Making alcohol a health priority
Opportunities to reduce alcohol harms and rising costs
Alcohol Concern
Alcohol Concern is the national agency on alcohol misuse campaigning for effective alcohol policy and improved services for people whose lives are affected by alcohol-related problems.

About Us
Alcohol Concern is a membership body working at a national level to influence alcohol policy and champion best practice locally. We support professionals and organisations by providing expertise, information and guidance. We are a challenging voice to the drinks industry and promote public awareness of alcohol issues.

This project was written and researched by Alcohol Concern.

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Making alcohol a health priority – Opportunities to reduce alcohol harms and rising costs

Foreword

Despite an increasing awareness of its dangers among both the media and the medical profession, alcohol misuse remains a serious and growing public health issue in the UK.

In the past 60 years, the average intake of alcohol per person in the UK has risen steadily, from 5 litres a year in the 1950s, to over 11 litres a year in 2007. Over 10m adults in England now drink more than the recommended daily limit, with 2.6m of them drinking more than twice that. There has also been a dramatic rise in drinking among women, with heavy drinking increasing by almost a third in the decade prior to 2008.

The risks of drinking to excess are well established. Long term alcohol abuse can lead to numerous health problems, including liver and kidney disease, acute and chronic pancreatitis, heart disease, high blood pressure, depression, stroke, foetal alcohol syndrome and several cancers.

This places a huge burden on the NHS. The number of hospital admissions due to alcohol misuse was 1.1 million in 2009/10, a 100% increase since 2002/03. If the rise continues unchecked, by the end of the current Parliament a staggering 1.5 million people will be admitted to hospital every year as a result of drinking.

The problem is not limited purely to healthcare. The damage that drinking causes echoes throughout society, contributing to 1.2 million incidents of violent crime a year, 40% of domestic violence cases and 6% of all road casualties.

Alcohol misuse is now estimated to cost the NHS £2.7 billion a year, almost twice the equivalent figure in 2001. But the cost of alcohol to society as a whole is even greater, estimated to stand at £17 - 22 billion, and by some estimates is as high as £55 billion.

Given the scale of the problem, alcohol misuse should be a public health and NHS priority. Yet consecutive governments have failed to successfully address a basic lack of sufficiently resourced and coordinated voluntary sector and NHS services designed to treat or prevent alcohol misuse or dependency.

Despite a raft of policy initiatives in recent years, and the Department of Health’s 2009 report Signs for Improvement – commissioning interventions to reduce alcohol-related harm, many PCTs have failed to draw up effective strategies for dealing with alcohol misuse.

While smoking and drug abuse have received vast attention and support from the public purse, services for alcohol misuse have remained shamefully under-invested in. The majority of PCTs allocate very small amounts of their budget to alcohol, do not adequately assess need or outcome and have no strategies in place. This has led to there being specialist treatment for fewer than 6% of dependent drinkers.
The Coalition Government’s proposed reform of the NHS presents an ideal chance to tackle this deficit in services. By 2013, the commissioning powers of PCTs are to be transferred to GP consortia, who will have the power to transform alcohol services. If GP consortia are engaged on the issue of alcohol misuse and if the policies in the recent Public Health White Paper, *Health Lives, Healthy People*, are implemented, there will be a real opportunity to embed alcohol misuse in the emerging approach to public health. Please see Alcohol Concern’s response to the Public Health White Paper in Annex A.

The evidence is clear that investing in alcohol services for all problem drinkers saves money and improves health outcomes. Indeed, for every £1 invested in specialist alcohol treatment, £5 is saved on health, welfare and crime costs.

Commissioners therefore have a good economic case for investing in alcohol dependence treatment and its prevention must be a major health priority, as an ‘invest to save’ measure.

Concerted action is needed at both a national and local level. Nationally, we urge the Secretary of State for Health to create and implement a treatment strategy for alcohol misuse to reduce the number of dependent drinkers and ensure that access to treatment is improved. On a local level, we urge local authorities to develop a comprehensive alcohol strategy for their area that includes early identification in general practices and hospital settings, and an improved capacity and quality of specialist treatment services.

Health services must be given incentives to improve the uptake of such measures. Existing and new tools can be employed to achieve this, such as adding alcohol screening measures to the Quality and Outcomes Framework for GPs and focusing public health and NHS outcomes on reducing alcohol-related harm.

To continue to ignore the growing problem of alcohol misuse will have alarming consequences, but we do have a choice. The Government should pledge to double our current investment, leading to improved public health and savings of £1.7 billion a year for the NHS. The alternative is to do nothing and watch the annual health cost rise to £3.7 billion.

This report makes recommendations to policy-makers and commissioners on improving alcohol services in England. Changes to the NHS over the coming years present us with an ideal opportunity to improve alcohol services. Together we can make a true difference to individuals and public health, while achieving real savings for the NHS.

Baroness Hayter of Kentish Town
Chair of the All Party Parliamentary Group on Alcohol Misuse

Don Shenker
Chief Executive
Alcohol Concern
Executive Summary

This report shines a spotlight on the rising trends of poor health and wellbeing linked to alcohol misuse in England and the poor state of the current public health response. This report calls to action those who can turn this around by ensuring that alcohol is a public health and NHS priority, with sufficient resourcing that will reach out and improve people’s lives, saving the NHS from a growing cost and disease burden that it can ill afford.

Over 10 million adults in England drink more than the recommended limits

An unsustainable burden
Drinking alcohol is a freedom that many enjoy, however, this must be balanced with the need to avoid harm and improve health outcomes. Alcohol misuse is a root cause of ill health. The conditions most strongly related to health inequalities, such as cancer and cardiovascular disease, are strongly associated with alcohol.1 Additionally, alcohol is the biggest cause of liver disease (50-60%).2 Liver disease is the fifth most common cause of death in England and its prevalence is growing, it could overtake stroke and coronary heart disease as a cause of death within the next 10-20 years.3

Alcohol is now the second biggest risk factor for cancer after smoking

People who drink alcohol
Things are getting worse. A quarter of people in England drink at hazardous levels,15 the number of dependent drinkers now stands at 1.6 million7 and the number that go into hospital for alcohol-related reasons rose by 52% between 1996-2006.15 The cost to the NHS of dealing with this is £2.7 billion every year,7 and is expected to continue rising to £3.7 billion.7 A burden that is unsustainable.4

Unmet need
Nationally, faced by a mounting problem, the response of previous Governments has ranged from the non-existent to the ineffectual.5 New policies and strategies introduced in recent years to date have not translated into a coordinated improvement of services across England. Efforts to tackle alcohol misuse compare unfavourably with the level of investment made in the other big public health issues, especially smoking and illegal drug misuse that have been given priority and significant investment that has delivered results.

Over 70% of the cost of alcohol-related ill health is spent on hospital treatment, of which inpatient costs alone account for almost 45%

While there are some exceptions, unfortunately, the majority of PCTs generally allocate very small amounts of their budget, do not adequately assess need, do not have strategies in place and even use specific money given by the Department of Health on other services. This has lead to there being specialist treatment for fewer than 6% of dependent drinkers.7

The opportunity in the new NHS
The Coalition Government’s plans to reform the NHS set out a bold vision for the future, with ambitions for “health outcomes and quality services that are among the best in the world”6. The Public Health White Paper aims to usher in “a new era for public health, with a higher priority and dedicated resources…helping people live

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6 Making alcohol a health priority – Opportunities to reduce alcohol harms and rising costs
longer, healthier and more fulfilling lives”.\textsuperscript{35} This presents the opportunity to make the changes required to turn around the growing rates of poor health and costs to our health service.

Use the evidence and invest to save

\textbf{An extra £217 million invested in alcohol services – double the current level – would bring about an annual saving of £1.7 billion for the NHS in England}

Evidence clearly shows what works: Identification and Brief Advice in a range of primary care settings, specialist treatment for dependent drinkers and access to alcohol health workers in hospitals and A&E. A modest investment in these interventions of an additional £217 million for England would bring about an annual saving of £1.7 billion for the NHS and more in terms of costs to society.\textsuperscript{7}

Call to action

The choice we face is a stark one, we either double our current investment leading to improved public health and savings of £1.7 billion a year for the NHS or we do nothing and can expect the annual health cost to rise to £3.7 billion.\textsuperscript{7} This is, therefore, a call to action for the Secretary of State for Health, and Health Ministers, Members of Parliament, Directors of Public Health, GPs, local authorities, and clinicians. To turn around this growing cost to the NHS and the dramatically rising rates of poor health from alcohol misuse, this report makes the following recommendations:

National policy-makers should:

- Make alcohol misuse a major health priority
- Introduce a national alcohol treatment strategy with the aim to reduce alcohol consumption, which leads to a reduction in alcohol-related harm and alcohol-related hospital admissions, and which ensures access to treatment for at least 15% of dependent drinkers
- Double the current investment in alcohol services, with a further £217 million in order to save £1.7bn for the NHS

Local health commissioners and Directors of Public Health should:

- Prioritise alcohol as an invest to save measure, which may also realise the planned reward for areas that reduce public health problems
- Assess the scale and nature of the problem in their area, the level of investment and the quality and range of provision to address need, and incorporate this into future Joint Strategic Needs Assessments, as set out by the Public Health White Paper
- Ensure there is a local strategy in place with a ladder of interventions based on evidence of what works, matched with suitable investment as set out in our example areas table (see page 11)

If we take this action, a real difference will be made and savings in alcohol-related costs seen up and down the country. If we continue to ignore alcohol misuse then the results could be disastrous for the NHS and for the health and wellbeing of our nation.
The unsustainable burden of alcohol misuse

Now over 10 million adults in England drink more than the recommended limits
The unsustainable burden of alcohol misuse

Trends in alcohol consumption
1. The amount an average person drinks has risen sharply since the 1950s, rising from 5 litres of alcohol per year to over 11 litres by 2007. Now over 10 million adults in England drink more than the recommended limits, accounting for 75% of all the alcohol consumed. 2.6 million of these drink more than twice the recommended limits.

2. There have also been worrying trends amongst women and children. The amount that young people, those aged under 16, drink has doubled since 1990. There has also been a dramatic rise in drinking by women, with heavy drinking increasing by almost a third in the decade up to 2008.

Types of drinking behaviour
3. People’s drinking varies in terms of the amounts of alcohol they consume and the frequency with which they drink. There are a number of different types of drinking behaviour that have been identified as a root cause of ill health (Table 1).

4. Dependent drinking can have many causes, including family history, anxiety or depression, the addictive pharmacology of

Table 1: Types of Drinking Behaviour

<table>
<thead>
<tr>
<th>Type of Drinking Behaviour</th>
<th>Description</th>
<th>Prevalence (England)</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous Drinkers</td>
<td>Those who drink over the sensible drinking limits, either regularly or through less frequent sessions of heavy binge drinking, but have so far avoided significant alcohol-related problems.</td>
<td>7.6 million people</td>
<td>For women the binge drinking rate (twice over the recommended limit once a week) increased from 7% in 1998 to 16% in 2006, similarly in men the proportion rose from 20% to 24% over the same period</td>
</tr>
<tr>
<td>Harmful Drinkers</td>
<td>Harmful drinkers are usually drinking at levels above those recommended for sensible drinking, typically at higher levels than most hazardous drinkers. Unlike hazardous drinkers, harmful drinkers show clear evidence of some alcohol-related harm.</td>
<td>2.9 million people</td>
<td>Heavy drinking rose amongst men from 19% in 2005 to 24% in 2007 and from 8% to 15% for women over the same period</td>
</tr>
</tbody>
</table>
Type of Drinking Behaviour | Description | Prevalence (England) | Trend |
---|---|---|---|
Dependant Drinkers | Those who are likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking. In severe cases, they may have withdrawal fits and may drink to escape from or avoid these symptoms. | 1.6 million people | There was a 24% increase in the number of moderate to severely dependent drinkers between 2000 and 2007 |

alcohol, and the environment in which people live. Hazardous and harmful drinking may be due to habit, lifestyle, lack of awareness of the health effects and an absence of obvious symptoms. In addition, the affordability of alcohol and the density of licensed outlets influence the level of alcohol harm.

The regional and local picture

5. There is considerable regional variation in levels of alcohol-related need. As Table 2 indicates, the prevalence of increasing risk drinkers, those who drink over 21 units per week for men and 14 units per week for women, varies between approximately 22% in London to over 32% in the North East. The prevalence of high risk drinkers, those who drink over 50 units per week for men and 35 units for women, shows an even more varied picture. The percentage of higher risk drinkers in Yorkshire and

<table>
<thead>
<tr>
<th>Region</th>
<th>% who are increasing risk drinkers</th>
<th>% who are higher risk drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>East of England</td>
<td>22.26</td>
<td>3.95</td>
</tr>
<tr>
<td>East Midlands</td>
<td>23.47</td>
<td>4.71</td>
</tr>
<tr>
<td>London</td>
<td>22.04</td>
<td>6.58</td>
</tr>
<tr>
<td>North East</td>
<td>32.07</td>
<td>9.60</td>
</tr>
<tr>
<td>North West</td>
<td>29.96</td>
<td>6.73</td>
</tr>
<tr>
<td>South East</td>
<td>24.75</td>
<td>6.34</td>
</tr>
<tr>
<td>South West</td>
<td>29.35</td>
<td>6.31</td>
</tr>
<tr>
<td>West Midlands</td>
<td>22.34</td>
<td>5.25</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>31.74</td>
<td>10.57</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>26.02</td>
<td>6.51</td>
</tr>
</tbody>
</table>

Table 2: Estimates of the proportion and number of increasing risk and higher risk drinkers of working age in England, by region

Making alcohol a health priority – Opportunities to reduce alcohol harms and rising costs
Humber is more than double those in the East of England.

6. By choosing a broadly representative sample of PCT areas (Table 3), we can see for each PCT area (Column A) the current number of alcohol attributable hospital admissions (Column B), and what that looks like as a percentage of the local GP list (Column C). If current levels of investment in these local alcohol services are neither cut nor increased, it is projected that by 2011/12 there will be an increased number of alcohol attributable hospital admissions (Column D), a rise of 6-20% on the 2009/10 figure in the areas chosen (Column E). There will be an over representation of dependent drinkers amongst those people going into hospital that could be reduced if they received specialist alcohol treatment. For each PCT area we have shown the estimated number of dependent drinkers (Column F) and shown how many people access specialist treatment services to help them reduce their drinking (Column G). These figures show that between only 0.5-6.4% of this population is receiving help. Research shows that 15% of dependent drinkers receiving help is considered to

<table>
<thead>
<tr>
<th>A. PCT Area</th>
<th>B. Number of alcohol attributable hospital admissions 2009/10</th>
<th>C. Percentage of GP list admitted to hospital for alcohol attributable reason</th>
<th>D. Projected number of hospital admissions in 2011/12</th>
<th>E. Percentage increase from 2009/10 to 2011/12</th>
<th>F. Estimated number of dependent drinkers</th>
<th>G. Numbers in treatment</th>
<th>H. Percentage of dependent drinkers in treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East Lincolnshire</td>
<td>3,352</td>
<td>2.6%</td>
<td>3,556</td>
<td>6%</td>
<td>5,899</td>
<td>332</td>
<td>5.6%</td>
</tr>
<tr>
<td>Hartlepool</td>
<td>2,476</td>
<td>3.4%</td>
<td>2,918</td>
<td>18%</td>
<td>5,412</td>
<td>282</td>
<td>5.2%</td>
</tr>
<tr>
<td>North Yorkshire and York</td>
<td>13,137</td>
<td>2%</td>
<td>14,521</td>
<td>11%</td>
<td>22,336</td>
<td>1,314</td>
<td>5.9%</td>
</tr>
<tr>
<td>Dudley</td>
<td>7,631</td>
<td>3%</td>
<td>9,183</td>
<td>20%</td>
<td>11,401</td>
<td>54</td>
<td>0.5%</td>
</tr>
<tr>
<td>Leicester City</td>
<td>7,667</td>
<td>3.3%</td>
<td>8,915</td>
<td>16%</td>
<td>8,578</td>
<td>329</td>
<td>3.8%</td>
</tr>
<tr>
<td>West Essex</td>
<td>5,130</td>
<td>2.3%</td>
<td>6,022</td>
<td>17%</td>
<td>7,229</td>
<td>346</td>
<td>4.8%</td>
</tr>
<tr>
<td>Ealing</td>
<td>6,644</td>
<td>2.6%</td>
<td>7,716</td>
<td>16%</td>
<td>7,483</td>
<td>476</td>
<td>6.4%</td>
</tr>
<tr>
<td>Eastern and Coastal Kent</td>
<td>13,382</td>
<td>2.3%</td>
<td>14,927</td>
<td>12%</td>
<td>16,957</td>
<td>622</td>
<td>3.7%</td>
</tr>
<tr>
<td>Devon</td>
<td>15,331</td>
<td>2.5%</td>
<td>17,464</td>
<td>14%</td>
<td>21,245</td>
<td>978</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

NOTE: The example PCT areas used in Table 3 were chosen to be a broadly representative sample using criteria including the regions of England, a range of small, medium and large population sizes and budgets, levels of alcohol-related harm, and unitary and two-tier local authorities.
be a medium level of access to treatment, and 20% considered a good level, so these figures fall well below this.16

Alcohol: a cause of ill health and death
7. For a significant and growing number of people in England, alcohol misuse is a major cause of ill health, contributing to a wide range of serious health problems and accidents that require health care. Excessive drinking causes accumulating harm in long-term ways, contributing to liver and kidney disease, acute and chronic pancreatitis, heart disease, high blood pressure, depression, strokes, and it can harm the developing foetus.5,9 Alcohol is now the second biggest risk factor for cancer after smoking, contributing to cancers of the mouth and throat, liver, laryngeal, colon (in men) and breast cancer.5
8. The disease burden is getting worse. Alcohol is the biggest cause of liver disease (50-60%).2 Liver disease is the fifth most common cause of death in England and its prevalence is growing, it could overtake stroke and coronary heart disease as a cause of death within the next 10-20 years.3 Alcoholic liver disease admissions to hospital increased by over 100% between 1989 and 2002, contributing to the overall number of alcohol-related hospital admissions in England rising at an alarming rate, and now standing at 1.1 million in 2009/10, an 100% increase since 2002/03.32 If the number of admissions increases by the annual average seen since 2002, then we can expect this to reach almost 1.5 million by the end of this Parliament as shown in Figure1.
9. The number of deaths from alcohol-related causes doubled in the 15 years to 2006.9 The main contributor to this increase is deaths from alcoholic liver disease in England, which rose by 36% from 2001-2008.12 From 1970-2000, deaths from chronic liver disease increased among

Figure 1: Number of Alcohol-Related Hospital Admissions and Projection based on current rate of increase17
25-44 years olds by over 900% at a time when deaths from chronic liver disease in other European countries were falling.

10. The total number of deaths in England attributable to alcohol in 2008 was 15,597. By using the factors that can be attributed to alcohol for oesophageal cancer and other conditions, then the figure is much higher, estimated at between 30,000 and 40,000 deaths per year. Furthermore, alcohol is responsible for 6% of breast cancer deaths, up to 45% of suicides and 50% of those presenting with self-harm.

11. Alcohol misuse can also be fatal, contributing to sudden deaths through acute alcoholic poisoning or accidents while people are intoxicated, as well as deaths due to long-term harmful drinking.

Costs to the NHS

12. The sharp rise in alcohol consumption and numbers of dependent drinkers has resulted in a steep rise in alcohol-related hospital admissions and deaths. This massively increased demand for healthcare is estimated to have accounted for £2.7 billion. This is almost double the figure in 2001 and is projected to reach £3.7 billion annually in the near future. The NHS Confederation stated that this burden would be unsustainable.

13. With the pressure to react to a growing number of urgent needs, preventative and specialist services have struggled to keep pace with demand for alcohol support. Subsequently, the front-line and mainstream NHS and hospitals have borne the brunt of the burden:
   - Every dependent drinker is estimated to cost the NHS £2,300 per year.
   - Over 70% of the cost of alcohol-related ill health (Figure 2) is spent on hospital treatment, of which inpatient costs alone account for almost 45%, compared to around 12% of hospital expenditure in 2001.
   - Over 6% of calls to London ambulances are for alcohol-related incidents. However, as ambulance crews only record the illness and not its cause, the real rate is likely to be much higher.
   - In Accident and Emergency Departments (A&E), 70% of peak time attendances and 40% of weekend attendances are caused by alcohol.
   - GPs are presented with a range of chronic physical, mental and social problems arising from alcohol. Problem drinkers consult their GPs twice as often as the average patient.

Alcohol: A major root cause of health inequalities

14. Health inequalities as a result of alcohol misuse are clearly evident, data shows that alcohol-related death rates are about 45% higher in areas of high deprivation.

15. The conditions most strongly related to health inequalities, such as cancer and cardiovascular disease, are strongly associated with alcohol.

16. Across all regions of England, hospital admissions for alcohol-specific conditions are associated with increased levels of deprivation. However, while people with lower socioeconomic status are more likely to abstain altogether, if they do consume alcohol, they are more likely to have problematic drinking patterns and dependence than people higher up the scale. In the most deprived areas men are five times, and women three times, more...
likely to die an alcohol-related death than those in the least deprived areas.\textsuperscript{27}

17. Reducing health inequalities is a matter of fairness and social justice,\textsuperscript{28} and one of the six strategies to achieve this put forward by the Marmot Review is to strengthen the role and impact of ill health prevention, recommending that population-wide interventions on alcohol are needed to reduce the social gradient with targeted interventions for particular groups.\textsuperscript{1}

The impact on wider society

18. Alcohol is not solely a health issue, as it also causes problems for society as a whole, contributing to around 1.2 million incidents of violent crime, 40\% cases of domestic violence, 6\% of all road casualties are people injured from drink driving,\textsuperscript{5} and it has a significant impact both on families and the workplace. Alcohol misuse amongst parents can have a substantial negative impact on their children, up to 2.6 million children live with a hazardous drinker.\textsuperscript{30}

19. The cost of alcohol to society is estimated at £17-22 billion,\textsuperscript{31} or even as high as £55 billion.\textsuperscript{5}

20. Up to 17 million working days are lost annually through absences caused by drinking.\textsuperscript{33}

The growing future burden

21. Hospital admissions related to alcohol have exceeded 1 million. If resource levels are not increased, then this will rise to nearly 1.5 million by 2014/15.\textsuperscript{17}

22. With alcohol dependency increasing to 1.6 million people, unless urgent action is taken to ensure they receive the support they need to tackle their drinking, the cost to the NHS could very soon be as high as £3.7 billion every year.\textsuperscript{7}
CASE STUDY 1: A Personal Story

I am a young woman. I am a mother. I am a dependent drinker. I have been sober for more than two years now and in that time the lives of my children and myself have drastically changed for the better. I have used drink practically my whole life. I raised my four beautiful children in madness. We lived in organised chaos, how we survived amazes me now.

When I couldn’t carry on living in the drama and pain any longer and my heart and body felt broken I knew I had to change. I had hit rock bottom. I had to get honest and ask for help, both of these were new to me and truly terrified me. I had been sober for about eight weeks and my children were angry, hurting, frightened and so was I. But as I was attending meetings at the alcohol treatment service, what about the kids? Had they not suffered too? So I decided it was now or never, my children deserved not to be forgotten and so I walked into the Social Services offices and told them everything.

My drinking had taken me to some very dark places and unfortunately the kids had always come with me. I had been in a violent relationship and my partner also drank, my children had witnessed domestic violence many times and they had already been on the ‘At Risk’ register six year earlier, it was a mess. They assessed me and sent a social worker to meet the kids, I couldn’t believe it – they wanted to help.

I was so scared of relapsing in the beginning but I knew I couldn’t go back as I could see myself recovering through my children; we began to get well together as a family. It wasn’t easy, I had to learn to live a normal life and they had to learn to trust me. I had to fight and shout to get some of the help and sometimes it was exhausting repeating my story to the different services but eventually it all came together. I had regular meetings with Social Services, the alcohol treatment service and the children’s schools were involved. This brought us all together in one place at the same time and so my life slowly began to get easier. The children received help and we have had family therapy, none of which has been pain free.

The shame and guilt I used to carry around is now changing to love and laughter. I have changed, my family has changed. If you want to change ask for help. If you want it bad enough do it now. They did not take my children; instead, I rebuilt my family.
How effective is our response to alcohol?

Alcohol must be a priority for the National Health Service as well as for Public Health.
How effective is our response to alcohol?

Policy summary

23. Despite the raft of policy initiatives on reducing alcohol-related harm in recent years, as indicated below, the response to these policies has been limited and, we would argue, too ineffective. In spite of the publication of the original alcohol strategy in 2004 and its successor in 2007, the lack of a specific national strategy on supporting problem drinkers through alcohol treatment has led to the piecemeal investment approach described in the last chapter. Unlike other therapy areas, such as heart disease and cancer, National Service Frameworks have set out clear requirements for care. Furthermore, alcohol has largely remained the poor sister of other public health issues such as smoking and drugs.

24. There is a new direction for both the NHS and public health. The NHS White Paper proposes that GP-led organisations will be responsible for managing the vast majority of NHS commissioning budgets by April 2013.34 The Public Health White Paper aims to safeguard spending on public health, establishing a specific ring-fenced budget helping to improve overall health outcomes.35 There is now a strong case for a balance between primary and secondary prevention for those with alcohol problems. Therefore alcohol must be a priority for the National Health Service as well as for Public Health.

Summary of policy initiatives on alcohol misuse

- The first national Alcohol Harm Reduction Strategy for England was published in 200436 and updated in 2007.37
- In 2006, Models of Care for Alcohol Misusers47 was published; introducing an approach based on integrated local alcohol treatment systems, which would have considerable benefits for hazardous, harmful and dependent drinkers, their families and social networks, and the wider community.
- 2008 saw concerns around the rising number of hospital admissions related to alcohol, which lead the Department of Health to put in place a new national Vital Signs indicator to measure this. That year also saw the Youth Alcohol Action Plan26 published by the Department for Children, Schools and Families.
- In 2009, the Department of Health published Signs for Improvement – commissioning interventions to reduce alcohol-related harm,25 identifying a number of High Impact Changes which areas were advised to adopt.
Progress against policy objectives

25. The policies detailed above were published after the Department of Health’s move to devolve NHS commissioning to the local level. Yet despite this, evidence shows that local PCTs were failing to draw up strategies to address alcohol harm.

26. In 2008, the National Audit Office found that there was little correlation between PCTs’ spending on alcohol services and the extent of alcohol problems in their local population.\(^9\)

27. In 2009, the All Party Parliamentary Group on Alcohol Misuse agreed, finding “inconsistencies in the level of funding, the participation of PCTs and the use of strategic guidance from Government, and a general lack of capacity and variety in alcohol treatment services, due to poor levels of funding and, in some cases, a harm reduction agenda driven largely by crime and disorder rather than health considerations”.\(^38\)

28. In 2010, the Health Select Committee delivered the damning verdict that “despite recent initiatives and improvements, the NHS remains poor at dealing with alcohol-related problems. Clinicians are poor at detecting alcohol abuse and urgently need to do better, but this will only be done effectively if there are specialist services which patients can be referred to. These are poorly funded and commissioning alcohol services remains a low priority for PCTs, despite the long-term returns it could produce”.\(^5\) Also that year, the NHS Confederation echoed these points, stating “despite Government concern, new policies and strategies have not yet translated into a coordinated improvement of services across England”.\(^4\)

29. This shows that not enough progress is being made as the alcohol-related ill health burden grows. Implementation of the Department of Health’s High Impact Changes has taken effect in some areas, with the introduction of Alcohol Health Workers and some innovative projects as highlighted by the Hub of Commissioned Alcohol Projects and Policies website (www.hubcapp.org.uk). Progress will only be made if alcohol is recognised as a major health priority.

In order to deliver improvements in public health and reduce the huge burden of alcohol-related poor health, we need adequate capacity and quality in services across the country to reach out and deliver what works for those who need it. However, it is clear that we are not in this position in most areas of England.

30. The previous Government increased its focus on alcohol-related harm, but despite the introduction of new policies and strategies, action at a local level has failed to tackle the consequences of alcohol misuse – overly relying on hospitals to meet the unmet need of alcohol-related disease. The Government also largely chose to focus on enforcement issues rather than public health.

The current state of provision

Commissioning

31. Many PCTs do not have a strategy for reducing alcohol harm, or a clear picture of their spending on services to address it, with a quarter of PCTs not accurately assessing the issue in their area.\(^6\) Without such assessments, PCTs cannot know what services they should be providing, and cannot assess whether the services they
32. Where local strategies are in place, they are often lacking or inadequate in many areas and service delivery is fragmented. Service provision has, as a consequence, varied widely, both in type and degree of provision.9

33. 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 mis-users.9

34. 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.9

35. The capacity of specialist alcohol treatment services for problem drinkers is insufficient to meet need, with PCTs spending on average only 0.1% of their budgets for dependent drinkers.9

36. From 2006/07 onwards, the Department of Health provided an extra £15 million annually for alcohol services to PCTs’ budgets. PCTs were not required to spend this on alcohol services, and as a result over half spent some on other services and only two-thirds of this went on reducing alcohol misuse.9

37. The White Papers on the NHS and Public Health will radically change the NHS commissioning landscape. If these changes are to improve the health and wellbeing of the population, improvements must be made to the quality of commissioning, the priority and the resource given to tackling alcohol misuse.

Identification, brief advice and brief interventions

38. Identification, brief advice and brief interventions are a vital source of quick wins in reducing the cost burden of alcohol to the NHS. However, GPs tend to under-identify alcohol use disorders, finding and offering support to only one in 67 male and one in 82 female hazardous or harmful drinkers.16 Less than a third of GPs use an alcohol screening questionnaire, and those who do only did so for an average of 33 patients in the last year.9

39. Brief advice is only sporadically provided by health workers,9 and with the exception of some notable examples, such as Paddington St Mary’s, the Royal Liverpool Hospital and the Royal Bolton Hospital are rarely used in other parts of the health service, such as A&E Departments and liver wards.

40. There are low levels of referral to specialist services, with GPs and health professionals citing long waiting lists as a reason.4,16 88% of doctors and nurses said that NHS investment in staff and services for treating alcohol-related harm had not kept up with demand or was suffering from serious under-investment and was currently inadequate.43
Access to treatment

41. Access to treatment varies greatly across England. The historical lack of high-level support for alcohol services has led to a piecemeal approach to planning, development and service implementation in both primary and secondary care. This is a costly approach, resulting in many areas where services are not sufficiently developed to meet demand, in the wrong place or hard to access.7

42. Only a small minority of dependent drinkers receive treatment, estimated at 1 in 18 – less than 6%.7 These figures are low, both in comparison to the treatment of illegal drug misuse and to other alcohol treatment in other countries. A study in North America found an access level of 10% to be considered to be low, 15% to be medium and 20% to be high. England currently falls well below this.7

43. It is worth noting that one research study found a high level of satisfaction with specialist services once access to them was achieved.16

Detoxification and rehabilitation

44. Provision of detoxification and rehabilitation services remains patchy across England. Just over half of PCTs commission residential rehabilitation services, while two-thirds commission detoxification services.5 Over 70% of GPs said there was a shortage of these services.9

45. There are significant variations in the distribution of liver units, with some regions having neither liver units nor inpatient alcohol units.9

46. In some areas patients are ‘detoxed’ at home, but a 2005 Alcohol Needs Assessment Research Project (ANWARP) survey found that there are a lack of provision for such services.9

47. There is a risk that people who need these services will remain untreated, having to access less appropriate alternative services, or rely on voluntary services and non-specialist primary care practitioners.

Please refer to Annex B for an explanation of the interventions and treatments for alcohol misuse and dependence.

Alcohol: the Cinderella of public health

48. Messages on smoking, illegal drug misuse and obesity are now widely accepted and appropriate investment has been made – we have not yet reached this position with alcohol.

49. For the estimated 1.6 million dependent drinkers, annual spend on alcohol treatment is £217 million, equating to £136 per dependent drinker. By comparison, for the estimated 332,000 dependent drug users, the annual spend on drug treatment is £436 million, or £1,313 per dependent drug user.7

50. Average PCT expenditure on alcohol services is just 0.1% (£600,000) of their annual budget, whilst on average £2.7 million was spent by each PCT on treating drug addiction.7

51. There is something unbalanced from a public health perspective with a situation where alcohol dependence affects 4% of the population and problem drug use rates are closer to 0.5%, yet access to treatment is considerably better for drug misusers
(1 in 2) than for alcohol misusers (1 in 18).\textsuperscript{5}

52. As a result of sustained investment in drug misuse, the National Audit Office report \textit{Tackling Problem Drug Use} concluded that there has been good progress, including increasing the number of problem drug users in effective treatment and an increasing number leaving treatment free from dependency.\textsuperscript{29} In comparison, on services for alcohol misuse the National Audit Office found that PCTs did not have alcohol strategies in place and failed to invest significantly in alcohol services.\textsuperscript{9}

53. The cost of smoking to the NHS has also been estimated at £2.7 billion per year.\textsuperscript{39} Good investment has been made in most areas in smoking cessation and all areas have seen reductions in the prevalence of smoking.

54. Rigorous evidence shows that alcohol brief advice in primary care leads to one in eight people reducing their drinking to within sensible levels. This compares well with smoking cessation where only one in 12 change their behaviour.\textsuperscript{13}

How can the Public Health White Paper proposals help to improve our response to alcohol?

55. The Public Health White Paper makes the case that investment in public health services is a cost-effective way to improve population health and reduce the need for NHS treatment services.

56. Key among the changes proposed for Public Health are that funding for health improvement will be ring fenced to improve overall health outcomes and must include the prevention of ill health by addressing lifestyle factors such as alcohol misuse. Public health funding allocations are to be provided according to baseline need and be used to reduce health inequalities. Local areas, which achieve improvements in public health outcomes will be rewarded for their achievements.\textsuperscript{35}

57. The NHS White Paper, Liberating the NHS: Local Democracy and Legitimacy in health, describes how smoking services will be funded, including the distinction between primary and secondary prevention. For instance smoking cessation services would be funded by local authorities (e.g. the 4% ring-fenced money), but treatment for individuals with impaired lung function through smoking would be funded by GP consortia.\textsuperscript{40} If applied to alcohol, this raises concerns regarding multiple commissioners across one therapy area and the need for alignment between commissioning of public health primary prevention services and GP funded secondary prevention services.

58. Good alcohol services are achievable if there is a stronger push from central Government and local health services. There is also an opportunity to secure the additional health premium for improvements in health outcomes which would be higher for disadvantaged areas.

\textit{Please see Annex A for Alcohol Concern’s response to the Public Health White Paper.}
Invest to save

For every £1 invested in specialist alcohol treatment £5 is saved on health, welfare and crime costs
Invest to save

Evidence of cost saving interventions

59. The Public Health White Paper states that “giving insufficient priority to public health services is likely to lead to lower improvements in health of the population over the medium to long term and a higher need for NHS treatment services. Digestive and liver diseases are expected to rise: both associated with long term rises in alcohol consumption. However, the incentives faced by PCTs and the Department of Health central budgets have not led to sufficient priority being given to public health.”

60. Clear evidence of the cost saving that can be made through evidence-based alcohol interventions:

- A meta-analysis of 22 Randomised Control Trials (enrolling 7,619 participants) shows that brief intervention is not only clinically effective, but also cost-effective. A UK model suggested that they would yield savings of around £2,000 per ‘life year’ saved.9
- A UK trial proved that, over a 6-month period, specialist treatment delivered savings of nearly £1,138 per dependent drinker treated and reduced admissions to hospital.25 The National Treatment Agency found that for every £1 invested in specialist alcohol treatment £5 is saved on health, welfare and crime costs.22
- One trial showed that social behaviour and network therapy saved about 5 times as much on expenditure for health, social and criminal justice services as they cost.42

61. Furthermore, in Signs for Improvement25 the Department of Health set out a series of High Impact Changes for those commissioning alcohol services, based on rigorous evidence of clinical and cost effectiveness. These have also been backed up as strong recommendations by a number of recent reports. Key amongst the High Impact Changes are:

- Appointing Alcohol Nurse Specialists in A&E departments and acute hospital clinics working with non-dependent drinkers and giving clinical advice to improve standards of care for alcohol dependent patients
- Appointing alcohol health workers in acute hospitals targeting dependent drinkers
- Improving the effectiveness and capacity of specialist treatment to ensure that at least 15% of estimated dependent drinkers in the area receive treatment
- Identification and brief advice as per the Directed Enhanced Service for all newly registered patients

A study has also shown that in A&E, 15% of patients that are admitted as critically ill (in the resuscitation room) have raised levels of Blood Alcohol Concentration. Patients are unable to receive brief advice when critically ill; therefore undertaking a blood test for alcohol concentration indicates to health workers whether a patient will require an
intervention for alcohol misuse once they have recovered.50

62. Drug-based ‘pharmacotherapies’ such as medication to assist detoxification, prevent relapse and provide nutritional supplements, can reduce longer-term health costs of problem drinkers.9

63. The key messages from this extensive and growing evidence base are:

- Quick wins can be made by identifying and treating harmful and dependent drinkers, future ill health can be avoided, health inequalities reduced, health outcomes improved, and substantial savings made by the NHS.
- Chief executives of NHS and local authorities should prioritise alcohol-use disorder prevention as an invest to save measure and that commissioners should ensure a local joint alcohol needs assessment is carried out.14
- We can be confident that money invested in IBA and specialist treatment is cost effective, helping to pre-empt the need for more expensive services to treat longer-term alcohol harm.9
- Commissioners have a “good economic case for investing in both brief interventions for hazardous and harmful drinkers and more intensive interventions for those with alcohol dependency.”22

Potential savings: local area examples

64. According to the Rush Model,45 an average sized PCT needs to invest £1.6 million to meet demand for treatment of alcohol dependency. However, we know that the average PCT only invests £600,000 in trying to meet this need.

65. The evidence shows that:

- A full time alcohol worker in an acute Trust will produce a net saving of £85,000.44
- Treating an additional 2% of dependent drinkers will generate net savings of between £39,000 and £167,000 depending on the size of PCT.44
- Screening and brief interventions in general practice will save £58,000 for every 1,000 patients screened.44

66. Table 4, opposite, shows that the current number of alcohol-related hospital admissions in the selection of PCT areas from across England used in Table 3 (Column A) are due to rise by 6-20% (Column B) by 2011/12 to the number in Column C if no additional investment is made in alcohol interventions. However, by focussing on rigorous, evidence-based interventions, a modest investment of 0.07-0.16% (Column D) of the PCT’s total budget, equating to the amount shown in (Column E), will avert a significant number of A&E admissions (Column F) and alcohol related hospital admissions (Column G), leaving a newly projected figure for alcohol-related hospital admissions in 2011/12 (Column G). This will give a benefit of around £0.8-£2.6 million in savings for the example PCT areas (Column I), and a return on investment of £2.7-£3 for every £1 spent on alcohol interventions (Column J).
Table 4: Example PCT Areas – Estimated return on investment in evidence based alcohol interventions

<table>
<thead>
<tr>
<th>A. PCT Area</th>
<th>B. Percentage rise in number of alcohol-related hospital admissions (ARHA) from 2009/10 to 2011/12</th>
<th>C. Current projected number of ARHA 2011/12</th>
<th>D. Percentage of total PCT budget needed for additional investment in alcohol</th>
<th>E. Additional investment required to invest in what works to meet need</th>
<th>F. Number of A&amp;E visits averted</th>
<th>G. Projected reduction in number of ARHA 2011/12</th>
<th>H. Projected ARHA 2011/12 with investment</th>
<th>I. Total Savings for NHS</th>
<th>J. Return on investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East Lincolnshire</td>
<td>6%</td>
<td>3,556</td>
<td>0.11</td>
<td>£299,006</td>
<td>1,043</td>
<td>728</td>
<td>2,828</td>
<td>£842,700</td>
<td>2.8</td>
</tr>
<tr>
<td>Hartlepool</td>
<td>18%</td>
<td>2,918</td>
<td>0.16</td>
<td>£277,714</td>
<td>1,043</td>
<td>646</td>
<td>2,272</td>
<td>£767,500</td>
<td>2.8</td>
</tr>
<tr>
<td>North Yorkshire and York</td>
<td>11%</td>
<td>14,521</td>
<td>0.08</td>
<td>£905,740</td>
<td>2,838</td>
<td>2,213</td>
<td>12,308</td>
<td>£2,693,500</td>
<td>3.0</td>
</tr>
<tr>
<td>Dudley</td>
<td>20%</td>
<td>9,183</td>
<td>0.13</td>
<td>£610,738</td>
<td>1,647</td>
<td>1,250</td>
<td>7,933</td>
<td>£1,747,700</td>
<td>2.9</td>
</tr>
<tr>
<td>Leicester City</td>
<td>16%</td>
<td>8,915</td>
<td>0.09</td>
<td>£466,326</td>
<td>1,482</td>
<td>1,058</td>
<td>7,857</td>
<td>£1,290,400</td>
<td>2.8</td>
</tr>
<tr>
<td>West Essex</td>
<td>17%</td>
<td>6,022</td>
<td>0.10</td>
<td>£419,680</td>
<td>1,440</td>
<td>1,007</td>
<td>5,015</td>
<td>£1,153,400</td>
<td>2.7</td>
</tr>
<tr>
<td>Ealing</td>
<td>16%</td>
<td>7,716</td>
<td>0.07</td>
<td>£413,330</td>
<td>1,504</td>
<td>1,058</td>
<td>6,658</td>
<td>£1,154,500</td>
<td>2.8</td>
</tr>
<tr>
<td>Eastern and Coastal Kent</td>
<td>12%</td>
<td>14,927</td>
<td>0.07</td>
<td>£848,529</td>
<td>2,533</td>
<td>1,931</td>
<td>12,996</td>
<td>£2,418,200</td>
<td>2.8</td>
</tr>
<tr>
<td>Devon</td>
<td>14%</td>
<td>17,464</td>
<td>0.08</td>
<td>£914,614</td>
<td>2,622</td>
<td>2,029</td>
<td>15,435</td>
<td>£2,621,700</td>
<td>2.9</td>
</tr>
</tbody>
</table>
CASE STUDY 2: A Successful Commissioning Framework

Bolton is one of very few areas in the country to have reduced its alcohol hospital admissions (by 2.4%). Alcohol Concern worked with Bolton PCT and Bolton Council to reconfigure the alcohol treatment system. Two key principles were agreed for the system. It should be as simple as possible to enter, and swift to respond.

The entry into specialist services is via a single point of entry and a triage assessment at ADS (Addiction Dependency Solutions) – a voluntary sector agency operating across the north of England. They then determine the best interventions for each person. The only exception to this pathway is made for pregnant women, in which case a referral can be made directly to the Community Alcohol Team (CAT). If in doubt the first point of referral is always ADS not the Community Alcohol Team. ADS will offer a triage assessment within three working days of contact. ADS can also offer a four-week programme of individual motivational interventions.

If a more intensive response is required a referral will be made to the CAT who will offer a comprehensive assessment, followed by detoxification, individual or group interventions as well as access to inpatient care and residential rehabilitation. Clients who complete these interventions will receive access to aftercare groups provided by ADS. Timescales for interventions are agreed. The expectation is that the service will offer a triage assessment within three working days of the request and CAT will offer a comprehensive assessment within two weeks of the request.

CASE STUDY 3: Providing alcohol identification and brief advice to hypertensive patients, Blackpool

Blackpool has the highest number of months of life lost attributable to alcohol in the whole of England. This project was triggered by the Alcohol Harm Reduction National Support Team (NST) visit to Blackpool in September 2008. Evidence presented by the NST outlined that Identification and Brief Advice sessions could be targeted towards people with increased risk of chronic ill health in particular those suffering from hypertension – high blood pressure.

Blackpool undertook an investigation of the research around hypertension and undertook a trawl of current patient registers for those identified with hypertension. People received personalised letters and the AUDIT questionnaire. Responding to this letter, people were asked to come into their GP surgery where they were seen by an Alcohol Health Worker. The analysis of GP practice data showed the link between alcohol consumption and those patients with hypertensive disease, showing them as being a patient population to target for specific interventions. For instance, at one GP surgery in those drinkers consuming over 20 units per week (3,582) 1,128 people (or 31.5%) suffered from hypertensive disease.
Call to action

Concerted action is needed at national and local level by the key partners
Call to action

67. Despite committed work by many in the NHS, the pace of change, especially in primary care, has been too slow and the cost burden of alcohol misuse is growing. The new opportunity to tackle alcohol misuse in public health and health services must not be missed. This report calls for concerted action at a national and local level.

National policy-makers

- **The Coalition Government must** make alcohol misuse a public health and NHS priority in realising ambitions set out in the White Papers on Public Health, the NHS and the forthcoming Liver Strategy.
- **The Secretary of State for Health** should ensure that a national treatment strategy for alcohol misuse is implemented, with clear ambitions to reduce alcohol consumption, which leads to a reduction in alcohol-related harm and alcohol-related hospital admissions and enables access to treatment for at least 15% of dependent drinkers.
- **Ministers** must show leadership in encouraging local areas to invest in alcohol services. Strategic investment in alcohol services is necessary, cost effective and beneficial to local communities. To continue to ignore the growing problem of increased alcohol misuse and static or shrinking support for those who need it is a recipe for disaster.7 Ministers should also ensure that future strategies for tackling liver disease and alcohol harm have a focus on alcohol-related health outcomes. We cannot expect to be able to tackle alcohol harm solely through enforcement or by engaging better with the drinks industry around responsible retailing. There must be a strong public health lead at the centre.
- **Public Health England**, in their planned role, will benefit the NHS by reducing pressures from avoidable illnesses, allowing the NHS to focus its efforts elsewhere. To achieve this, they will need to prioritise the reduction of alcohol consumption in order to lower levels of alcohol-related hospital admissions and decrease the incidence of liver disease and cancers caused by alcohol.
- **Department of Health and the NHS Commissioning Board** should ensure the NHS Operating Framework and the QIPP (Quality, Innovation, Productivity and Prevention) programme for the NHS have a specific aim to reduce alcohol-related harm, including making savings from prevention of alcohol misuse. The new Health Outcomes Framework should include not only a measure on reducing alcohol-related hospital admissions but also one to ensure that 15% of dependent drinkers receive treatment.

Local decision-makers

- **MPs** should aim to find out what the extent of ill health caused by alcohol is in their constituency and look at the level of investment made by commissioners. MPs should encourage local priority, focus and investment in alcohol services using the “invest to save” principle. It is important to make sure that alcohol misuse stays high on the agenda during this period of great change within the health service.
• **Directors of Public Health** will be the strategic leaders for public health and health inequalities in local communities, having a major role in setting the public health agenda for their area, choosing local priorities and directing investment as well as service design. It will be important for them to make the connection between alcohol and the full range of public health issues that it impacts on, and to understand the level of need and costs relating to alcohol misuse in their area. The Public Health White Paper makes clear that they will be expected to focus on personal public health services such as brief interventions.

• **Commissioners (PCTs and GPs)** must ensure that action is taken now on reducing alcohol-related poor health and wellbeing and that this issue does not fall further behind other public health problems in the changeover from PCT to GP commissioning. Furthermore, NICE recommends that chief executives of the NHS and local authorities should prioritise alcohol misuse treatment as an invest to save measure. Doing so offers a good opportunity to attain the planned rewards for achieving reductions in public health problems. Additionally, it will be important to take account of the new NICE alcohol dependence quality standard, which will be published in 2011.

• **GPs** should be given incentives to improve early detection of problem drinkers through screening by including a measure for alcohol consumption in the Quality and Outcomes Framework (QOF), which provides financial incentives for GP Practices.

• **Local authorities** and the proposed statutory Health and Wellbeing Boards should take a lead role for reducing alcohol harm. They must understand the scale of the problem of alcohol misuse they are facing, if they are to adequately inform future Joint Strategic Needs Assessments and plan, resource and improve alcohol interventions. Local authorities should ensure that a comprehensive alcohol strategy for their area includes early identification in general practices, improved capacity and quality of specialist treatment services building on existing drug treatment infrastructure where appropriate and training for nursing and medical staff to improve their understanding of the effect alcohol has in general health. They should also ensure that the wider impact of alcohol is considered in the range of local provision on offer, such as in mental health, offender health, domestic violence, support for Black Minority Ethnic and Refugee groups, the Night Time Economy, Fire Services and Teenage Pregnancy.
Conclusion

68. The choice is a stark one, we either double our current investment leading to improved public health and savings of £1.7 billion a year for the NHS or we do nothing and can expect the annual health cost to rise to £3.7 billion.

69. To turn around this growing cost to the NHS and the dramatically rising rates of poor health from alcohol misuse, the key people must act now.

National policy-makers should:

- Make alcohol misuse a major health priority
- Introduce a national alcohol treatment strategy with the aim to reduce alcohol consumption, which leads to a reduction in alcohol-related harm and alcohol-related hospital admissions, and which ensures access to treatment for at least 15% of dependent drinkers
- Double the current investment in alcohol services, with a further £217 million in order to save £1.7bn for the NHS

Local health commissioners and Directors of Public Health should:

- Prioritise alcohol as an invest to save measure, which may also realise the planned reward for areas that reduce public health problems
- Assess the scale and nature of the problem in their area, the level of investment and the quality and range of provision to address need, and incorporate this into future Joint Strategic Needs Assessments, as set out by the Public Health White Paper
- Ensure there is a local strategy in place with a ladder of interventions based on evidence of what works, matched with suitable investment as set out in our example areas table (see page 11)

If the challenge of alcohol misuse is not addressed at a local and national level, then the results could be disastrous for the NHS and for the health and wellbeing of our nation. The reforms to the NHS and public health white paper offer a new opportunity for a fresh start on alcohol misuse. Together we can stem the tide of alcohol misuse, improving the health and wealth if our nation.
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Annex A. Consultation on Public Health White Paper

The Department of Health published the Public Health White Paper, Healthy Lives, Healthy People, on 30 November 2010. The paper sets out the Coalition Government’s vision for a public health service at a national and local level.

Alcohol Concern urges readers of this report to respond to the consultation, calling on the Secretary of State for Health to make alcohol a major health priority, in both the public health service and the NHS.

We have outlined our views on the key questions raised in the consultation document below. The consultation period closes on 31 March 2011, please visit the Department of Health website for further details.

Alcohol Concern consultation response

Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

Alcohol misuse must be a health priority for the National Health Service, as well as for Public Health England. As Healthy Lives, Healthy People states “The creation of Public Health England, and the strengthening of the role of local government in public health, must not lead to the NHS stepping back from its crucial role in public health.”

Facing a significant and growing burden of alcohol misuse, it is vital that GPs become increasingly proactive in reducing alcohol-related harm. We recommend this can be achieved through the following actions:

- **The implementation of a national treatment strategy for alcohol misuse:**
  A plethora of strategies and policies has been produced over recent years. A national overarching strategy for the NHS will create impetus and provide a framework for GPs and healthcare professionals to work within.

- **Collaborative commissioning and outcomes:**
  The distinction between primary and secondary prevention in public health can be complex, particularly in relation to alcohol misuse. Public Health England is to commission primary prevention in the form of information and behavioural change campaigns and GPs secondary prevention, such as screening and psychological interventions. However, brief advice administered in healthcare settings can also be regarded as primary prevention, as it promotes guidance on sensible drinking. Thus, setting collaborative outcomes between local authorities and GPs will ensure a joined up approach to alcohol services.

- **Outcomes measures for alcohol misuse:**
  The new Health Outcomes Framework should not only measure the level of alcohol-related hospital admissions, but also the number of dependent drinkers receiving treatment, we recommend 15% of dependent drinkers should be in treatment.

- **QOF points on alcohol misuse:**
  Encourage GPs to reduce alcohol consumption which leads to alcohol-related harm through QOF points on targeted screening, brief advice and brief interventions.
How can Public Health England address current gaps (in public health evidence) such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

Other major public health issues, such as tackling smoking and illegal drugs, have benefitted from political and public support, matched by proper investment, which has in turn led to a reduction in these problems.

Alcohol dependence affects 4% of the population and over 10 million people drink over the recommended limits, compared to 0.5% of people who use drugs. Yet, access to treatment is considerably better for drug misusers (1 in 2) than for alcohol misusers (1 in 18). This would indicate that the cost of alcohol misuse to health services and wider society have not been fully recognised by commissioners. Alcohol misuse has not only led to increased hospital admissions, but it also increases the risk of liver disease and cancer.

Interventions in alcohol misuse, such as brief advice and interventions, have been shown to be cost effective. An extra £217 million invested in alcohol services would bring about an annual saving of £1.7 billion for the NHS in England. Public health evidence must therefore take into account the cost effectiveness and wider health benefits of services and treatments, particularly in relation to alcohol misuse.
Annex B. Better health through evidence based interventions

70. Interventions for alcohol misuse must be evidence-based and rigorous. The Department of Health’s Models of Care for Alcohol Misusers document provides a stepped care model of alcohol interventions across four tiers to support the commissioning of alcohol services:

- Tier 1: Non-specialist services offering screening, identification and brief advice in a range of primary health and social care settings for hazardous drinkers
- Tier 2: Open access, low threshold services for hazardous and harmful drinkers
- Tier 3: Structured community-based specialist treatment services for harmful and dependent drinkers
- Tier 4: Inpatient detoxification and residential rehabilitation services for severely dependent drinkers

71. GPs should be providing help to encourage people to drink less, for example, by screening all newly registered patients in GP practices. Locally and Directed Enhanced Schemes to do this should be in place in all areas.

72. Across a range of primary care settings, health practitioners should identify hazardous or harmful drinkers, offering them brief advice, whilst referring any dependent drinkers to specialist treatment services. Brief advice is a short opportunistic intervention offering advice on the risks a patient is running by drinking too much, conducted by any healthcare professional. A brief intervention is a specific structured interview by a trained Alcohol Health Worker for 20 to 30 minutes, setting goals to reduce alcohol consumption, and providing written materials such as advice leaflets, with the offer of follow up in the community, including by their General Practitioner.

73. Currently, a key part of identification and brief advice is hospital-based through specific alcohol health worker posts, in A&E or on wards, training and supporting hospital staff, arranging detoxification regimes and the management of dependent drinkers who are in hospital for other reasons.

Tiers 2 & 3: Specialist Alcohol Treatment Services

74. Specialist alcohol treatment services target harmful and dependent drinkers addressing both the effects of alcohol misuse and drinking behaviour. These services include walk-in clinics, structured psychological interventions, and alcohol services linked to hospital units, such as liver units. Treatment can be provided in primary care (e.g. a GP or practice nurse providing ‘extended brief advice’ during a series of consultations at Tier 2), acute hospitals (e.g. alongside the treatment of liver disease) and other specialist settings (such as counselling in a substance misuse service at Tier 3).

75. Alcohol treatment goals are usually measured through progress towards measurable outcomes such as: reductions in alcohol consumption or dependence and amelioration of related poor health.
Tier 4: Inpatient Detoxification and Residential Rehabilitation

76. NHS trusts provide hospital-based treatment such as inpatient detoxification for the physical and mental effects of withdrawal from alcohol for severely dependent drinkers. This may require the prescription of a drug, usually chlordiazepoxide, given in a reducing dose regime to prevent serious withdrawal symptoms.

77. Following detoxification, PCTs and local authorities, often through Drug and Alcohol Action Teams, will have some resource to fund individuals with alcohol dependency to have placements in residential rehabilitation units. Rehabilitation for alcohol misuse covers a variety of counselling approaches to prevent relapse including group therapy, behaviour therapies, and involvement with mutual-help groups. These services are mostly provided by private businesses or charities.

Guidance and Guidelines

78. Guidelines on the prevention, management and treatment of alcohol disorders have, and are, being developed by the National Institute for Health and Clinical Excellence (NICE). Completed public health guidance includes:

- **Alcohol-use disorders: preventing harmful drinking**
  Identifying how government policies on alcohol pricing, its availability and how it is marketed could be used to combat such harm.

- **School based interventions on alcohol**
  Aimed at teachers, school governors and health practitioners in schools, recommendations focus on encouraging children not to drink, delaying the age at which they start drinking and reducing the harm it can cause among those who do drink.

Completed guidelines include:

- **Alcohol-use disorders: physical complications**
  Setting out the treatment and management of patients with physical health problems that are completely or partly caused by alcohol use relating to acute alcohol withdrawal, lack of thiamine, liver disease and inflammation of the pancreas.

Guidance currently in development includes:

- **Alcohol dependence and harmful alcohol use**
  Setting out the diagnosis, treatment and management for alcohol dependence and harmful drinking.

79. NICE will also develop an alcohol dependence quality standard in 2011. The quality standard will be key to delivering high-quality services for screening and treating people alcohol problems. The quality standard is one of 150 to be produced by NICE. It is expected to be a driver of healthcare improvement, setting out measureable markers of high-quality clinical standards and cost effective patient care across a pathway or clinical area.

80. The forthcoming Liver Strategy may also indicate quality requirements for alcohol interventions relating to the prevention of liver disease.
Making alcohol a health priority

Opportunities to reduce alcohol harms and rising costs