed (45 out of 87) 'had not assessed the numbers of hazardous, harmful and dependent drinkers in their area'¹¹; despite these being readily accessible from individual Local Alcohol Profiles. The NAO survey of PCTs for this report found that a significant minority – 22 per cent – of PCTs had not carried out a local needs assessment for alcohol services since January 2004. Since April 2008, however, PCTs and local authorities are required to undertake a formal 'Joint Strategic Needs Assessment'¹² of the future health and wellbeing needs of the local population. The process is designed to identify current levels and gaps in provision to inform the planning of future services.

Management responsibilities and performance management

2.11 According to our survey, some 58 per cent of PCTs either had developed their own alcohol strategy or had participated in a joint strategy developed with other local bodies. Such strategies often included an assessment of the local issues and need for services and outlined indicators and targets for alcohol harm. More than half (53 per cent) of PCTs responding to our survey had a nominated clinical lead (a medical or other healthcare professional with an advisory role within the PCT) whose remit included alcohol, often alongside other public health responsibilities such as smoking and obesity.

2.12 Additionally, in the absence of central targets and frameworks on alcohol, some PCTs have set their own. According to our survey, 45 per cent of PCTs reported having alcohol-related targets, including maximum waiting times for services, and numbers of hospital admissions.

2.13 Within PCTs' management structure, however, it is often not clear who is responsible for planning and commissioning particular alcohol services. Survey responses showed that leadership responsibility for planning alcohol services could rest with a number of different PCT functions, such as public health or commissioning, or be devolved to the local Drug and Alcohol Action Team, and there was frequently a lack of clarity within PCTs about who was responsible.

2.14 Those PCTs who do commission services for alcohol misuse frequently do not monitor the results such services deliver. Almost a third (30 per cent) of PCTs reported in our survey that they did not manage the performance of the alcohol services they commission within primary care, such as identification and brief advice. Almost a quarter (22 per cent) did not manage the performance of services provided by non-NHS agencies, such as residential rehabilitation.

The role of Drug and Alcohol Action Teams

2.15 Drug and Alcohol Action Teams are 149 local partnerships which bring together local authorities and other public bodies such as PCTs, the police, probation services, and private and voluntary sector providers, to address drug and alcohol problems in the local area. Drug and Alcohol Action Teams were formed from Drug Action Teams in response to the 2004 National Alcohol Strategy, which recommended that such teams should be encouraged, but not required, to assume greater responsibility in the commissioning and delivery of alcohol treatment services.

2.16 While our survey found that 81 per cent of Drug Action Teams had taken on that additional responsibility, illegal drug use remained their overriding concern. While Drug and Alcohol Action Teams' main source of direct Government funding, a Pooled Treatment Budget, (£385 million in 2006-07) is provided by the Department and the Ministry of Justice, the money is 'ring-fenced' for treating misusers of illegal substances and cannot be used to provide services for people over 18 who are dependent on alcohol alone. It can, however, be used for people who misuse both alcohol and drugs, and for under-age drinkers who only misuse alcohol.

¹¹ Alcohol Concern, *The Poor Relation – has the emphasis on 'localism' really improved alcohol commissioning?* (2008).

¹² The requirement for a JSNA is part of the Local Government and Public Involvement in Health Act (2007).

2.17 In addition to the Pooled Treatment Budget, Drug and Alcohol Action Teams also received additional funding from local public bodies including PCTs, but only a small proportion of this extra money was 'ring-fenced' for alcohol services. The 121 DAATs who responded to our survey received, on average, almost £2 million each in additional funding from local bodies, but only 13 per cent, or £29 million in total, was 'ring-fenced' for alcohol misuse services alone. Alcohol-related services commissioned by Drug and Alcohol Action Teams were generally intended for harmful and dependent drinkers rather than identification and early interventions for hazardous drinkers.

2.18 PCTs usually play a part in the management and oversight of Drug and Alcohol Action Teams but the nature of this relationship varies. In some areas there is a single Drug and Alcohol Action Team and a single PCT covering the same geographical area, while other areas have groups of PCTs or Drug and Alcohol Action Teams which work together in joint commissioning arrangements. Some Drug and Alcohol Action Teams are operated from local authority offices, by social services department staff, while others sit within their local PCT or are subsumed within larger local commissioning bodies, such as Safer Community Partnerships.

New performance measures

2.19 In April 2008, the Department became a partner in delivering a new Public Service Agreement (PSA) on alcohol and drugs, led by the Home Office (Appendix 3). The 2008-09 NHS operating framework is supported by a 'Vital Signs' indicator set which includes the rate of hospital admissions per 100,000 population for alcohol-related harm. Two-thirds (65 per cent) of PCTs have adopted this indicator in their operating plans for the three years from 2008-09 to 2010-11. The 'Vital Signs' alcohol indicator is also included in the 'National Indicator Set' of targets on which Local Area Agreements are based. PCTs are partners in Local Strategic Partnerships, which are led by local authorities and bring together at a local level the different parts of the public, private, community and voluntary sectors. Just over half (52 per cent) of the new Local Area Agreements, which came into effect in April 2008, incorporate the hospital admissions indicator. It will be used to measure progress on the PSA, which also includes an indicator measuring 'perception of drunk or rowdy behaviour as a problem' and three indicators relating to illegal drugs.

2.20 According to the Department's own analysis, out of the 50 PCTs showing the highest rate of alcohol-related hospital admissions, 46 have included the new alcohol indicator in their operating plans and for many of these

(32), the indicator is also included in the corresponding Local Area Agreement. Where, however, the alcohol indicator has been made a priority in a PCT's operating plan but not in a Local Area Agreement, there is a risk that PCTs will not get the wider support they need from other local agencies, for example in promoting sensible drinking messages or helping to educate and advise alcohol misusers about how they might get help from the health service.

2.21 In our survey, PCTs reported their budgeted spending on alcohol services for 2007-08 was, on average, 12 per cent higher than in 2006-07. At the time our survey was carried out, in February–March 2008, actual expenditure figures for the financial year 2007-08 were not available. Ninety-seven PCTs reported figures both for expenditure in 2006-07 (averaging £595,000) and budgeted spend for the following year (£665,000). The extra money was being spent both on expanding existing services and on commissioning some entirely new services.

2.22 The Department's Strategic Framework, published in July 2008, set out its plan for supporting the delivery of its strategic objectives. A key feature of the approach is to give greater control to local commissioners. While the Department's strategic objectives are not directly translated into NHS targets, the 'Vital Signs' indicators are used by PCTs to determine their objectives and set their local priorities. The alcohol indicator is optional. As a result, the indicator on alcohol has no accompanying targets, sanctions or rewards. However, the Department does plan to publish benchmarking information on PCT performance against all of the indicators, annually.

2.23 Strategic Health Authorities can challenge a PCT if they have evidence of particularly large and overlooked need (based, for example, on the Local Alcohol Profile for the area), but have no power to determine PCTs' spending priorities. Evidence suggests that the indicator will be responsive to provision of specialist services and early interventions (although it is also sensitive to other policies such as programmes to reduce alcohol-related crime and disorder). A wide range of data has been produced on alcohol in 2008, including new figures on hospital treatment for alcohol-specific conditions. To strengthen the rigour of PCTs' local prioritisation and commissioning decisions concerning alcohol, the Department will need to deepen and develop the evidence available to PCTs on the causes and forecast trends of both alcohol health costs and alcohol-related hospital admissions, and also develop further evidence for the link between the PSA alcohol indicator and early interventions.

2.24 At the regional level, there have been few means to coordinate action on alcohol between PCTs or to spread best practice. The ten Regional Directors of Public Health in England, who have a dual role as a representative of the Department of Health in the Government Offices for the regions, and in leading public health issues for the Strategic Health Authority, include alcohol in a wide public health portfolio alongside issues such as sexual health, smoking and obesity. With a recently strengthened role, a few have launched their own initiatives on alcohol, such as regional conferences and campaigns to encouraging better links between local delivery partners and the dissemination of good practice, but action on alcohol has been limited overall. From September 2008, however, the Department has been establishing a network of Regional Alcohol Offices to provide dedicated resources at the regional level.

2.25 Where an alcohol indicator is established, PCTs need to develop more effective commissioning strategies based on a better understanding of local need and what works best to address that need. The Department has published a number of guides to commissioning of alcohol services, such as its 2006 *Models of Care for Alcohol Misusers*, and is developing a framework of guidance for commissioners to be published in late 2008.

2.26 The Department commissioned a comprehensive study of the effectiveness of different types of treatment, which was published in 2006.¹³ In 2010 the National Institute for Clinical Excellence (NICE) will publish guidance on the effectiveness and cost effectiveness of

different alcohol interventions. At a local level, however, PCTs need to develop better data on outcomes. Hospital Episode Statistics will be used to measure the new PSA indicator relating to the trend in alcohol-related hospital admissions. The National Drugs Treatment Monitoring System, which records the number of people within specialist services and the treatment they receive, began collecting data on alcohol-specific services on 1 April 2008 and has potential to be an important data source. As a result, all providers of specialist alcohol treatment have been asked to support the submission of data on clients receiving specialist treatment for their alcohol misuse.

2.27 There are various examples of good practice in commissioning alcohol services, where PCTs have identified the need for services and have then, using existing sources of funding, been able to introduce new services. One such example is North Tyneside PCT, which has set itself specific targets to address alcohol harm (**Case example 1**).

2.28 In December 2007 the Department launched the World Class Commissioning programme to improve PCTs' commissioning capabilities. The programme sets out a new approach to commissioning health and care services. World Class Commissioning includes a nationally consistent, locally applied annual assurance process for PCTs, under which they will need to demonstrate that local commissioning relates directly to local needs; this approach will need to be applied in particular to alcohol services.

CASE EXAMPLE 1

Improving commissioning using locally-set targets – North Tyneside PCT

North Tyneside PCT is located in a region with particularly high levels of alcohol harm. Both men and women in North Tyneside experience among the highest levels of alcohol-related harm in England for alcohol-related months of life lost, death from chronic liver disease, and alcohol-related hospital admissions. A study commissioned by the Department in 2005 also revealed that the level of provision is also comparatively low: only 1 out of every 102 people with an alcohol problem in the North East receives appropriate alcohol treatment, compared to a national average of 1 in 18.

North Tyneside PCT has developed its alcohol services using local targets and existing funding streams. The area's first Local Area Agreement (LAA) included three locally agreed alcohol targets, and the most recent LAA will also include alcohol targets, such as delivering 1,350 identification and brief advice interventions on alcohol by 2010.

The PCT has used a number of non-health-specific funding streams to allow it to provide additional alcohol-related services. For example, it secured £33,500 in 2006-07 and £28,000 in 2007-08 in Neighbourhood Renewal Funding from the local authority for the delivery of identification and brief advice, and a workplace training package which includes alcohol as one of a number of health issues. It also received £87,862 of 'pump priming' money to help it deliver the target on identification and brief advice within the LAA. This target is a 'stretch target', and if it is met, the PCT will receive an estimated £600,000 of additional funding as a 'performance reward grant'.

North Tyneside PCT has been able to commission additional services – for example 13 GP practices are now running identification and brief advice programmes – and, as a result, it is on target to meet the related LAA target. Further, the PCT has recently agreed a Vital Signs target with its Strategic Health Authority, to slow the year-on-year rise in the rate of alcohol-related hospital admissions in North Tyneside.

¹³ Riasstrick, D.; Heather, N.; Godfrey, C. (2006). *Review of the Effectiveness of Treatment for Alcohol Problems* (November 2006).



Provision of education, identification and advice

3.1 This Part focuses on the work of the Department, GPs and other NHS staff to educate the public about alcohol, identify alcohol misusers, provide ‘first-line’ services and refer on those who need further help.

The sensible drinking guidelines

3.2 The Department provides guidance to the public in the form of recommended ‘sensible limits’ for lower-risk alcohol consumption, defined in terms of units¹⁴ of alcohol. In 1995, this guidance¹⁵ was revised, from weekly to daily limits (see Figure 8). In May 2007, the Department also strengthened its guidance on drinking and pregnancy, following the publication of a 2006 report¹⁶ which found a possible link between low or moderate alcohol consumption and spontaneous abortion. It also advises that, for example, it is sensible not to drink when driving or when taking certain medications.

3.3 The Department promotes these public health guidelines through its publications, campaigns and an interactive website and through health education material such as leaflets and posters in doctors’ surgeries. Sensible drinking messages are also communicated by the Drinkaware Trust (described in paragraph 3.8).

3.4 However, some consumers do not fully understand the guidelines.

- The Office for National Statistics, which monitors drinking patterns and awareness of the guidelines on behalf of the Department, found in 2006 that 69 per cent people had heard of daily guidelines for alcohol consumption but almost two-fifths of those could not say what the recommended daily limits were.

8 Sensible drinking guidelines		
Population	Current guidance	Previous guidance
Men	Should not regularly drink more than 3–4 units per day	(pre-1995) no more than 21 units of alcohol per week
Women	Should not regularly drink more than 2–3 units per day	(pre-1995) no more than 14 units of alcohol per week
Women who are pregnant or trying to conceive	Should avoid drinking alcohol. If they do choose to drink, to minimise the risk to the baby, no more than 1–2 units of alcohol once or twice a week and should not get drunk	(pre-2007) 1–2 units of alcohol once or twice a week and should avoid getting drunk

Source: Department of Health

14 A unit of alcohol is defined in the UK as 10 millilitres (ml) of ethanol. For example, a pint of ordinary strength lager contains two units, a standard pub measure of spirits has one unit, a 175 ml glass of wine at 13 per cent strength has 2.3 units and a 125 ml glass of wine at 9 per cent has one unit.
 15 Department of Health, *Sensible Drinking: The Report of an Inter-Departmental Working Group* (1995).
 16 National Perinatal Epidemiology Unit, University of Oxford, *Review of the fetal effects of prenatal alcohol exposure: report to the Department of Health* (2006).

- A small survey, commissioned by the Department before the start of its education campaign on units in May 2008, found that more than four out of five respondents (82 per cent) claimed to know what a unit of alcohol was. However, 77 per cent did not know how many units were contained in a typical large glass of wine and 35 per cent did not know that an average pint of beer contained two units.

The Department's education campaigns on alcohol

3.5 Since October 2006 the Department, in collaboration with the Home Office, has funded a series of public health campaigns on alcohol under the 'Know Your Limits' banner. The campaigns were initially aimed at binge drinkers aged 18–24, and were the subject of a series of evaluations¹⁷ which found that consumers in that age range were aware of the campaigns and could recall and understand the messages.

3.6 In 2008-09 the Department has broadened the focus of the 'Know Your Limits' campaigns to include unit awareness and has tripled the campaign funding to more than £6 million (from £2 million in 2007-08), with the Home Office contributing a further £4 million. The Units campaign, in particular, targets all drinkers over the age of 25 and aims to increase public understanding generally about alcohol units and the health risks of exceeding the guideline amounts. The expanded campaign includes broadcast advertisements, billboards, websites and promotional activity as well as the provision of information and educational materials aimed at GPs and NHS staff. The impact of the new campaign is being evaluated by the Department from summer 2008. A further strand of campaign activity, a pilot specifically to tackle harmful drinking behaviour, started in May 2008 with £750,000 funding from the Department. It includes: a booklet, *Your Drinking and You*, developed to help alcohol misusers reduce their consumption; a website, DrinkCheck, where people can assess whether their drinking places them at risk; and information for GPs and other health staff encouraging them to provide 'brief advice'. The Department plans to monitor this and will be assessing its effectiveness during 2008-09.

3.7 Education campaigns cannot usually show a direct and measurable impact on people's behaviour, but it is possible to measure changes in consumer awareness of a campaign's messages. The Department did not set measurable goals for consumer awareness but aims to continue to track reported consumer awareness and behaviour change. The Department jointly commissioned research in spring 2008 which showed that, when prompted, 99 per cent of the target audience could recognise at least one of the binge drinking advertisements dating from the first stage of 'Know Your Limits' campaign in 2006-07. For its new pilot, the Department is measuring behaviour change through follow-up interviews with people who order an alcohol-related booklet on the NHS website aimed at those drinking over the guideline amounts. The next phase, piloted since September 2008, aims to encourage more drinkers to access the information and advice. The Department has largely followed the principles laid down in the two main sources of government guidance on such campaigns, the Cabinet Office's Engage programme designed to improve strategic communications in government, and guidance from the National Social Marketing Centre.¹⁸ Some experts have questioned the effectiveness of public education campaigns compared to other initiatives for reducing alcohol harm, such as some specific alcohol treatments.

3.8 There have been some small-scale, local campaigns on alcohol. According to our surveys, 19 per cent of PCTs and 34 per cent of Drug and Alcohol Action Teams funded such campaigns in 2006-07. These campaigns were usually small-scale, however; PCTs spent an average of £8,900 per campaign and Drug and Alcohol Action Teams spent an average of £23,600. In total these accounted for £3.9 million of expenditure by PCTs and Drug and Alcohol Action Teams in 2006-07. Such campaigns often addressed alcohol as one of a number of general health education messages (such as advice on healthy eating and how to stop smoking) but often had not been formally evaluated. To help local bodies run campaigns, in 2007 the Department produced a toolkit, 'Every Unit Counts' advising them on how to approach communications or campaigns activity.¹⁹ The toolkit was updated in May 2008 to include binge drinking as well as units and a new guide on developing a campaign.

¹⁷ TNS (2007) *Alcohol Harm Reduction Campaign Evaluation 2006-2007 Report* (2007) and *TNS Know Your Limits – 'Binge' Campaign Evaluation 2008* (2008).

¹⁸ The NSMC is largely funded by the Department of Health. It promotes the use of social marketing in government. Social marketing is the systematic application of marketing tools to achieve a public or social good.

¹⁹ Accessed at: http://www.alcoholstakeholders.nhs.uk/stake_units-toolkit.html and http://www.alcoholstakeholders.nhs.uk/stake_binge-toolkit.html

3.9 Of the locally funded education campaigns, many are school-based and are designed to prevent and reduce alcohol use among young people. In November 2007, the National Institute for Health and Clinical Excellence (NICE) published guidance on school-based interventions, offering advice both on incorporating alcohol education into the existing curriculum and on helping children to access the right support. Furthermore, the Department for Children, Schools and Families, in collaboration with the Home Office and the Department, has been conducting research to provide evidence for the improvement of alcohol education in schools. There are also specific examples of local public bodies working together to provide these types of campaigns (**Case example 2**).

CASE EXAMPLE 2

Alcohol education within schools – Wakefield

In Wakefield, Yorkshire school education campaigns are provided through a collaborative approach between school, police, primary care trust and other local agencies. The education programme is aimed at all year 7 students (aged 11–12), identified as a key transition period for young people, moving from primary to secondary school. Acknowledging that a holistic approach was needed to ensure that all the students receive a consistent message in relation to health and wellbeing the programme involves the provision of core content alongside a prepared range of optional additional training resources.

As a new initiative, a session on safe and sensible drinking will form part of the core content and will enable a health professional to engage with the young people in their school environment and court debate what constitutes safe drinking, how to manage peer pressure, and the different relationships with alcohol including those exhibited in young people's own homes or by close family members.

The initiative is designed to give the school workforce the knowledge and skills to both identify young people at risk and take the required action. Delivery of the pilot education programme began in September 2008.

Working with the alcohol industry

3.10 In parallel with its own communications campaigns, the Department also works with organisations representing the alcohol industry (manufacturers and retailers of alcoholic drinks) to communicate messages about sensible drinking. This work has included the following developments in recent years.

- The Drinkaware Trust was established as an independent charity in early 2007. The Trust is funded through voluntary donations which it raises from the industry, and it is expected to raise a total of £12 million in the first three years of operation, to carry out educational and campaign work. The results of the Trust's work, including, for example, a website with self-assessment tools and advice on responsible drinking, have not yet been evaluated.
- The Portman Group was established in 1989 by the UK's main alcohol producers and has focused on drinks manufacturers' marketing practices. For example, the Portman Group has a voluntary code of practice for drinks producers, which "seeks to ensure that drinks are marketed in a socially responsible way and to an adult audience only".
- Negotiating a voluntary agreement with the drinks industry on the inclusion of health and units information on packaging and labelling of alcoholic drinks. The extent to which the drinks industry has complied with this agreement has been evaluated. A first-stage report undertaken in March 2008²⁰ found that take-up for the scheme is slow: 57 per cent of products showed information on the alcohol content and only three per cent used the labelling scheme in its entirety. The industry has until March 2009 for the majority to be fully compliant.
- On 2 June 2008, the Department, Home Office and the Department for Culture Media and Sport announced plans to work with the alcohol industry to develop a new 'alcohol retailing code' with a view to making it mandatory. The plans are subject to the outcome of a public consultation launched in July 2008.

20 Campden & Chorleywood Food Research Association Group (CCFRA) *Monitoring Implementation of Alcohol Labelling regime (including advice to women on alcohol and pregnancy)* (June 2008). Published by the Department in July 2008, details at: www.dh.gov.uk/en/PublicHealth/healthimprovement/Alcoholmisuse

Simple interventions such as identification and brief advice

3.11 Within the health service, initial identification of alcohol misuse (often called ‘screening’) can take place in a number of different settings: during a patient consultation with a GP or practice nurse; during or after a visit to an accident and emergency (A&E) department; or on a hospital ward through a consultation with a doctor or nurse. Identification is carried out using a range of screening questionnaires which typically ask the sorts of questions shown below. These have been shown to be quick and effective.²¹

Alcohol screening questionnaires

Alcohol screening questionnaires typically include questions such as:

- How often do you have a drink containing alcohol?
- How many units of alcohol do you drink on a typical day when you are drinking?
- How often do you have six or more units of alcohol on one occasion?
- How often during the last year have you failed to do what was normally expected from you because of drinking?
- How often during the last year have you been unable to remember what happened the night before because you had been drinking?
- Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?

The questionnaires are accompanied by a scoring system which helps the health professional using it to diagnose problematic drinking patterns.

3.12 Health service data on alcohol screening is poor. It is difficult therefore to get a clear picture of the extent to which questionnaires are used, and in what way. For example, the system of ‘Read codes’ which GPs use to record their activity is currently confused for alcohol-related activity, with 39 possible different codes. New, standardised codes for alcohol-related activity are being created by NHS Connecting for Health, the new NHS-wide IT system, at the request of the Department.

3.13 According to our survey of GPs, relatively few (422 of 1435, or 29 per cent) use an alcohol screening questionnaire such as those described above. Those who did use questionnaires said they did so for an average of only 33 patients in the last year. This figure is low

compared to the average 8,409 consultations made by each GP in a year. GPs do, however, ask about their patients’ alcohol use in less formal ways. Almost half (45 per cent) said they carried out ‘regular checks’ on their patients’ alcohol use and a similar proportion (48 per cent) used a health questionnaire for new patients, nearly always including questions about alcohol use.

3.14 Fewer than half (47 per cent) of our sample of GPs felt that they had adequate training to recognize alcohol-related health problems in their patients. Similarly, only half of GPs (56 per cent) reported having undertaken alcohol misuse training during their basic medical training. In 2007 a guidance document for all medical schools, *Substance misuse in the undergraduate medical curriculum*, was launched by the Department. The Department also provided £650,000 of funding in 2008-09 for medical schools to develop training that is intended, within ten years, to produce 60,000 new doctors specifically trained to identify and advise or treat people who are drinking too much. In November 2008, the Department plans to launch an online training package available to all NHS professionals designed to develop the skills required to undertake identification and brief advice.

3.15 After screening, individuals identified as misusing alcohol can be offered ‘brief advice’. While such advice can be provided by a range of trained practitioners, it is most usually given by NHS staff: GPs or practice nurses in primary care and specialist nurses in hospitals.

Brief advice

‘Brief advice’ is defined in the Department’s guidance as short advisory interviews, often delivered after screening identifies alcohol as a potential problem. Brief advice sessions have been shown to be effective in reducing people’s drinking, as well as cost-effective, in a variety of settings (see Appendix 6). They are provided by a ‘competent practitioner’ such as a GP, nurse or trained non-medical professional, in about five to ten minutes. The advice given may include the risks a patient is running by drinking too much, setting goals to reduce alcohol consumption, and providing written materials such as advice leaflets.

The Department has funded a £3.2 million pilot programme of identification and brief advice, the *Screening and Intervention Programme for Sensible Drinking (SIPS)* in order to provide more evidence on the delivery, effectiveness and cost effectiveness of a range of alcohol identification and brief advice approaches across settings in England. The programme, which was launched in autumn 2006, will report in 2009.

²¹ Raistrick, D.; Heather, N.; Godfrey, C. (2006). *Review of the Effectiveness of Treatment for Alcohol Problems* (November 2006).

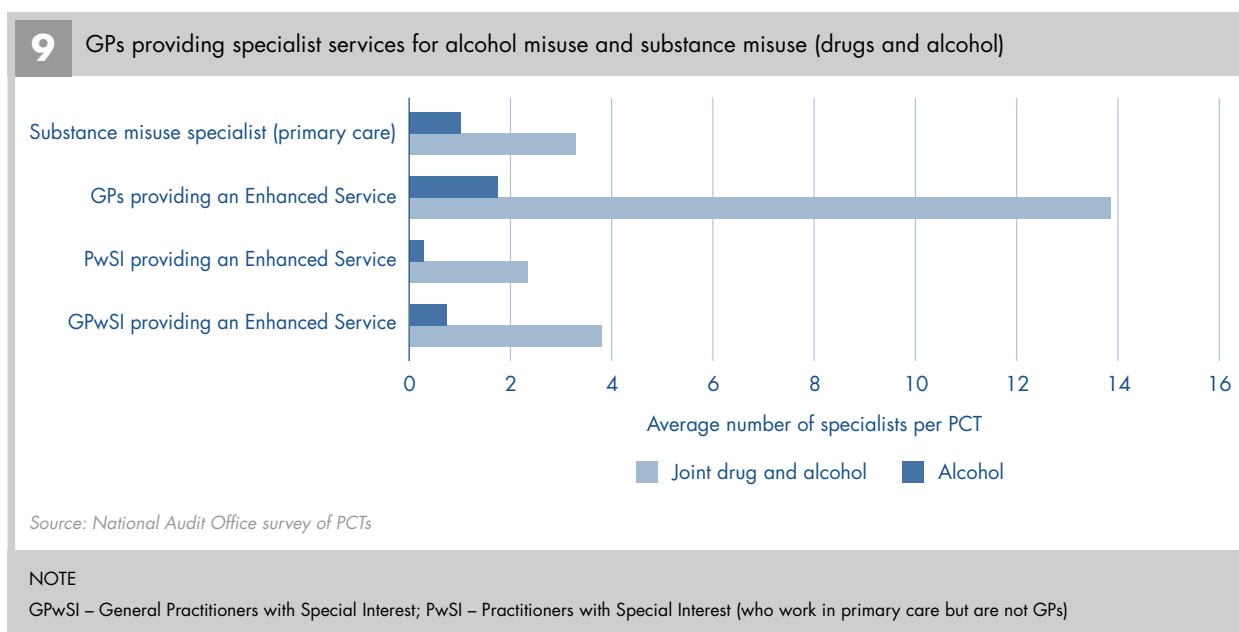
3.16 The provision of brief advice in primary care, as reported by PCTs, varies significantly. Nearly a third (31 per cent) of PCTs who responded to our survey said that no GP practice in their area was offering such a service.²² Interviews with PCTs also revealed that some did not know the extent of provision, or suggested that it was 'likely to be sporadic'. Those GPs who did offer brief advice reported that they did so for an average of 66 patients each in the last year. In theory, without considering other demands on their time, GPs could have the opportunity to offer brief advice to as many as 200 patients per year.²³

3.17 There is currently no reference to alcohol-related activity in the Quality and Outcomes Framework which forms part of the payment package for GP services and thus there is currently no specific national financial incentive for more systematic alcohol screening or brief advice by GPs. The Framework is negotiated annually between NHS Employers, which represents NHS trusts on workforce issues, and the British Medical Association. The Department is able to offer financial incentives to primary care for offering services to a set specification, through Directed Enhanced Services. These Services must be provided by all PCTs and therefore have the potential advantage of ensuring an equal level and standard of provision. To date these nationally-set Services have not covered alcohol treatment or prevention.

In September 2008, however, a new Directed Enhanced Service to screen newly-registered GP patients for alcohol consumption, from 2009-10, was announced.²⁴ This provides an additional incentive of £8 million for GPs to undertake identification and brief advice.

3.18 PCTs can, however, commission additional services from GP practices and other primary care providers through locally agreed 'enhanced services' contracts. Thirty-four of the PCTs in our survey (24 per cent) reported having commissioned some form of local enhanced service for alcohol misuse (although the majority are provided as joint drug and alcohol services). In one such case, for example, 31 GP practices received £1,000 each to train at least two staff to deliver identification and brief advice, record their work and report back to the PCT. In June 2008 the Department issued a new Primary Care Service Framework that defines more clearly what primary care services for alcohol should look like.

3.19 There are also a number of GPs and primary care practitioners who have chosen to take a special interest in alcohol misuse and who offer specialist services (see box). Our survey revealed that most are involved in treating both drug and alcohol misuse (see Figure 9). In the case of alcohol misuse there is no specific guidance on what such a 'Special Interest' service should include.



22 55 per cent of PCTs responded that they did have a GP practice offering brief advice and the remaining 14 per cent did not know.

23 The average number of adults per GP list is 1250, so if all hazardous and harmful drinkers were the target, we could anticipate that each GP has about 325 patients drinking above the guidelines. Around 63 per cent of adults visit their GP in year, so GPs could have the opportunity to identify over 200 patients per year.

24 Details of the five new Directed Enhanced Services announced on 4 September 2008 can be found at: <http://www.nhsemployers.org/aboutus/mediacentre-listing.cfm/pressrelease/818>

Alcohol misuser and family's perspectives on effective GP intervention for a dependent drinker

A couple living in the North-East went together to see their GP about the husband's drinking problem. Both felt the GP responded very well. The surgery had a GP with a special interest in alcohol and the couple were passed promptly to this doctor. The husband was assessed as being alcohol dependent and was given a home detoxification along with a referral to a support group. His wife was referred to a group for partners and families of problem drinkers, which she found helpful.

The wife said she felt that they had been very lucky not to have lived through the years of difficulties she heard about from others, and that they had been able to find effective help. Her husband had found adjusting to not drinking very difficult but the support group provided a focus during his recovery, a benefit in realising he was not alone and a means of creating the alternative lifestyle he needed in order to continue without drinking.

3.20 Brief advice can also be provided in other health settings such as hospital wards and A&E departments. Provision is, however, patchy: 44 per cent of PCTs reported that brief advice was being provided in A&E in their areas, and in these areas nearly two-thirds of A&E departments (63 out of 98) were providing such advice. One established and highly regarded service provided within A&E is that at St Mary's Hospital, Paddington (**Case example 3**). Work has also been carried out in piloting identification and brief advice in sexual health clinics. These clinics provide a potentially effective setting for such interventions since many of the population may not be registered with a GP, and research has suggested that the levels of alcohol misuse among those attending such clinics are high in relation to both the general population and other medical settings.²⁵ Likewise, research suggests that identification and brief advice would also be effective if provided in outpatient clinics to patients with alcohol-related facial injuries.²⁶

CASE EXAMPLE 3

Identification and brief advice service to reduce re-attendances – St Mary's Hospital, Paddington

In St Mary's Hospital, Paddington, in London, all A&E patients with conditions that are often alcohol-related (such as falls, head injuries or assaults, road traffic accidents, gastrointestinal problems, psychiatric problems and cardiac symptoms) are assessed for alcohol misuse using the Paddington Alcohol Test (PAT) questionnaire. Patients whose score indicates hazardous or harmful drinking are offered a meeting with the hospital's alcohol health worker, a trained nurse, who carries out a more in-depth assessment of the patient's lifestyle and alcohol use, and then offers brief advice. Where the patient is dependent, the alcohol health worker also works to improve the management of alcohol withdrawal on the wards, and to improve the education of medical students about alcohol.

Research evaluating the service¹ found that the introduction of 30-minute appointments for extended brief advice, which can be provided at little cost, results in those referred to the alcohol health worker consuming less alcohol after six months than those who are not referred. The service was also found to have reduced reattendance rates at the A&E department, by an average of 0.5 visits per person over the first 12 months.

NOTE

1 Barrett, B., Byford, S., Crawford, M., Patton, R., Drummond, C., Henry, J., Touquet, R. (2006) *Cost-effectiveness of screening and referral to an alcohol health worker in alcohol misusing patients attending an accident and emergency department: A decision-making approach*. *Drug and Alcohol Dependence*, 81, 47–54; and Crawford, M., Patton, R., Touquet, R., Drummond, C., Byford, S., Barrett, B., et al. (2004). *Screening and referral for brief intervention of alcohol-misusing patients in an emergency department: A pragmatic randomised controlled trial*. *The Lancet*, 364, 1334–1339.

25 Crawford, M.J., PC Lowe, L Greene, C Brooking (2004) *The prevalence of excessive alcohol consumption and the acceptability of brief advice in a sexual health clinic: cross sectional survey*. *Sexually Transmitted Infection*, 80, 415–421.

26 Smith, A.J., Hodgson, R.J., Bridgeman, K., Shepherd, J.P. (2002) *A randomized controlled trial of a brief intervention after alcohol-related facial injury*. *Addiction*, 98, 43–52.

Working with other partners

3.21 Many people may drink alcohol quite heavily over a long time and have no contact with the health service until eventually they develop a serious alcohol-related health problem or have an accident due to drinking. Such people may, however, come into contact at an earlier stage with occupational health professionals and other public officials such as social workers, the police and probation officers (see box). These encounters provide an opportunity for officials who have been appropriately trained to offer brief advice to alcohol misusers. There is limited evidence that these opportunities are being exploited, but in one or two cases new initiatives have been introduced. For example, the National Offender Management Service, part of the Ministry of Justice, has developed an alcohol information pack for offender managers, including guidance and tools to help them identify offenders with alcohol related needs, deliver brief advice, and offer onward referral to those who may need more intensive intervention.

Alcohol misuser's perspective on symptomless heavy drinking

B, a successful businessman aged 49, regularly drinks over 50 units a week. B 'never needs' to see his GP, but was once 'breathalysed' (given a breath test to check alcohol levels) and taken to a police station for a second test. He saw this as 'a bit of a wake-up call' and a sign that he needed to 'take it easy' (by cutting down his drinking). He does not feel he has any health problems from his drinking – 'if I do feel bit ropy in the morning once too often, I just cut it back for a week or two'. He does need to lose weight, however: 'The only thing I think is an issue about the amount I drink is that it doesn't help me keep my weight down'.

Referring patients to specialist services

3.22 As well as delivering brief advice, bodies outside the health service can also help direct alcohol misusers towards specialist treatment where needed. The 2004 National Alcohol Strategy recommended that this wider network of referral routes should be established, including non-health bodies such as social services, police and probation. Our survey of PCTs indicated, however, that there is scope for more effective referral, revealing that a quarter of PCTs felt that referral routes from criminal justice agencies could be improved and a fifth that referrals from social services could be likewise improved.

3.23 Our survey of GPs found that each GP referred an average (mean) of eleven patients for specialist alcohol treatment in the last year. GPs point to patients' lack of awareness that their alcohol use is excessive, and a general shortage of local specialist services, as the most important reasons why they do not refer more patients for further help. In accordance with previous research²⁷ 71 per cent of GPs in our survey said there was a shortage of detoxification services, 73 per cent reported a shortage of rehabilitation services, and 63 per cent said there were too few alcohol counselling services.

27 Department of Health, *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (November 2005).



PART FOUR

Provision of specialist alcohol treatment services

4.1 This Part focuses on specialist alcohol treatment services, predominantly designed to treat the more serious harmful and dependent drinkers. The specialist alcohol services discussed cover treatments for both the effects of alcohol misuse and the behaviour itself, and include walk-in clinics, home-based detoxification programmes, residential rehabilitation, structured psychological interventions, and alcohol services linked to hospital units, such as those for a liver transplant. Treatments can be provided in primary care (for example, a GP or practice nurse providing 'extended brief advice' during a series of consultations), acute hospitals (alongside the treatment of liver disease, for example) and other specialist settings (such as counselling services in a substance misuse or addiction service, which may be run by a private or voluntary sector provider).

4.2 The NHS has no specific objectives relating to the provision of specialist alcohol treatment services, which is in the hands of local commissioners. PCTs and Drug and Alcohol Action Teams control the provision of services outside hospitals. In general, PCTs directly commission specialist services, such as a weekly alcohol clinic, from primary care practices, NHS trusts or voluntary sector providers. PCTs may provide funding to Drug and Alcohol Action Teams, who commission substance misuse services from various providers. There is, however, no standard model for the partnership relationships of PCTs and Drug and Alcohol Action Teams and PCTs may commission substance misuse services directly from providers, acting alone or in joint commissioning arrangements with other PCTs.

Provision of specialist services

4.3 With numerous types of services potentially available, devolved decision-making by PCTs, and a range of views amongst experts on the right make-up of local services, there is no particular benchmark for assessing the appropriate level of specialist provision. The most authoritative estimates of the need for specialist alcohol treatment were published in 2005 by the Alcohol Needs Assessment Research Project (ANARP), commissioned by the Department.²⁸ The ANARP study found that only a small minority of dependent drinkers were receiving treatment, estimating that approximately 1 in 18 (5.6 per cent) alcohol dependent people were accessing specialist alcohol treatment in England each year.²⁹ These figures are low, both in comparison to other countries and to the treatment of illegal substance misuse. A study in North America found an access level of 1 in 10 (10 per cent) which the researchers considered to be 'low'. The study considered a level of access of 1 in 7.5 (15 per cent) to be medium and 1 in 5 (20 per cent) to be high.³⁰ In England, an estimated 1 in 2 (55 per cent) problem drug misusers gain access to treatment each year.³¹

4.4 These figures are not simply caused by low referral rates, which are discussed in Part 3 of this report. Many people do not take up services even when they are referred. The ANARP study found that for every 2.7 referrals, only one person actually made use of specialist services.³² There were various reasons, such as many dependent drinkers not being ready to agree to treatment or even to acknowledge that they have a problem; patients' lack of confidence in the effectiveness

²⁸ Department of Health, *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (November 2005).

²⁹ Likewise, Alcohol Concern reported that in 41 per cent of the areas with usable data, access to treatment was less than 10 per cent.

³⁰ Rush, B 1990 *A systems approach to estimating the required capacity of alcohol treatment services*. *British Journal of Addiction*, 85: 49-59, cited in Department of Health, *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (November 2005).

³¹ 180,000 people were successfully engaged in treatment in 2006-07 (Source: National Treatment Agency for Substance Misuse. *Better Treatment, Better Outcomes: Annual Report 2006/07*) compared to 330,000 problem drug users (Source: research commissioned by NTA on prevalence of PDU in England from the University of Glasgow).

³² Department of Health, *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (November 2005).

of the service offered; and waiting times. The ANARP study found the average waiting time for assessment was 4.6 weeks. Similarly, our survey found that reported average waiting times for specialist services were approximately one month.

Local variation in service levels

4.5 There is considerable regional variation in access to specialist services: the 2005 ANARP study estimated that only one per cent of alcohol dependent people were accessing treatment in a year in the lowest rated region, the North East, compared to eight per cent in the highest rated region, the North West.³³ Local variations in particular types of services are discussed further below.

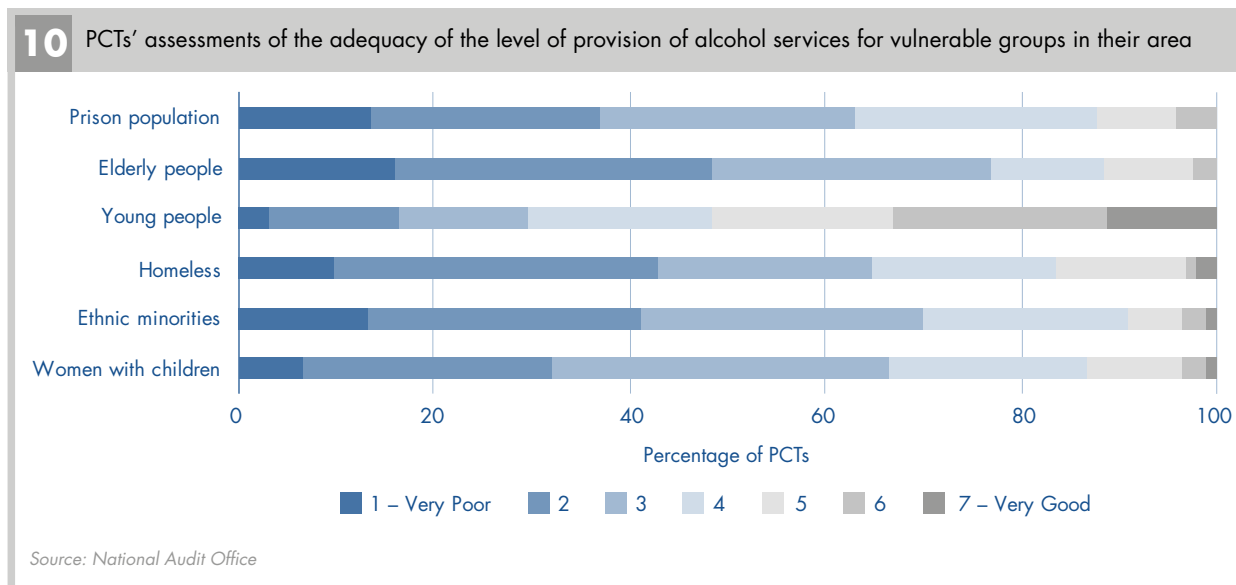
4.6 Provision of specialist services is a particular issue for some groups of alcohol misusers. The 2004 National Alcohol Strategy identified a particular need for services for vulnerable and at-risk groups and highlighted problems with links between alcohol treatments and other health and social care services.

4.7 Our survey of PCTs found that most respondents thought services for vulnerable groups were inadequate (**Figure 10**). These results are in accordance with the 2005 ANARP study, in which Drug and Alcohol Action Team

professionals identified groups such as black and ethnic minorities, rural communities, homeless people and asylum seekers as having inadequate services.³⁴ Our own survey found that elderly people were especially poorly served, which is also consistent with previous research.

4.8 PCTs' perceived adequacy of provision for young people, under 18, was high relative to the other groups. Unlike alcohol services for adults, young people's alcohol services can make use of funding from the Pooled Treatment Budget, provided by the Department and the Ministry of Justice, to Drug and Alcohol Action Teams. The budget, worth £385 million in 2006-07, must be used to provide treatments for 'substance misuse' – i.e. use of illegal drugs – which includes alcohol misuse by young people, since they cannot legally purchase alcohol.

4.9 Beyond the straightforward interventions (identification and brief advice) described in Part 3, primary care services can also provide a range of treatments: for example, our survey of GPs found that 65 per cent of GPs had prescribed nutritional supplements, such as vitamins, for dependent drinkers, 32 per cent had prescribed medication to promote abstinence or prevent relapse and 30 per cent had offered medically assisted withdrawal.



³³ *ibid.* The National Treatment Agency told us that its most recent figures suggest that access to services in the North East is now closer to the national average.
³⁴ Department of Health, *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (November 2005).

Specialist NHS hospital-based treatments

4.10 NHS trusts provide hospital-based treatment, such as inpatient detoxification, for the physical and mental effects of alcohol misuse which requires medical support. They also provide acute care for associated conditions, including heart disease, liver and kidney disorders and various cancers. Hospital services may be provided in specialist alcohol or substance misuse units, or as part of general medical services.

4.11 The demand for hospital treatment for the three main alcohol-specific conditions (mental health, liver disease, acute intoxication) has risen rapidly; hospital admissions for such conditions have more than doubled in the last 11 years (from 93,459 in 1995-96 to 207,788 in 2006-07). This increase is significant even in the context of a general increase in all admissions (by a third over this period) and the greater detail with which people's diagnoses are now recorded. New data on alcohol-related hospital admissions, which estimates the amount that alcohol misuse is attributable to a range of illnesses, shows that the health harms are greater than previously thought, accounting for 811,443 admissions in 2006-07. Similarly, there has been a two-fold increase in alcohol-related fatalities in the UK over 15 years (up from 4,144 in 1991 to 8,758 in 2006).³⁵

4.12 While many alcohol-related conditions are treated as part of hospitals' mainstream services, additional, specialist provision is needed for some conditions. Liver units bring together specialist equipment and expertise for the treatment of liver conditions, whether or not caused by alcohol misuse. In 2006-07, around 48 per cent (11,600 patients) of the total number of patients admitted to hospital with a primary diagnosis of liver disease (24,127) had alcoholic liver disease.³⁶

4.13 The other main hospital-based services are inpatient alcohol units, which provide medically supervised withdrawal. In-patient treatment services can be located in general psychiatric units or may be simply part of general medical wards. In-patient services are also provided by the voluntary and independent sectors, often as the first stage to a wider package that includes residential rehabilitation described in *Community and Residential services*, below.

4.14 Provision of such services remains patchy; our survey found that there were significant variations in the distribution of liver units. Certain regions have neither liver units nor inpatient alcohol units, as highlighted by **Figure 11**.

Community and residential services

4.15 Community and residential services are usually aimed at harmful and dependent drinkers. Community detoxification normally takes place in the patient's home and involves withdrawal from alcohol, with the support of a GP, nurse or alcohol treatment worker, whilst residential services are for clients who are not suitable for community treatment. The majority are run by private or voluntary organisations: of the 696 agencies identified in the 2005 ANARP study, more than half were non-statutory (voluntary), one-third statutory (NHS) and eight per cent private sector-run. The agencies that provide the services can be funded by the NHS and other local public bodies such as local authorities and Drug and Alcohol Action Teams, through charitable donations or by private payment from individual patients.

4.16 The 2005 ANARP study found that nationally there was a lack of provision of such services. The report also found that there was a wide regional variation in the number of alcohol treatment services, ranging from an estimated 198 organisations providing services in London and 130 in the South East, to 32 in the North East and 20 in the East Midlands.

4.17 Where community and residential services are available, they are often general substance misuse services, dealing with users of illegal drugs, as well as alcohol misusers. Of the 696 specialist services identified by the ANARP study, a third were primarily alcohol services and 58 per cent were joint drug and alcohol services.

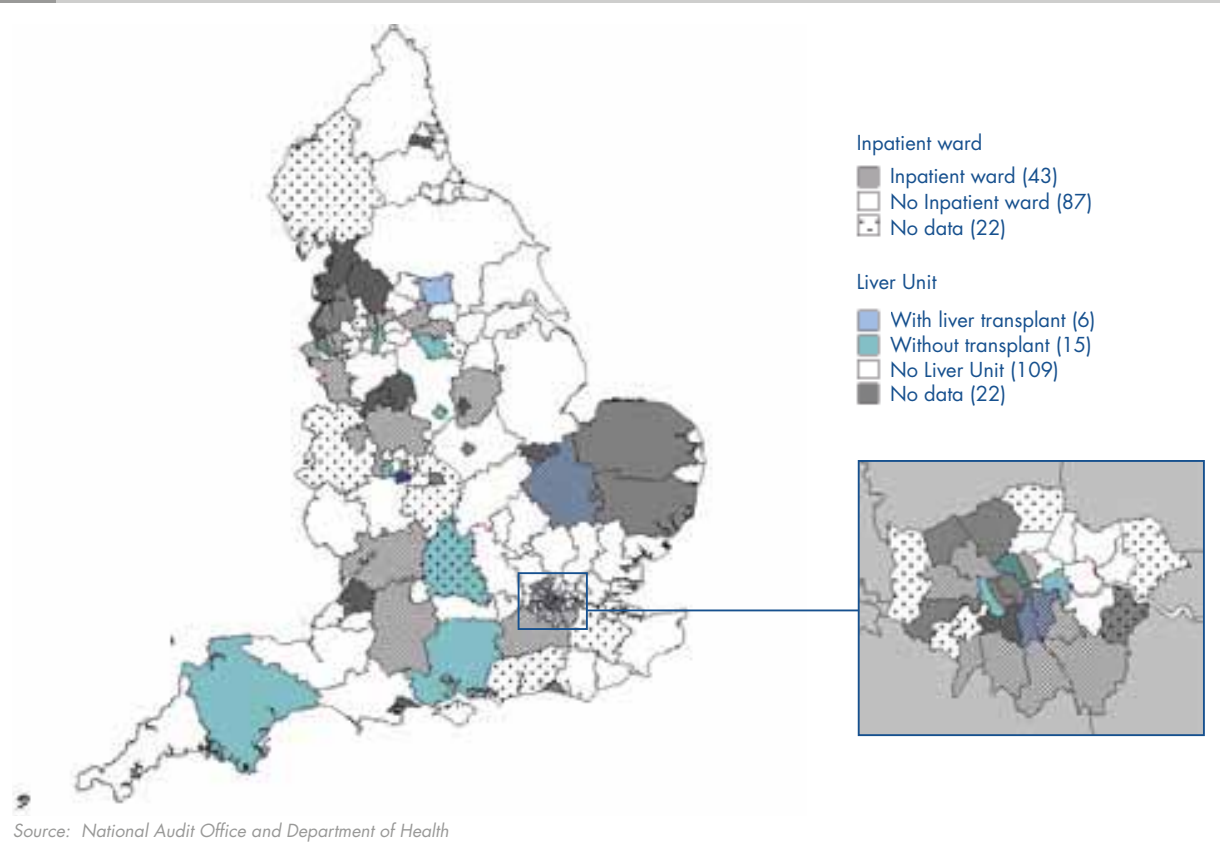
4.18 The types of community and residential services provided in different areas vary, as shown in **Figure 12** below. Just over half of the PCTs surveyed commissioned residential rehabilitation services, while a somewhat larger proportion, 67 per cent, commissioned or jointly commissioned community detoxification services. There is a risk that, in some areas, people who need these services will remain untreated, have to access less appropriate alternative services or, if provided, have to rely either on voluntary services that are not commissioned by the PCT or Drug and Alcohol Action Team, or on primary care practitioners who may not have appropriate training or support to provide these services effectively. Previous research on the provision of residential and community services found that there was regional variation in average waiting times for assessment, with the shortest wait in the South East region (3.3 weeks) and the longest wait in the North East region (6.5 weeks).³⁷

³⁵ Alcohol-related fatality figures count only deaths for which a specific alcohol-related condition (including mental and behavioural disorder due to use of alcohol, alcoholic liver disease and poisoning by exposure to alcohol) was recorded as the underlying cause.

³⁶ Source: Hospital Episode Statistics.

³⁷ Department of Health, *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (November 2005).

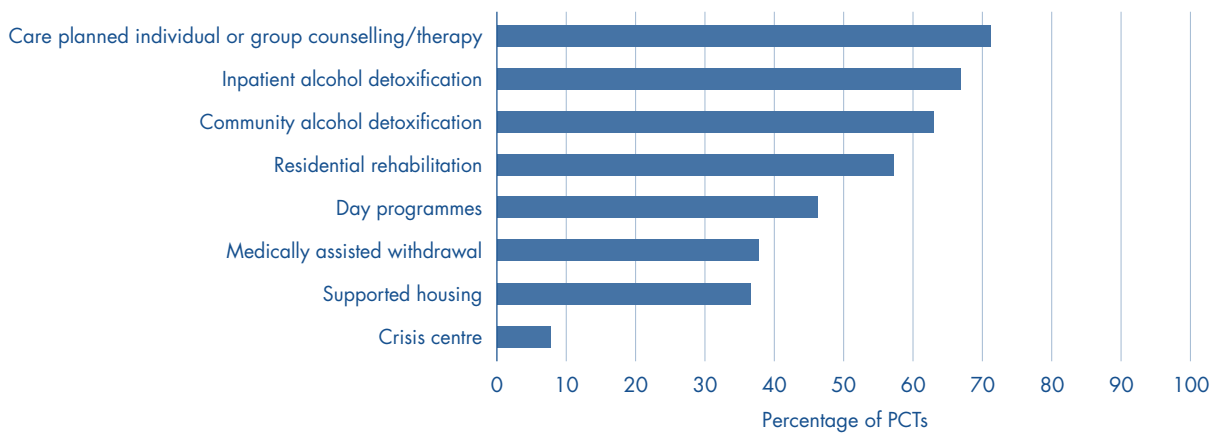
11 Provision of liver units and dedicated specialised alcohol inpatient wards in England



NOTE

Hashed areas have inpatient wards, blue areas have liver units with liver transplant services, and turquoise areas have liver units without transplant services.

12 Provision of specialist services by PCTs



Source: National Audit Office survey of PCTs

NOTE

Medically assisted withdrawal or relapse prevention relates to the prescribing of the drugs acamprosate and disulfiram.

Effectiveness of specialist services

4.19 Since the provision of specialist services is fragmented, and there have been no overall objectives or targets against which performance can be monitored, the effectiveness of specialist treatment services is unclear. There is evidence from academic research, in the UK and elsewhere, that specialist services can be effective (discussed in Appendix 6 of this report). To date, however, little data has been available on the overall results of specialist treatment for alcohol misuse in England, either on short-term achievements or on long-term impacts on health.

4.20 In April 2008, however, a new system came into effect which will provide national data on the effectiveness of alcohol treatment. As part of the National Drug Treatment Monitoring System, which collects data on people receiving specialist drug treatment, all providers of specialist alcohol treatment, including the care provided by GPs under 'enhanced services', have been asked to submit data on clients receiving specialist treatment for their alcohol misuse. This data can be used to calculate proxy outcome measures, such as waiting times and retention of clients within the services, to indicate the effectiveness of alcohol treatment. However, the System will not include some less structured alcohol treatments (such as confidential advice provided by the voluntary sector) and the data providers are not yet required to complete Treatment Outcome Profiles, which directly measure the effectiveness of services, although they are encouraged to do so.

Integration between services

4.21 The Department has recommended, in the 2004 and 2007 National Alcohol Strategies and in its guidance to commissioners, that as well as providing alcohol services which are appropriate to local needs, PCTs should also ensure that individual services are integrated with each other, to provide complete 'care pathways'³⁸ for patients. For example, people who are discharged from hospital treatment such as detoxification or surgery will often need follow-on support and counselling.

4.22 Service integration is limited in many areas at present. Our focus groups and interviews identified many examples of service users who had 'fallen through the gaps' between different types of service (see box). Survey data also showed limited efforts by PCTs to deliver integrated care pathways:

- only approximately a third of local areas³⁹ reported having a liaison alcohol service for the acute medical/psychiatric sector (usually undertaken by a doctor or nurse to help coordinate services so that alcohol misusers are referred between acute and psychiatric services if appropriate); and
- some 43 per cent of PCTs reported having regular contact with services provided by voluntary organisations, who often see clearly where individuals have 'fallen through the gaps' in service provision and could hold an insight into possible changes in the services commissioned.

4.23 One example of good practice in integrating services is at Liverpool, where the hospital-based Alcohol Specialist Nurses work to liaise with other medical professionals, run primary care clinics and refer on to other services (**Case Example 4**). A report by the Royal College of Physicians in 2001, recommended that every acute hospital should have at least one trained health worker, such as an Alcohol Specialist Nurse.⁴⁰

4.24 Health services also need to be integrated with other support services such as help for families and carers, and assistance with employment or housing issues. Such linkages are frequently weak, however (see box). As referred to in Part 2, where a Local Area Agreement establishes alcohol as one of its priorities, there is potentially increased pressure for effective joined-up working between agencies, since there will be closer performance monitoring and scrutiny by external agencies, of how those priorities have been tackled.

38 Care pathways include a definition for the treatment, objective and client group served; a referral pathway; development of agreed treatment goals; and departure planning, aftercare and support.

39 In our surveys, 37 per cent of PCTs and 33 per cent of Drug and Alcohol Action Teams reported having a liaison alcohol service for the acute medical/psychiatric sector.

40 Royal College of Physicians, *Alcohol – can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals* (2001).

CASE EXAMPLE 4

Improving and coordinating services through Alcohol Specialist Nurses for all types of alcohol misusers – The Royal Liverpool University Hospital

Research into Accident and Emergency attendances at the Royal Liverpool University Hospital demonstrated that alcohol misusers were placing a large burden on the service. The study recommended that education, identification and intervention strategies should be implemented in the hospital's A&E department.

To address this issue, the hospital developed the role of an Alcohol Specialist Nurse (ASN) to improve the treatment received by patients coming to hospital with alcohol-related problems. As a result, all patients identified by either a nurse or doctor as having an alcohol-related problem are referred to the ASN who will:

- screen the patient using an alcohol screening questionnaire (AUDIT);
- give brief advice where appropriate;
- liaise with other medical staff to help those with other health problems or illnesses;
- prescribe medication for the management of acute alcohol withdrawal; and
- develop follow-up care pathways to manage patients in primary care clinics.

As a result of the ASN service, there has been a reduction in the average alcohol consumption of patients treated, reduced re-attendances, and improved staff attitudes and knowledge. In a 20-month period, the ASN's work saved at least £175,000 in hospital costs, solely through the earlier discharge of patients.

The role has since been further developed and expanded and since 2004 is undertaken by a nurse-led Alcohol Services Lifestyle Team. Three more nurses have now been brought into the Team, which now costs around £300,000 per year. The local Drug and Alcohol Action Team supports one of the nursing posts, whilst the PCT directly funds the others. Their work now includes alcohol clinics in seven primary care practices in the Liverpool area; one is held somewhere in the city every day of the week, treating approximately 1,000 patients a year.

Alcohol misusers' families' perspectives on patients 'falling through the gaps' in services and the need for family support services

From the wife of a dependent drinker: 'My husband drank for years...He'd be in and out of the hospital with broken bones and the like. Every few months. They'd have him on stuff whilst he was in there – to stop the fits and all – but just send him out home with nothing, nothing. I pleaded, "there must be something someone can do." The nurse just said, "Mrs F, most just leave them by the time they are this bad, you know." No one would do anything...The best it got was when alcohol just rotted his body – he was practically housebound. I controlled his beer and at least for the last few years things were tolerable. He died 18 months ago.'

From the grandmother of a young dependent drinker: 'My grandson's lived with me for two years. I didn't want to see him go into care so I said I would have him. He drinks and has not been to school all this time – years. No one comes near us. I had to get his drink for him. He'd give hell if I didn't. He's locked me in me own house before now. But since I've been up the Cottage [a community service for people affected by others with a drink problem], I've learnt so much, about what it does, how to handle him. I don't buy his drink now and he has stopped roaring around the place. It's much better. I go there, have a cup of tea with the others and we talk. I know so much now and could really help others if I weren't so old!'

APPENDIX ONE

Department of Health commitments from 2004 and 2007 alcohol strategies

This appendix summarises the Department of Health's commitments on reducing alcohol harm as outlined in the 2004 and 2007 cross-government strategies. The numbering of the recommendations summarised here is discontinuous, reflecting this report's focus on the health service (omitted recommendations are those relating to the Home Office, other government departments or the drinks industry).

Recommendations for the Department of Health from the Alcohol Harm Reduction Strategy for England (2004)

Recommendation

Response

1–10: Education and communication

Recommendations including, for example: that the Department should identify the most effective message and media for communicating with binge and chronic drinkers; and that the Department should 'strongly encourage' retailers to add messages on sensible consumption and unit content to the labels of alcoholic products.

The Department has launched various alcohol education campaigns and joint initiatives with the alcohol industry, which are discussed in the main text (paragraphs 3.2 – 3.10) of this report.

13–21: Identification and treatment

The Department committed itself to various initiatives on identification and treatment, including pilot schemes for screening and brief interventions and an audit of the provision of alcohol treatment in England.

The 'SIPS' pilot project, discussed in the main text (3.15) of this report, is due to report in 2009. The Alcohol Needs Assessment Research Project (ANARP) was published in November 2005.

The Department has also developed online training to produce health professionals with the skills required to undertake identification and brief advice. The training was launched in autumn 2008 and the Department plans to extend its coverage to social care and criminal justice professionals.

25–35: Alcohol-related crime and disorder (recommendations shared by the Department of Health and the Home Office)

The Department and the Home Office shared responsibility for the introduction of voluntary social responsibility schemes for alcohol retailers and for action by the justice system on alcohol.

The Home Office published a *Review of Social Responsibility Standards for the production and sale of Alcoholic Drinks*, commissioned from KPMG, in 2008.

39–40: Delivery and implementation

These recommendations outlined ministerial responsibilities and the overall control of the alcohol harm reduction strategy.

Government departments work together under the Alcohol Harm Reduction Programme, to oversee delivery of the strategy.

New actions for the Department, from *Safe. Sensible. Social. The next steps in the National Alcohol Strategy (2007)*

Recommendation	Response
<p>3 Set up collaboration to disseminate the early results of 'trailblazer' (SIPS) programmes on screening and brief advice.</p>	<p>Launched in April 2008. The Department has commissioned work to support 20 'early implementation' PCTs which will be selected by October 2008.</p> <p>In March 2008, the Department launched HubCAPP, a database of case-studies of local alcohol interventions, commissioned from Alcohol Concern.</p>
<p>4 National review of the cost of alcohol-related harm to the NHS.</p>	<p>The Department published <i>The cost of alcohol harm to the NHS in England: An update to the Cabinet Office (2003) study</i> in July 2008.</p>
<p>5 Establish a framework to support commissioners in planning local investment.</p>	<p>The Department has published a number of documents to comprise a commissioning framework, including information on the need for services (Local Alcohol Profiles for England and calculation for number of alcohol-related hospital admissions) and details on how to deliver the alcohol-related Public Service Agreement. The Department plans to publish a programme bringing together this guidance in November 2008.</p> <p>Guidance for PCTs and Local Authorities on needs assessments and commissioning will be published in late 2008.</p>
<p>6 Establish alcohol 'arrest referral pilot' (recommendation shared by the Department and the Home Office).</p>	<p>In October 2007, the Home Office funded alcohol arrest referral projects in four pilot sites. A further nine new areas have been chosen to implement alcohol arrest referrals by the end of 2008.</p>
<p>13 Independent national review of evidence on relationship between alcohol price, promotion and harm, to lead to public consultation and consideration of the need for regulatory change in the future, if necessary.</p>	<p>In July 2008, the Department launched a consultation, <i>Safe, Sensible, Social – Consultation on further action</i>, asking for the views of the public and key stakeholders on what action the Government should take in response to the rising levels of alcohol harm and crime and disorder. Alongside this, it also published a summary of the international evidence from the independent review, and will publish detailed policy models in the autumn of 2008.</p> <p>To inform the consultation, the Department also published impact assessments on an alcohol retailing code, implementation of the voluntary agreement on alcohol labelling, and on changes to alcohol advertising. Ministers will consider the results of this consultation in autumn 2008.</p>
<p>15 Consultation, during 2008, on the need for legislation in relation to alcohol labelling (depending on the results of the voluntary labelling scheme discussed in the main text of this report).</p>	<p>Covered by <i>Safe, Sensible, Social. Consultation on further action</i>, which was launched by the Department on 22 July 2008.</p>
<p>16 National campaigning to challenge public tolerance of drunkenness and harmful drinking.</p>	<p><i>Know Your Limits: 18 – 24 binge drinking campaign</i> launched in April 2008.</p>
<p>17 National campaigning on public awareness of units of alcohol.</p>	<p><i>Know Your Limits: Units campaign</i> launched in June 2008.</p>
<p>18 and 20 Targeted information for people who drink at harmful levels, their families and friends.</p>	<p>Social marketing campaign launched alongside advertising campaigns in spring 2008, including a booklet <i>Your drinking and you</i> and the interactive Drinkcheck website. The units campaign has also included information for GPs and other health staff, encouraging them to provide 'brief advice' on alcohol and providing them with materials to give to patients. (A pilot information and advice campaign focused on the North West was also launched in September 2008).</p>
<p>19 Reworded pregnancy advice to be communicated to women who are pregnant or trying to conceive.</p>	<p>A booklet, <i>Pregnancy and Alcohol</i>, was published in May 2008.</p>

APPENDIX TWO

International context

The National Audit Office commissioned RAND Europe to conduct international research on alcohol policies and programmes in five comparator countries, covering the scale and nature of alcohol misuse and alcohol-related harms in these countries. The scope of this research was wider than the remit of this study in that it covered not only health service provision of alcohol services but also the broader public policy response to alcohol misuse.

The five countries, selected to be broadly comparable to England in terms of economic development and patterns of alcohol consumption, were Australia, Canada, Germany, the Netherlands and the USA.

Methodology

RAND Europe conducted a literature review of relevant documents in English, German and Dutch. The firm also contacted experts in the field of alcohol policy (primarily government officials in the five countries) to complement the literature review, supplement any missing data and information, and discuss the initial findings of the review. Experts were contacted from the following organisations:

Australia

- Committee of the Australian National Alcohol Strategy 2006-2009
- Australian National Council on Drugs

Canada

- Drug Strategy and Controlled Substances Programme of Health Canada
- Canadian Executive Council on Addictions
- Canadian Centre for Addiction and Mental Health

Germany

- Bundesministerium für Gesundheit (Federal Ministry of Health)
- Deutsche Hauptstelle für Suchtfragen (German Centre for Addiction Issues)

Netherlands

- Algemene Rekenkamer (Dutch Audit Office)

USA

- National Institute on Alcohol Abuse and Alcoholism
- Substance Abuse and Mental Health Services Administration

Main findings of the RAND report

Alcohol harm is a significant public health issue in all the countries examined. While different ways of collecting data make direct comparison difficult, the UK generally tends to have higher rates of alcohol misuse (heavy and binge-drinking) than European Union and World Health Organization averages.

Amongst the countries studied, there is a trend towards specific national alcohol strategies, which reflects the increasing recognition of alcohol as a growing problem. Australia and the Netherlands, like England, have specific national alcohol strategies in place encompassing a range of health and non-health interventions. In Germany and Canada national alcohol strategies are still part of wider drug and addiction strategies, which focus largely on illegal drugs, but both countries are currently moving towards specific national alcohol strategies. Although the USA has various policies and organisations at federal and state level to tackle different aspects of alcohol harm, it does not have an overarching strategy to address alcohol harm at the national level. Specific targets, rather than political objectives, are not common in the alcohol strategies in the five countries studied.

Health care systems in the countries examined use a similar set of interventions to tackle alcohol harms, but have different funding and delivery structures and systems. As is the case in England, the use of brief advice is not widespread. Barriers to the use of screening and brief advice amongst healthcare professionals include lack of knowledge and skills to use the interventions, limited time with patients, and lack of financial incentives. The lack of governance structures to incentivise healthcare professionals to use screening and brief advice is common to all the countries examined. Specialist alcohol treatment does not feature prominently in the alcohol strategies of the countries studied, and as is the case in England, only a small proportion of the alcohol-dependent population are receiving specialised alcohol treatment.

In the countries studied for this report, a number of education and awareness campaigns aimed at preventing alcohol misuse and harms have been developed, implemented and financed by the governments' departments of health. However, for none of these campaigns has their effectiveness in altering drinking behaviour been demonstrated.

Some non-health policies to reduce alcohol harm have been shown through international research to be effective, if adequately enforced. International studies have concluded that increases in the prices of alcoholic beverages lead to reductions in consumption and alcohol harm. Pricing and taxation, however, are not systematically and explicitly part of the alcohol strategies of the countries examined in this report. In spite of evidence that raising alcohol prices reduces consumption and attendant harms, the trend in the real price of alcoholic beverages is decreasing in the countries studied. With few exceptions, alcohol taxes serve primarily fiscal and not public health functions. There is also strong evidence from international studies of the effectiveness of other policies, particularly restrictions on the availability of alcohol; drink-driving counter-measures; and minimum legal drinking ages. However, there are significant differences in how these are implemented and enforced in the countries studied. For example, the minimum legal drinking age varies internationally from 16 to 21.

APPENDIX THREE

Alcohol misuse and the response in Scotland, Wales and Northern Ireland

As an aspect of public health, alcohol misuse is a so-called 'devolved' issue, to which the national governments of Scotland, Wales and Northern Ireland can respond, within the limits of their respective powers. Of the three 'devolved' national administrations, Scotland has the most powers, established under the Scotland Act of 1998. The Scottish Parliament has a £30 billion annual budget, can vary the basic rate of income tax and can create new laws. The National Assembly for Wales cannot make new laws but can alter existing, UK-wide laws. The Northern Ireland Assembly has been suspended several times since it was established in 1998, so its actions have been limited, but it does have the power to create new laws. The three countries have different rates of alcohol misuse to those in England and have chosen to respond in different ways; this Appendix provides a summary of their main actions. The discussion focuses on Scotland, as the country with the second-largest population in the UK (5.1 million in 2006), the most power of the devolved administrations, and a cross-government policy response that differs substantially from England's.

Rates of people drinking above sensible guidelines and binge drinking vary between the countries of the UK. Alcohol-related death rates also vary, and are higher in Scotland, Wales and Northern Ireland than they are in England.⁴¹

The Scottish Executive published a Plan for Action on Alcohol Problems in 2002, which was updated in 2007. Policy developments in Scotland have diverged significantly from those in England. In contrast to the situation in England, where the Department of Health have made no further commitments to increase spend on alcohol treatment and interventions since it provided an extra £15 million through the *Choosing Health* agenda (see Appendix 7), the Scottish Government announced an £85 million increase in funding for tackling alcohol misuse including prevention, treatment and support services, bringing total spend to £120 million over the next three years.

Both the English and Scottish Governments launched consultations on tackling alcohol misuse in the summer of 2008. Key proposals in the Scottish consultation document included:

- raising the minimum age for 'off-sales'⁴² alcohol purchases, to 21;
- setting a minimum price at which a unit of alcohol can be sold;
- ending 'three for the price of two' type promotions, which encourage impulse buying of extra alcohol;
- a 'social responsibility fee' for some alcohol retailers, to help pay for the consequences of alcohol misuse and reduce the burden on the general taxpayer; and
- introducing alcohol-only checkouts in large off-sales premises, so that alcohol, like cigarettes, is thought of as a special case and not 'just another product'.

Following the consultation, the Scottish Government envisages legislating in time for many of the measures to coincide with the new Licensing Act coming into force in September 2009.

⁴¹ These data are 2002-04 averages. Source for all countries: Office for National Statistics (2005) *Alcohol-related deaths in the United Kingdom*.

⁴² 'Off-sales' is a term used in the UK and Ireland to refer to sales of alcohol for consumption away from the premises where it is sold, i.e. sales by shops such as specialist alcohol retailers ('off-licences'), convenience stores and supermarkets.

Since the Welsh Assembly Government has more limited devolved powers than Scotland in relation to controlling the availability of alcohol, more of their policy in this area is tied to that of England. In Wales there is no alcohol specific policy, but the Welsh Assembly Government published a substance misuse strategy in 2000⁴³ and, on 1 October 2008, published *Working Together to Reduce Harm*, a new strategy for tackling substance misuse, which includes a range of alcohol-specific actions. The

strategy sets out the Welsh Assembly Government's support for stricter controls on the availability of alcohol, and its commitment to work with the UK Government on this issue, and also to consider the scope for seeking more powers in relation to alcohol licensing. In Northern Ireland, the Department of Health, Social Services and Public Safety published a *Strategy for Reducing Alcohol Related Harm* in 2000, and the *New Strategic Direction for Alcohol and Drugs* in 2006.

13 Maximum daily alcohol consumption in a week and rates of alcohol-related deaths

		England	Scotland	Wales	Northern Ireland ³
Percentage of heavy drinkers ¹	Men	40	40	42	33
	Women	23	23	21	26
Percentage of binge drinkers ²	Men	29	28	30	43
	Women	14	13	11	33
Alcohol-related deaths (per 100,000 population) ⁴	Males	15	39	17	20
	Females	7	16	8	9

Source: Office for National Statistics (2005) *Alcohol-related deaths in the United Kingdom*

NOTES

1 Heavy drinking is defined here as exceeding, on the heaviest drinking day in the past week, the daily sensible drinking guidelines (4 units for men and 3 units for women). The English, Scottish and Welsh figures represent the entire population. The Northern Irish figures are based on drinking 21 units per week for men and 14 units for women over the week. Men and Women refer to males and females aged 16 and over – data was recorded in 2006.

2 Binge drinking is defined here as drinking twice the recommended daily intake in one sitting. The levels in England, Scotland and Wales are based on men drinking more than 8 units in a sitting, and women drinking more than 6 units, in the week prior to interview. For Northern Ireland, these quantities are more than 10 and 7 units respectively.

3 The Northern Ireland figures are not directly comparable since they are based on people aged 18 to 75 and they are the percentage amongst those people who drank during that week rather than the whole population. The figures are for 2005.

Sources: The NHS Information Centre (2008), United Kingdom Health Statistics; Health Promotion Agency for Northern Ireland (2006), *Adult drinking patterns in Northern Ireland 2005*.

4 These data are 2002-2004 averages.

43 The National Assembly for Wales, *Tackling Substance Misuse in Wales: A partnership approach* (April 2000).

APPENDIX FOUR

The new Public Service Agreement (PSA) on alcohol and drugs

Public Service Agreements (PSAs), first introduced in 1998, lay out government's priorities for public services. Each PSA is underpinned by a single Delivery Agreement, shared across all contributing departments, and developed in consultation with delivery partners and front-line workers. In 2007 the government announced a new set of 30 PSAs which reflected a collective government set of priorities, rather than each department leading on a separate PSA, as was previously the case.

PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs

This new PSA, which came into effect in April 2008, is part of the new set of 30 PSAs which run for the three-year spending period ending in March 2011. It aims to reduce the harms caused by drugs and alcohol to: the community (as a result of crime, disorder and anti-social behaviour), to the health and well-being of people who use drugs or drink and to the development and well-being of young people and families. The Government's delivery strategy for reducing alcohol is divided into three strands: laws and licensing powers; prevention, information and support; and collaborative work by all agencies to shape an environment that actively promotes sensible drinking. The main delivery levers relating to the health aspects of alcohol harm outlined in the Agreement are:

- reducing the indicators outlined in the PSA;
- use of costing tools in the commissioning of cost effective treatment;
- performance management of Local Strategic Partnerships by Government Offices; and
- performance management of PCTs by Strategic Health Authorities.

Performance against the indicator will also be assessed by the Healthcare Commission and the Audit Commission as part of their normal oversight of local bodies' performance.

Five indicators will be used to measure progress against the PSA, two of which relate to alcohol:

- 1 Percentage change in the number of drug users recorded as being in effective treatment
- 2 **Rate of hospital admissions per 100,000 for alcohol-related harm**
- 3 The rate of drug-related offending
- 4 The percentage of the public who perceive drug use or dealing to be a problem in their area
- 5 **The percentage of the public who perceive drunk and rowdy behaviour to be a problem in their area**

The indicator on alcohol-related hospital admission aims to measure the effect of alcohol misuse on the health service and, therefore, drive reduction of the harms caused to health and well-being by frequent consumption of harmful levels of alcohol. The indicator is also designed to measure the impact of prevention interventions. Specifically, the measure to reduce the trend in the increase in alcohol-related hospital admissions per 100,000 population has 2006 as baseline year. It will be measured using Hospital Episode Statistics, which contains details of all admissions to NHS hospitals in England. PCTs have been sent details of which diagnoses within an admission are attributable (wholly or in part) to alcohol. Data will be reported monthly. This measure is now a tier 3 (optional) Vital Signs indicator in PCTs' operating frameworks. Information on performance against all tier 3 Vital Signs will be published, helping to identify areas which are performing strongly, or weakly, in addressing alcohol harm.

The indicator on perceptions of drunk and rowdy behaviour will be reported quarterly and based on the British Crime Survey. It is aimed at driving a reduction of the harm caused to the community by alcohol-related disorder.

In addition to these indicators, there are further indicators within other PSAs that are linked to reducing alcohol harm, such as:

- Increase the number of children and young people on the path to success (PSA 14) which relates to their use of drugs, alcohol and volatile substances); and
- Make communities safer (PSA 23) which is linked to alcohol-related violent crime and disorder.

APPENDIX FIVE

Methodology

The study methodology was designed to evaluate the activities of the Department of Health and of the NHS at a local level, which were aimed at reducing alcohol harm, and the results of these programmes to date. Our main methodologies were as follows:

Survey of commissioners

We sent out an electronic questionnaire to all PCTs and Drug and Alcohol Action Teams in February 2008 and pursued responses through follow-up emails and telephone calls. We received responses from 141 (of 152) PCTs and 121 (of 149) Drug and Alcohol Action Teams, a total response rate of 87 per cent. In order to verify the data this survey yielded, 20 PCTs that had completed questionnaires were randomly selected and asked to participate in telephone interviews to discuss the responses given. The resulting 15 interviews covered responses on levels of spending and what was provided, and sought to determine the accuracy of responses and the nature and scale of activity.

The questionnaires asked about commissioning responsibilities, local alcohol strategies, expenditure on services, levels of provision and access to services of various types, and performance management systems, as well as seeking commissioners' opinions on various aspects of alcohol services. Responding to the questionnaire would therefore require information from different functions within the PCTs and DAATs. We provided detailed guidance for completion of the survey. The financial information from the survey has not been subject to audit, however and therefore the spending figures which respondents provided may be affected by different interpretations of the guidance by individual organisations. All completed questionnaires were approved by the responding organisations' Chief Executives, as Accounting Officers.

Survey of General Practitioners (GPs)

We contracted the market research company Doctors.net.uk to conduct a survey of GPs, including administering the questionnaire, collecting all responses, and analysing the information. The objectives of the survey were to investigate GPs' views on the provision of alcohol and substance misuse services and, in particular, to examine GPs' activities in relation to alcohol misuse by their patients and the reasons why GPs might or might not address alcohol misuse.

1,453 GPs completed the online survey between 7 February and 10 March 2008. The survey was open to the 36,497 GP members of the Doctors.net.uk network practising in England. The GPs who completed the questionnaire were geographically representative of GPs in England. Quotas were set according to the distribution of GPs by Strategic Health Authority in England, and final recruitment closely corresponded to the expected regional distribution.

GPs were informed of the subject of the questionnaire before they began to complete it, and some of those GPs who started the survey did not complete it. Some response bias is therefore possible, because more GPs with a greater interest in the topic may have completed the questionnaire. This may have biased results upwards, inflating reported levels of alcohol-related GP activity.

Analysis of quantitative data

We also commissioned Mark Bellis from the North West Public Health Observatory to undertake some quantitative analysis. This predominantly involved creating a single PCT-level measure of alcohol harm (as used in Figures 6 and 7), allowing for an overall comparison between areas. The single measure was developed from a number of indicators of alcohol harm (based on: male and female alcohol specific mortality; male and female alcohol-attributable hospital admissions; alcohol-related crimes; alcohol-related incapacity benefit; hazardous

drinking; harmful drinking; binge drinking). Analysis showed that these indicators were strongly correlated and so an overall high rank in the single measure is a sign that alcohol is likely to be a problem across most dimensions.

Further to this analysis, the study team also undertook some preliminary analysis using the Hospital Episode Statistics (HES) and National Drug Treatment Monitoring Service (NDTMS) databases to investigate whether they could be used for future performance management of services.

Interviews and visits

Between November 2007 and June 2008, we visited and interviewed a range of stakeholders, including:

- Specialist service providers: both statutory and non-statutory;
- General Practitioners and primary care practice workers;
- NHS hospital trusts;
- Commissioners: Drug (and Alcohol) Action Team and PCT employees;
- Government Offices and Strategic Health Authorities;
- Ministry of Justice, Department of Health, Department for Education and Schools;
- Academics from research institutions.

We also undertook an in-depth case study within Essex in November and December 2008, designed to give the study team an understanding of the organisations involved in commissioning and providing alcohol services rather than form findings for the report. The case study was based on a number of semi-structured interviews with a range of local stakeholders. We are grateful for the help from Essex Drug & Alcohol Partnership in coordinating the interviews.

Interviews and focus groups with alcohol misusers and their carers

We commissioned Ranzetta Consulting to collect views from people drinking at various levels, their families and carers, about their experience of NHS services. In all, 46 people were interviewed in four focus groups and 14 individual interviews, in the South West, the North East, and different areas within Greater London. The work was conducted between March and June 2008.

International research

We commissioned RAND Europe to examine the structure and effectiveness of healthcare and non-healthcare interventions aimed at preventing and reducing alcohol harm, in five comparator countries: Australia, Canada, Germany, The Netherlands and the United States. Further details of the RAND Europe work, which was conducted between December 2007 and June 2008, are given in Appendix 2.

Expert panel

We held a meeting of an expert panel to discuss the emerging findings from the various parts of our research, where we were able to draw on the specialist knowledge of a range of academic experts and people involved in the commissioning and provision of specialist alcohol services. The members of the panel were:

- Tony Goodall – Alcohol and Substance Misuse Lead – Leeds Primary Care Trust;
- Clare Brighton – DAAT Coordinator – Islington Drug and Alcohol Action Team;
- Briony Enser – Programme Manager – Department of Health;
- Stephen Mitchell – Deputy Director, Head of Governance – Department of Health;
- Dr Nick Sheron – Consultant hepatologist and senior lecturer – Southampton University;
- Professor Colin Drummond – Chair of Alcohol Addiction – Kings College London;
- Professor Eileen Kaner – Professor of Public Health – Newcastle University;
- Dr Michael Farrell – Senior Lecturer and Consultant Psychiatrist – Royal College of Psychiatrists;
- George Roycroft – Senior Policy Executive – British Medical Association;
- Don Shenker – Chief Executive – Alcohol Concern;
- Libby Ranzetta – Director – Ranzetta Consulting.

APPENDIX SIX

Cost-effectiveness of alcohol treatments

This Appendix summarises evidence available to date on the cost-effectiveness of the range of interventions which the health service may provide to address alcohol harm. There is good evidence to show that interventions for alcohol misuse are effective, reducing the alcohol consumption of a proportion of patients and mitigating the damage to their health. Many such interventions have also been shown to be cost-effective, i.e. the costs of providing them are outweighed – in some cases many times over – by reducing the ‘full social cost’ associated with alcohol consumption. This full social cost includes, for example, expenditure by the criminal justice system due to alcohol-related crime and disorder. However, the evidence does not suggest that all interventions can be justified in terms of savings to the health service alone. For some interventions, such as brief advice and some specialist treatments, the available evidence indicates a net saving to the health service, but for a few pharmaceutical treatments the cost of the intervention is unlikely to be offset either by improved health outcomes or by financial benefits to the health service.

The Department of Health’s chief source of evidence in this area is a major review carried out by researchers from the Universities of Northumbria and York and the Leeds Addiction Unit, which was published by the National Treatment Agency for Substance Misuse in 2006.⁴⁴ This review covered the full range of interventions, from screening and brief advice to specialist treatment, and drew together the findings of three previous systematic reviews carried out in Australia, Sweden and Scotland in 2003, along with more than 500 other scientific papers.

The National Treatment Agency review found that treatment for alcohol problems is cost-effective, on the basis of a full social cost analysis, going beyond the costs to the health service alone. Commissioners had a “...good economic case for investing in both brief interventions for hazardous and harmful drinkers and more intensive interventions for those with alcohol dependence”, the review found. There was a need for more research in relation to the English health care system on some aspects of cost-effectiveness, including the screening and identification of hazardous drinkers. The review’s main findings on cost-effectiveness are summarized below:

- **Brief interventions** aimed at hazardous drinkers had “...the potential to save future costs, as well as bringing individual benefits in terms of reducing risk of premature death and alcohol-related morbidity”. Most evaluations of brief interventions had been based on economic modelling techniques rather than primary data collection; for example, a UK model suggested that brief interventions would yield savings of around £2,000 per ‘life year’ saved. In a US study quoted in the review, brief interventions were found to generate overall benefits of US \$56,263 for every \$10,000 in costs. The National Treatment Agency’s review also quoted the results of work at the Royal Liverpool Hospital and at St Mary’s Hospital, Paddington (see Case Examples 2 and 3 in the main text of this report), which suggested significant cost savings to the health service. Although not assessing cost-effectiveness, a meta-analysis of 22 randomised control trials concluded that, overall, brief interventions lowered alcohol consumption.⁴⁵ Further, a US study review of existing evidence suggested that brief advice had one of the highest cost-effectiveness rankings of the 25 effective primary care services evaluated.⁴⁶

44 Raistrick, D.; Heather, N.; Godfrey, C. (2006). *Review of the Effectiveness of Treatment for Alcohol Problems* (November 2006).

45 Kaner EFS., Dickinson HO, Beyer FR, Pienaar EDE D, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B. *Effectiveness of brief alcohol interventions in primary care populations*. Systematic Reviews 2007, Issue 2. Art. No.: CD004148. DOI: 10.1002/14651858.CD004148.pub3.

46 Solberg L, Maciosek M, Edwards N. *Primary care intervention to reduce alcohol misuse: ranking its health impact and cost effectiveness*. American Journal of Preventive Medicine. 2008;34(2):143-52.

In October 2006, the Department of Health began a new research programme designed to provide additional evidence on the delivery, effectiveness and cost-effectiveness of brief advice approaches in different regions and across primary care, A&E departments and criminal justice settings. The results of this Screening and Intervention Programme for Sensible drinking (SIPS) are expected to be available in 2009.

- The review also examined the cost-effectiveness of **intensive treatments** for alcohol misusers with more serious problems. It found that:
 - (i) a variety of **psychosocial interventions**, such as ‘behavioural self-control training’, ‘coping and social skills training’, and ‘cognitive behavioural marital therapy’, were effective for different types of clients. These interventions “...can be delivered at reasonable cost, will have wider social cost savings and achieve reductions in drinking and alcohol problems”. In a major trial carried out in 2005⁴⁷, researchers found that for some types of psychosocial treatment for dependent drinkers, the public sector would save £5 for every £1 spent on treatment.
 - (ii) drug-based ‘**pharmacotherapies**’ such as medication to assist detoxification, prevent relapse and provide nutritional supplements, “...can reduce longer-term health costs of problem drinkers”. Some treatments had a net cost to the health service, however.

The National Institute for Health and Clinical Excellence (NICE) produces guidelines, for health service providers and commissioners and other organisations involved in public health, on the costs and benefits of treatments. NICE is currently developing three sets of guidance on interventions for alcohol misuse, with the first two expected to be published by 2010. The guidance will cover all parts of the ‘care pathway’ for alcohol misuse, from prevention and early identification to the management of alcohol dependency. The guidance will recommend interventions which are shown, benchmarked against other services previously approved by NICE for the NHS, to be suitably cost-effective.

47 UKATT Research Team (2005b), *Cost-effectiveness of treatment for alcohol problems: Findings of the UK Alcohol Treatment Trial*, British Medical Journal 331, p544-547.

APPENDIX SEVEN

Terms used in this report

Alcohol Needs Assessment Research Project (ANARP)

The main focus of this project was to measure the gap between the need and supply of specialist alcohol treatment services in England at a national and regional level. The research was conducted between September 2004 and February 2005, and the report was published in November 2005. It was commissioned by the Department of Health, and was jointly conducted by St George's Hospital, University of London, Kable Ltd and MORI Social Research Institute.

Binge drinking

Binge drinking is drinking to excess or drinking with the intention to get drunk. Since alcohol affects different people in different ways, it is hard to quantify the level of consumption, but the most widely used measure for binge drinking is drinking more than twice the recommended daily guidelines in one session (more than eight units for men and six units for women).

Brief advice (or brief interventions)

Brief advice, previously referred to as brief interventions, is a short interview provided by a trained medical professional, such as a GP or nurse, or other professional, including social workers and probation officers, when an individual has been identified as drinking above guideline levels. The structured interview lasts around five to ten minutes and involves giving medical information about alcohol consumption, encouragement to the patient to consider the negatives of their drinking behaviour, and support and help to the patient in cutting down on their drinking. Brief advice is not intended for dependent drinkers but is often successful in reducing alcohol consumption among patients who are able to control their drinking. Several brief intervention packs have been developed, including the Universities of Newcastle and Northumbria's *How Much Is Too Much?* (available at <http://www.ncl.ac.uk/ihs/news/item/?brief-interventions-alcohol-and-health-improvement>)

Choosing Health

The Government published the *Choosing Health* White Paper in 2004. It aims to support the public to make healthier and more informed choices with regard to their health, and gives the six priorities targeted for action: smoking, obesity, exercise, alcohol, mental health, and sexual health. For alcohol, the plans set out in the White Paper included work with the alcohol industry to develop a voluntary scheme of social responsibility for alcohol producers and retailers, and investing to improve services to help the NHS tackle alcohol problems at an early stage. In 2007-08 the Government provided £342 million to Primary Care Trusts to support the initiatives set out in the White Paper, including £15 million for alcohol services. Primary Care Trusts were encouraged to invest this additional funding in improving their local arrangements for commissioning and delivering alcohol interventions, but were not obliged to use it in this way.

Commissioning	The processes local bodies undertake to make sure that services funded by them meet the needs of the patient. In particular, Primary Care Trusts and Drug and Alcohol Action Teams, may fund services to address alcohol harm from a range of providers, including GPs, hospitals and mental health trusts, and voluntary and private organisations.
Dependent drinking	Dependent drinkers have difficulty controlling their consumption of alcohol, despite negative consequences. The Department of Health classifies dependent drinkers as ‘moderate’ or ‘severe’. Severe dependence is usually associated with physical withdrawal symptoms when the person stops drinking, which can include delirium tremens (tremors, hallucinations, anxiety, disorientation) and seizures. The Department estimated in July 2008 that approximately 1.1 million people in England have some level of alcohol dependency.
Detoxification	In this context, deliberate withdrawal from alcohol for dependent drinkers. Alcohol withdrawal can be dangerous, should be supervised by medical staff and may need to be managed with the use of prescribed medication to relieve withdrawal symptoms. It can be carried out either at home or in a hospital or other in-patient facility.
Directed Enhanced Services (DESs)	See Enhanced Services.
Drug and Alcohol Action Teams (DAATs)	Local partnerships working together to address drug and alcohol problems. They comprise professionals from local authorities and other public bodies such as Primary Care Trusts, the police and probation service, and treatment providers from the private and voluntary sectors. These teams are primarily responsible for planning and commissioning health services for users of illegal drugs. They developed from Drug Action Teams. In many areas DAATs have merged or work closely with community safety or crime reduction partnerships, to which they are primarily accountable.
Enhanced Services	<p>Services that go beyond the normal daily activities of general practice, and which may require specialist skills. They were introduced to develop and expand primary care. Under the new General Medical Services contract for GP practices, which came into effect in 2004, all practices must provide essential services, but can negotiate with their Primary Care Trust the provision of a range of other services, and additional resources are available for these. There are three types of enhanced service:</p> <ul style="list-style-type: none"> ■ Directed Enhanced Services (DESs) must be provided by Primary Care Trusts for their populations, although individual practices are not obliged to participate. Five new clinical DESs have been agreed for 2009-10, including one for brief interventions on alcohol, which provides £8 million in extra funding, for work by GPs with newly-registered patients. ■ National Enhanced Services (NESs) are commissioned to meet local needs, but in line with nationally set standards and prices. There is an alcohol National Enhanced Service, for which the Department of Health has produced an enhanced service specification. ■ Local Enhanced Services (LESs) are locally developed services designed to meet local health needs. <p>Since June 2008, a Primary Care Service Framework for alcohol had been available to support the development of alcohol-related Enhanced Services.</p>

Harmful and hazardous drinking

These two categories of alcohol misuse classify drinkers who are not yet alcohol-dependent and retain control over their consumption. **Hazardous drinkers** are drinking at levels over the Department's guidelines, but have so far not experienced significant alcohol-related problems with their health or social function. **Harmful drinkers** are drinking above sensible levels, usually more than hazardous drinkers, and are already experiencing damage to their physical or mental health, or causing social harms. In England, it is estimated that 18 per cent of the adult population (7.6 million) are drinking at 'hazardous' levels; another 7 per cent (2.9 million) are showing evidence of harm to their own physical and mental health, including approximately 1.1 million who have a level of alcohol addiction (dependency).

Hospital Episode Statistics

The Hospital Episode Statistics database contains records for each data year (1 April to 31 March) detailing inpatient (12 million records added each year) and outpatient care (40 million) provided by NHS hospitals in England, including day cases. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. Each HES record contains over 50 items of information collected directly by hospital providers – including diagnoses and surgical procedure codes, various dates, the location of treatment and details relating to the patient.

Indicators

Indicators on alcohol harm include:

- Public Service Delivery Agreement 25, for reducing the harm caused by alcohol and drugs, includes two indicators to measure progress in reducing alcohol-related harm. The indicator relevant to health services is the number of alcohol-related hospital admissions.
- The Local Alcohol Profiles for England use 23 indicators to measure alcohol misuse in the separate local authority areas, e.g. months of life lost due to alcohol misuse, and alcohol-related violent crimes.
- The Operating Framework for the NHS includes indicators known as 'Vital Signs' to inform the planning and management of health priorities and these indicators include the number of alcohol-related hospital admissions.

Joint Strategic Needs Assessment

The Local Government and Public Involvement in Health Act 2007 requires PCTs and local authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing of their local community.

Local Alcohol Profiles for England (LAPE)

These profiles are produced by the North West Public Health Observatory in association with the Department of Health in order to help provide local areas with measures of alcohol-related harm. They comprise 23 different indicators, including levels of alcohol-related admission into hospital, alcohol-related deaths and alcohol-related crime, and are produced for each local authority and Primary Care Trust area. They have been publicly available on the internet since 2006.

Local Area Agreement (LAA)	A new form of contract between central and local government, designed to devolve greater power over public services to local communities. They are negotiated between the Government Offices for the regions and ‘top tier’ local authorities (unitary authorities and County Councils) acting on behalf of Local Strategic Partnerships. Outcome targets are drawn from the National Indicator Set of around 200 indicators and are chosen by negotiation between central and local government based on a local area’s priorities. LAAs were first introduced as a pilot in 2005 and were rolled out across the following two years to all top tier authorities. In April 2008 new three-year LAAs came into force for all Local Strategic Partnerships.
Local Strategic Partnerships (LSPs)	Non-statutory, multi-agency partnerships, led (and coterminous) with Local Authorities and which include Primary Care Trusts. The Partnerships bring together at a local level the different parts of the public, private, community and voluntary sectors; allowing different initiatives and services to support one another. Local Strategic Partnerships are responsible for the delivery of Local Area Agreements – three-year contracts between central government and LSPs.
Models of Care for Alcohol Misusers (MoCAM)	Guidance published in 2006 by the Department and the National Treatment Agency on best practice for local health organisations and partners in delivering planned and integrated services for alcohol misusers.
National Drug Treatment Monitoring System	Collects data on clients in specialist drug treatment, and is a key data source for providing information on the numbers of clients receiving specialist treatment, the types of interventions being offered to clients, and how long clients spend in treatment. The National Treatment Agency began data collection and monitoring of specialist alcohol treatment from 1 April 2008. All providers of specialist alcohol treatment are asked to submit data on clients receiving specialist treatment for their alcohol misuse. The data collection will not include some less structured alcohol treatments (e.g. Alcoholics Anonymous), or treatment in other parts of the NHS for secondary complications arising out of the misuse of alcohol (e.g. treatment for liver disease). Data will be collected from general practice where specialist care is provided under enhanced contracts to address alcohol misuse.
National Treatment Agency for Substance Misuse (NTA)	The NTA was created by the Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England. The Agency’s role includes: ensuring that tax payers’ money is spent on expanding and running effectively; promoting best practice in drug treatment; and improving the performance and availability of drug treatment workers. The NTA’s aim is to ensure that the Government’s ring fenced funding for drug misuse (including underage drinking) – the Pooled Treatment Budget, which was £398 in 2007/08 – is spent to best effect, on treatment that really works and that meets the needs of local people.
National Institute for Health and Clinical Excellence (NICE)	The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. The guidance, which is developed using the expertise of the NHS and the wider healthcare community including NHS staff, patients, industry and the academic world, covers public health, health technologies, and clinical practice. NICE is funded by the Department of Health.

Portman Group

This representative body was established in 1989 by the UK's main alcohol producers. The Group's members, who collectively account for approximately 60 per cent of the UK alcohol market, are Bacardi-Martini, Beverage Brands (UK) Ltd, Brown-Forman, Carlsberg UK, Coors Brewers UK, Diageo Great Britain, InBev UK Ltd, Pernod Ricard UK, and Scottish and Newcastle. The group focuses on the social responsibility issues surrounding alcohol, including the ways in which alcohol products are promoted. The Portman Group represents its members on these issues.

Primary Care Trust (PCT)

Responsible for assessing local needs and planning and commissioning health services (from general practice, hospitals and independent or voluntary providers) to improve the health of a local population. There are 152 Primary Care Trusts in England. Each is directly accountable to its regional Strategic Health Authority.

Public Service Agreement (PSA)

Agreement between Government Departments and the Treasury, setting out the Government's priorities for public services. Each PSA includes targets and states the Department is responsible for their delivery, how progress against the targets will be measured and how success will be defined. In 2007 the Government announced a new set of 30 PSAs which reflected a collective Governmental set of priorities, rather than each Department leading on a separate PSA, as was previously the case; they include PSA 25 for reducing the harm caused by alcohol and drugs.

Quality and Outcomes Framework (QOF)

The incentive scheme under which GPs are paid according to achievement or delivery of services against a set of specific criteria. The QOF was introduced as part of the GP contract in 2004.

Rehabilitation

Rehabilitation for alcohol misuse encompasses a variety of counselling approaches to prevent relapse including group therapy, behaviour therapies, and involvement with mutual-help groups. Rehabilitation usually follows the initial phase of alcohol dependency treatment (which may involve detoxification and/or medical and/or psychiatric treatment).

Screening

In the context of alcohol misuse, screening is a method of identifying alcohol consumption at a level above the Department's guidelines. Screening can be carried out using a specially developed questionnaire, but can also take the form of relevant questions asked during the course of a consultation, e.g. at a GP's surgery. The Department does not promote screening based on medical tests such as blood alcohol concentration or liver function since it is relatively expensive, intrusive, and no more accurate than questionnaires.

Screening and Intervention Programme for Sensible Drinking (SIPS)

A £3.2 million pilot programme of screening and brief advice, funded by the Department in order to provide more evidence on the delivery, effectiveness and cost effectiveness of a range of alcohol screening and brief advice approaches across settings in England. The programme, which was launched in autumn 2006, will report in 2009.

Sensible drinking

Sensible drinking is drinking in a way that is unlikely to cause oneself or others significant risk of harm. The Department advises that adult women should not regularly drink more than two to three units of alcohol a day; adult men should not regularly drink more than three to four units of alcohol a day; and pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby they should not drink more than one to two units of alcohol once or twice a week and should not get drunk.

The Department also advises that the risk of harm from drinking above sensible levels increases as more alcohol is drunk and the more often people drink above sensible levels. Sensible drinking also involves a personal assessment of the particular risks and responsibilities of drinking at the time; for example, it is sensible not to drink when driving or when taking certain medications.

Strategic Health Authority (SHA)

Responsible for developing plans for improving health services in their local area; making sure local health services are of a high quality and performing well; and acting as a link between the Department of Health and the NHS to ensure national priorities are integrated into local plans. This involves managing the performance of Primary Care Trusts within their geographical region. There are ten SHAs in England.

Substance misuse

Substance misuse is the use of substances, including alcohol and drugs, which harm health or social functioning.

Vital Signs

The Operating Framework for the NHS, published in autumn 2007, introduced a new approach to planning and managing health priorities both nationally and locally, the Vital Signs indicators. Primary Care Trusts are now required to agree three-year operating plans, based on their local needs and covering the financial years 2008-09 to 2010-11, with their Strategic Health Authority. These plans include a number of Vital Signs indicators, some of which are mandatory (tiers 1 and 2) for all Primary Care Trusts, while others can be included in the plan if the PCT decides that the local need merits their inclusion. The number of alcohol-related hospital admissions is an optional (tier 3) Vital Sign.

World Class Commissioning

Introduced by the Department in December 2007, the World Class Commissioning programme sets out a new approach to commissioning health and care services. This includes a nationally consistent, locally applied annual assurance process for PCTs, under which they will need to demonstrate that local commissioning relates directly to local needs. Details can be found on the DH website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085148.

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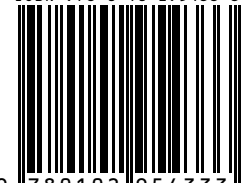
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