South Kent Coast and Thanet - Alcohol Integrated Care Pathway Service Specification Document *

It is important to note that this service specification must be read with reference to “TSKC Alcohol ICP Tool v5” Interactive Alcohol Integrated Care Pathway Tool.

1. Population Needs

1.1 Background

Alcohol consumption accounts for around 10% of the UK’s burden of disease. It is one of the highest lifestyle risk factors for disease and death in the UK, after poor nutrition, smoking and obesity. Alcohol dependence in the UK is significantly under-diagnosed and under-treated with only 6% of alcohol dependent patients aged 16–65 years receiving treatment each year. Improving services for screening and treatment may have a profound impact on the public harm caused by harmful consumption of alcohol.

The relationship between alcohol consumption and risk is complex. It has been consistently found that the risk of ill health increases with the amount people drink and the number of occasions they drink to excess. As alcohol consumption is exponential to risk so reducing higher risk drinking and the number of people with alcohol dependence is likely to generate savings associated with reduced health harm and the subsequent use of healthcare resources as a result of reducing higher risk and dependent drinking.

Alcohol misuse means drinking excessively or more than the recommended limits of alcohol consumption. In the UK, the Department of Health has categorised types of drinking by level of risk, as shown in Table 1. One alcohol unit is equal to 10ml (in volume) or 8g (in weight) of pure alcohol. While it is not possible to say that drinking alcohol is absolutely safe, by keeping within the recommended guidelines, there is only a low risk of harm in most circumstances.

<table>
<thead>
<tr>
<th></th>
<th>MEN</th>
<th>WOMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Risk</td>
<td>No more than 3-4 units a day on a regular basis</td>
<td>No more than 2-3 units a day on a regular basis</td>
</tr>
<tr>
<td>Increasing Risk (hazardous)</td>
<td>More than 3-4 units a day on a regular basis</td>
<td>More than 2-3 units a day on a regular basis</td>
</tr>
<tr>
<td>Higher Risk (harmful)</td>
<td>More than 50 units per week (or more than 8 units per day on a regular basis)</td>
<td>More than 35 units per week (or more than 6 units per day) on a regular basis</td>
</tr>
<tr>
<td>Binge Drinking</td>
<td>Consuming more than twice the lower risk levels in one day (&gt; 8 units)</td>
<td>Consuming more than twice the lower risk levels in one day (&gt;6 units)</td>
</tr>
</tbody>
</table>

* This document was developed as part of a joint working project with Lundbeck Ltd in line with ABPI/DoH guidelines. For more information please see http://www.lundbeck.com/uk/our-focus/joint-working
† Regular in this context means drinking at this sort of level every day or most days of the week; whilst for weekly drinking, it refers to the amounts drunk most weeks of the year
Alcohol Dependence

Drinking behaviour characterised by an inner drive to consume alcohol, continued drinking despite harm and commonly withdrawal symptoms on stopping drinking

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>MEN (increases risk by)</th>
<th>WOMEN (increased risk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>Four times</td>
<td>Double</td>
</tr>
<tr>
<td>Stoke</td>
<td>Double</td>
<td>Four times</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>1.7 times</td>
<td>1.3 times</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>Triple</td>
<td>Double</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>13 times</td>
<td>13 times</td>
</tr>
</tbody>
</table>

Table 1: Summary of definitions of alcohol harm

Excessive consumption of alcohol significantly increases risk to long-term health. There is a strong correlation between the extent of alcohol consumption and the risk of developing dependence and physical harm. A dose-dependent relationship between level of alcohol consumption and disease risk has been shown for several categories of disease.

Excessive alcohol consumption significantly increases risk to long-term health. There is a strong correlation between the extent of alcohol consumption and the risk of developing dependence and physical harm. A dose-dependent relationship between level of alcohol consumption and disease risk has been shown for several categories of disease.

Table 2: Increase in risk of ill health in higher risk drinkers

Alcohol is associated with more than 40 serious medical conditions, including liver disease and mouth, bowel and breast cancer and is one of the major preventable causes of death in England. In particular, liver disease, to which alcohol is a contributor, is the only major cause of death still increasing year on year. Increase in risk of ill health in higher risk drinkers is summarised in table 2 above.

1.2 National context and evidence base

Nationally, alcohol misuse places a huge burden on the NHS at a cost of approximately £2.7 billion each year. In 2009/10, the number of hospital admissions due to alcohol misuse reached 1.1 million; a 100% increase since 2002/03. If this rise continues, by 2015 1.5 million people will be admitted to hospital every year as a result of health problems associated with excess alcohol consumption. Moreover, alcohol dependence in the UK is significantly under-diagnosed and under-treated with only 6% of alcohol dependent patients aged 16–65 years receiving treatment each year.

1.2.1 National Alcohol Strategy

The Government's Alcohol Strategy, published March 2012, acknowledges the harms associated with current levels of alcohol consumption in England and set out six outcomes for addressing alcohol harm.
and reducing the number of people drinking to excess:16

- A change in behaviour so that people think it is not acceptable to drink in ways that cause harm to themselves or others
- A reduction in the amount of alcohol fuelled violent crime
- A reduction in the numbers of adults drinking above NHS guidelines
- A reduction in the number of people ‘binge drinking’
- A reduction in the number of alcohol related deaths
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed

It originally proposed that these outcomes would be achieved through a range of methods including the introduction of a minimum unit price (MUP), banning the sale of multi-buy discount deals; zero tolerance of drunken behaviour in A&E departments; a late night levy to get pubs and clubs helping to pay for policing; and improved powers to stop serving alcohol to drunks. However, following consultation, the Government announced it would not be introducing an MUP or a ban on multi-buy promotions.

1.2.2 National indicators and key drivers
There are a number of relevant national indicators and key drivers for alcohol and these include indicators within the NHS and Public Health Outcomes Frameworks, the Clinical Commissioning Group (CCG) Outcomes Indicators and targets within the Government Alcohol Strategy.

In 2009, Department of Health identified seven High Impact Changes which, if undertaken by NHS and local government, have been found to have the greatest impact on health commissioned outcomes for reducing alcohol-related harm.4 The High Impact Changes are as follows:

- Influence change through advocacy
- Find high-profile champions to provide leadership within partner organisations and a focus for action to reduce alcohol harm. Provide more help to encourage people to drink less through identification and brief advice
- Deliver opportunistic identification and brief advice to patients drinking at increasing or higher risk levels that are not typically complaining about or seeking help for an alcohol problem.
- Appoint Alcohol Health Workers
- Appointment of a dedicated Alcohol Health Worker or an Alcohol Liaison Nurse in each major acute hospital
- Improve the effectiveness and capacity of specialist treatment
- Provide evidenced based, effective treatment and increase treatment opportunities for dependent drinkers.
- Develop activities to control the impact of alcohol misuse in the community
- Make use of all the existing laws, regulations and controls available to all the local partners to minimise alcohol related harm.
• Work in partnership
• Local partners will need to prioritise alcohol in relation to local need and co-ordinate action to maximise the impact on alcohol-related harm.
• Amplify national social marketing priorities
• Social marketing is the systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, for a social good. For alcohol, the goal is to reduce alcohol-related hospital admissions by influencing those drinking at increasing and higher risk levels to reduce their use of alcohol to within lower risk levels.

This Integrated Care Pathway specification seeks deliver a partnership between KCC Public Health Team and South Kent Coast CCG and Thanet CCGs in a leadership role in establishing a clearer and more integrated care pathway across health and social care, and other service providers (e.g. police/ambulance etc.)

Alcohol is a key risk factor for many of the indicators within 2014-15 NHS outcome indicators. Specifically it relates to those below, as well as being a highly significant risk factor for liver indicators:

1. Preventing People from dying prematurely
   • Reducing premature mortality from the major causes of death
   • Under 75 mortality from cardiovascular disease (NHS OF 1.1)
   • Cardiac rehabilitation completion
   • Myocardial infarction, stroke & stage 5 kidney disease in people with diabetes
   • Mortality within 30 days of hospital admission for stroke
   • Under 75 mortality from liver disease (NHS OF 1.3)
   • Emergency admissions for alcohol related liver disease
   • Under 75 mortality from cancer (NHS OF 1.4)
   • One and five year survival from all cancers (NHS OF 1.4.i and ii)
   • One and five year survival from breast, lung & colorectal cancers (NHS OF 1.4 iii and iv)

1.2.3 NICE Clinical Guidelines and Quality Standards:
1.2.3.1 NICE CG115 recommends 4 types of treatment (Description of tiers is from MoCAM):
   • T1: Brief advice in primary care
   • T2: Psychological +/- pharmacological interventions in primary care/3rd sector/specialist services
   • T3: Community Assisted withdrawal
   • T4: Inpatient assisted withdrawal

CG115 states that all people who misuse alcohol should be offered interventions to promote abstinence or moderate drinking, and to prevent relapse in community-based settings. It recommends that:
   • For harmful drinking or mild dependence without significant co-morbidity and where there is
adequate social support, consider a moderate level of drinking as the treatment goal unless the service user prefers abstinence or there are other reasons for advising abstinence.

- For mild alcohol dependence, if service users have not responded to psychosocial interventions alone, or specifically request pharmacological intervention, it should be offered.
- For those with moderate and severe dependence, assisted alcohol withdrawal is recommended, followed by psychosocial intervention and pharmacotherapy that maintains abstinence and prevents relapse.

1.2.3.2 NICE QS11 For health and social care staff recommendations are made through the Quality Statement for NICE QS11. Training and awareness is covered in Quality Statement 1 and Quality Statement 4.

Quality Statement 1: Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.

a) Evidence of local arrangements to ensure that alcohol awareness training that promotes respectful, non-judgmental care is delivered to all health and social care staff who potentially work with patients or service users who misuse alcohol.

b) Evidence of local arrangements to ensure that local patient and service user feedback, in the form of surveys and complaints, is collected, analysed and acted upon within all health and social care settings.

Quality Statement 4: People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff.

a) Evidence of local implementation of current guidance from the Royal College of Psychiatrists and Royal College of General Practitioners on training and competence for doctors working in substance misuse.

b) Evidence of local arrangements to ensure that all staff carrying out initial assessments in specialist alcohol services are trained in the key elements of motivational interviewing.

c) Evidence of local arrangements to ensure that care coordination with other agencies (for example, housing, employment and social care) is delivered by appropriately trained and competent staff working in specialist alcohol services.

d) Evidence of local arrangements to ensure the use of competence frameworks developed from relevant treatment manuals that guide the structure and duration of psychological interventions for people who misuse alcohol.

e) Evidence of local arrangements to ensure that staff responsible for assessing and managing assisted alcohol withdrawal are trained and competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms, and the use of drug regimens appropriate to the setting in which the withdrawal is managed.

f) Evidence of local arrangements to ensure that staff working in specialist alcohol services receive appropriate monitoring and supervision.

1.2.4 NICE Public Health Guideline PH24:
The CCG has a responsibility to work with Public Health in the delivery NICE PH24 which flags the
following objectives:

- Prioritise alcohol use disorders as an investment to save commissioning
- JSNA to include an alcohol needs assessment chapter
- Plans must include screening and brief interventions for hazardous and harmful drinking
- Plan to include an increasing number of T2/3/4 referrals
- Ensure at least 1 in 7 can get treatment locally
- Evaluate treatments/interventions to increase cost effectiveness
- Nurse/consultant lead identified for NHS services (i.e. acute?)
- Ensuring community and voluntary services governed/supervised
- Provide enough resource to screen and complete brief interventions in primary care
- Deliver a programme of extended brief intervention training where required

Despite all the above NICE national guidance there are large gaps in the service provision and standards of care across GP practices, significant under resourcing and a lack of integration. This is described in detail in section 1.4 below.

1.3 Financial Cost to the NHS

Alcohol-related harm is now estimated to cost society in England £21 billion annually. These costs can be broken down as:

- NHS costs, at about £3.5 billion per year (at 2009–10 costs)
- Alcohol-related crime, at £11 billion per year (at 2010–11 costs)
- Lost productivity due to alcohol, at about £7.3 billion per year (at 2009–10 costs, UK estimate)

In terms of healthcare provision alone, results from one peer-reviewed paper published in 2011 suggested that as a behavioural risk factor, alcohol-related ill health is as costly to the NHS as smoking. The following costs were aligned to behavioural risk factors:

- £5.8 billion poor diet ill health
- £3.3 billion alcohol-related ill health,
- £3.3 billion on smoking related ill health
- £0.9 billion on physical inactivity-related ill health.

Other reports estimate the annual burden of alcohol-related harm in England alone to range from £20 billion to £55 billion, taking into account a variety of non-medical factors.

1.4 Kent-wide Context

The Kent JSNA (2012-15) highlights that limited provision of IBA treatment capacity for increasing risk and higher risk drinkers is currently provided across the county which is concerning as demand is likely to increase. There is a need to have greater links with primary care to identify those at risk given the estimated number of increasing risk and higher risk drinkers.
Alcohol IBA and referral to treatment services is not routinely undertaken by all health care professionals as part of the diagnosis and referral process. This is especially relevant for cancer, gastro and CVD services (notably hypertension and stroke), where alcohol misuse can predispose to and exacerbate the condition. This also links with urgent care commissioning.

There is a strong correlation between the extent of alcohol consumption and the risk of developing dependence and physical harm\textsuperscript{20}. A dose-dependent relationship between level of alcohol consumption and disease risk has been shown for several categories of disease\textsuperscript{21,22}.

The Kent JSNA flags, among others, the following commissioning needs\textsuperscript{23}:

1. Industrialise routine delivery of IBA in A&E and Acute services generally for patients experiencing falls/accident/assault/head injury: gastro-intestinal, cardiac, mental & behavioural problems: collapse or feeling unwell. Use referral tools and pathways already agreed by commissioners and providers. NHS Acute contracting team need to ensure that Hospital Trusts provide accurate data recording and data extraction, to monitor progress of initiatives, by building specifications on this into contracts and service level agreements. This will ensure that relevant data are available for performance management and to inform further JSNA refresh.

2. Industrialise routine delivery of IBA in Primary Care through inclusion in NHS Health Checks wherever and however commissioned and delivered, to mitigate risk of development of chronic conditions and identify patients requiring specialist treatment for alcohol harm reduction.

3. Industrialise routine delivery of IBA in Primary Care generally for patients experiencing gastro-intestinal, cardiac, mental & behavioural problems or feeling unwell. Use referral tools and pathways already agreed by commissioners and providers.

4. Industrialise routine delivery of IBA in Community Nursing, for the same groupings of patients and others who demonstrate health risk behaviour (e.g. in sexual health services). Use referral tools and pathways already agreed by commissioners and providers. Community commissioners to require accurate data recording and effective data extraction processes, by building specifications on data collection and data sharing into contracts / SLAs to monitor progress of initiatives.

5. Work for further development of generic young people’s risk reduction services to include brief advice for alcohol identification and referral to specialist services (pathway development). This would be the responsibility of Child Health Commissioners, through and with KDAAT, alongside KCC Education.

6. Develop a joint working policy, procedure and care pathway for clients with mental health and alcohol misuse problems (significant co-morbidity with mental illness requires pathway development into alcohol / mental health dual diagnosis services). Use referral tools and pathways already agreed by commissioners and providers.

7. Develop links with the IAPT programme once that service is well-established.

The Kent Alcohol Strategy (2014-16) outlines the following:

Kent, like many regions in the UK experiences the widespread impact of alcohol misuse. Excessive drinking is a major cause of disease, accounting for 9.2\% of disability-adjusted life years (DALYs)
The strategy includes 6 KEY pledges (seven high impact steps). These are:

- Improve prevention and identification
- Improve quality of treatment
- Coordinate enforcement and responsibility
- Local action
- Target vulnerable groups and Health Inequalities
- Protect Children and Young People

This ICP project focusses on 3 main pledges and seeks to address several key actions the strategy identifies:

• The introduction of screening and brief interventions for hazardous and harmful drinkers in non-alcohol-specialist setting e.g. primary care, A & E and criminal justice settings
• A more strategic approach to communication and public awareness is required
• Improving links with those who present at A&E to identify the additional needs of adults and young people who are misusing alcohol.

In Kent it is estimated that alcohol harm accounts for approximately £108m of commissioning resource each year (see chart one below). Much of the above spend is in acute services, which may be PbR costs to the CCG. As such, improving identification and early intervention at Tiers 1 and 2 is an effective means of averting A&E attendances and alcohol-related hospital admissions. This links well into current priorities in the CCGs QIPP plans.
Chart 1 – Data Extracted from NHIS Alcohol Impact Model

1.5 Local Context in Thanet and South Kent Coast CCG

Healthcare commissioning costs for alcohol across Thanet and South Kent Coast CCGs are summarised in Table 1 below:

<table>
<thead>
<tr>
<th>Type of cost (£000s)</th>
<th>Actual or modelled data</th>
<th>Thanet</th>
<th>S Kent Coa</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Alcohol-related inpatient admissions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis codes</td>
<td>Wholly attributable</td>
<td>Actual data</td>
<td>£1,293</td>
</tr>
<tr>
<td></td>
<td>Partly attributable</td>
<td>Actual data</td>
<td>£4,634</td>
</tr>
<tr>
<td>External Cause codes</td>
<td>Wholly attributable</td>
<td>Actual data</td>
<td>£0.0</td>
</tr>
<tr>
<td></td>
<td>Partly attributable</td>
<td>Actual data</td>
<td>£281</td>
</tr>
<tr>
<td>2. Alcohol-related outpatient visits</td>
<td>Modelled data</td>
<td>£1,153</td>
<td>£1,587</td>
</tr>
<tr>
<td>3. Alcohol-related A&amp;E attendances</td>
<td>Modelled data</td>
<td>£2,083</td>
<td>£2,239</td>
</tr>
<tr>
<td>4. Alcohol-related emergency ambulance journeys</td>
<td>Modelled data</td>
<td>£1,371</td>
<td>£1,946</td>
</tr>
<tr>
<td>5. Alcohol-related GP consultations</td>
<td>Modelled data</td>
<td>£276</td>
<td>£380</td>
</tr>
<tr>
<td>6. Alcohol-related practice nurse consultations</td>
<td>Modelled data</td>
<td>£38</td>
<td>£53</td>
</tr>
<tr>
<td>7. Alcohol dependency-prescribed drugs</td>
<td>Actual data</td>
<td>£2</td>
<td>£3</td>
</tr>
<tr>
<td>8. Specialist alcohol treatment services</td>
<td>Modelled data</td>
<td>£162</td>
<td>£233</td>
</tr>
<tr>
<td>9. Other alcohol-related healthcare usage</td>
<td>Modelled data</td>
<td>£220</td>
<td>£303</td>
</tr>
</tbody>
</table>

Aggregated data

<table>
<thead>
<tr>
<th>Type</th>
<th>Thanet</th>
<th>S Kent Coa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost (£000s)</td>
<td>Various</td>
<td>£11,494</td>
</tr>
<tr>
<td>Adult population (16+)</td>
<td>Actual data</td>
<td>115,057</td>
</tr>
<tr>
<td>Cost per adult (£)</td>
<td>Various</td>
<td>£100</td>
</tr>
</tbody>
</table>

Table 1: Alcohol Impact Model Commissioning Costs

Much of the above spend is in acute services, which may be direct PbR costs to the CCGs, or operational costs to GP surgeries. As such, improving services, especially those around the early identification and intervention at Tiers 1 and 2 may be considerably effective at averting A&E attendances and alcohol-related hospital admissions.

Social costs to the population in SKC CCG can be summarized as follows:

<table>
<thead>
<tr>
<th>SKC Societal costs</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal justice system</td>
<td>£703,034</td>
</tr>
<tr>
<td>Workplace &amp; activity</td>
<td>£648,996</td>
</tr>
<tr>
<td>Wider social costs</td>
<td>£745,491</td>
</tr>
<tr>
<td>Total</td>
<td>£2,097,521</td>
</tr>
</tbody>
</table>

Social costs to the population in Thanet CCG can be summarized as follows:

<table>
<thead>
<tr>
<th>Societal costs</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal justice system</td>
<td>£478,665</td>
</tr>
<tr>
<td>Workplace &amp; activity</td>
<td>£441,873</td>
</tr>
<tr>
<td>Wider social costs</td>
<td>£507,572</td>
</tr>
<tr>
<td>Total</td>
<td>£1,428,110</td>
</tr>
</tbody>
</table>

This service specification aims to improving and integrate the pathway holistically from prevention/early identification, delivery of screening, brief intervention all the way to extended intervention services and...
other treatments. It is recognized this is an untapped CCG commissioning area.

**Alcohol Integrated Care Pathway Commissioning Business Case:**
Developing an integrated service specification for alcohol may help prepare Thanet and South Kent Coast CCGs to deliver efficiency savings in financial year 2015/16. As this area is relatively untapped from a primary care service provision, it is expected the project may yield significant savings moving forward. The modelling in chart 1 above highlights the total impact of alcohol to be around £108m on the NHS in Kent. Using the NHiS AIM model\(^30\), Alcohol Concern’s report (2010)\(^31\), and the Alcohol Ready Reckoner (2009)\(^32\), it is possible to make the assumptions on cost savings that might be made by improving the pathway, identification, screening and treatment in each CCG in Kent (see below for examples for SKC and Thanet). This can be scaled up allowing a total impact forecast for taking this approach across all of Kent.

**Thanet CCG:** For Thanet CCG, modelling highlights public health investing £50,715 improving pathway identification and treatment to assumptions outlined in the objectives would deliver around £596k savings for A&E and acute hospital activity. These savings do not include potential savings on other CCG spend, such as alcohol-related emergency ambulance journeys, GP consultations, practice nurse consultations, alcohol treatment services or other alcohol-related healthcare usage. They also do not account for societal costs that may be impacted upon via better service provision, such as criminal justice costs etc.

<table>
<thead>
<tr>
<th>Current Assumptions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Population</td>
<td>140,872</td>
</tr>
<tr>
<td>Current Population 16+</td>
<td>115,057</td>
</tr>
<tr>
<td>Current No. Patient Screened per annum (2%)</td>
<td>1811</td>
</tr>
<tr>
<td>Current No. Dependent patients treated (6%)</td>
<td>321</td>
</tr>
<tr>
<td>Additional cost per additional person screened</td>
<td>£7.00</td>
</tr>
<tr>
<td>Additional saving per additional person screened</td>
<td>£53.03</td>
</tr>
<tr>
<td>Additional cost per dependent person treated</td>
<td>£199.96</td>
</tr>
<tr>
<td>Additional saving per dependent person treated</td>
<td>£610.87</td>
</tr>
</tbody>
</table>

**SKC CCG:** For SKC CCG, public health investing £72,685 improving pathway identification and treatment to assumptions outlined in the objectives would deliver around £855k for A&E and acute hospital activity. As with Thanet these savings do not include potential savings on other CCG spend, such as alcohol-related emergency ambulance journeys, GP consultations, practice nurse consultations, alcohol treatment services or other alcohol-related healthcare usage. Again, these efficiencies do not account for societal costs that may be impacted upon via better service provision, such as criminal justice costs etc.
costs that may be impacted upon via better service provision, such as criminal justice costs etc.

### Current Assumptions

<table>
<thead>
<tr>
<th>Current Assumptions</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Population</td>
<td>199,887</td>
</tr>
<tr>
<td>Current Population 16+</td>
<td>164,899</td>
</tr>
<tr>
<td>Current No. Patient Screened per annum (2%)</td>
<td>2596</td>
</tr>
<tr>
<td>Current No. Dependent patients treated (6%)</td>
<td>459</td>
</tr>
<tr>
<td>Additional cost per additional person screened</td>
<td>£7.00</td>
</tr>
<tr>
<td>Additional saving per additional person screened</td>
<td>£53.03</td>
</tr>
<tr>
<td>Additional cost per dependent person treated</td>
<td>£199.96</td>
</tr>
<tr>
<td>Additional saving per dependent person treated</td>
<td>£610.87</td>
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</table>

### Improving Quality, Innovation, Productivity and Prevention (QIPP) Aims

<table>
<thead>
<tr>
<th>A&amp;E</th>
<th>Hospital</th>
<th>Cost to ES CCG</th>
<th>Saving to ES CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% screening</td>
<td>751</td>
<td>688</td>
<td>£72,685</td>
</tr>
<tr>
<td>12% dependent treated</td>
<td>162</td>
<td>202</td>
<td>£183,748</td>
</tr>
<tr>
<td>Overall QIPP Efficiency</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 2. Outcomes

#### 2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>Preventing people from dying prematurely</td>
<td>YES</td>
</tr>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
<td>YES</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
<td></td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
<td>YES</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
<td></td>
</tr>
</tbody>
</table>

#### 2.2 Local defined outcomes – CCG Outcome Indicators – 2014/15

The service outcomes will impact on the indicators relating to:

1. Preventing People from dying prematurely
   a. Reducing premature mortality from the major causes of death
      i. Specifically: Emergency Admissions for alcohol related liver disease
      ii. Related: All other disease areas where increasing or higher risk alcohol use increases risk of associated disease/death

Local KPIs can also be built around alcohol related HRGs/ICD 10 coding using NHS admissions data, and also a modelled dataset will be used to run alongside this to capture "alcohol related" admissions in line
with other national approaches. It is hoped that once the service specification is in place, work can begin around data collection to improve understanding of the alcohol related estimates by close partnership between Public Health and CCG commissioners. This will enable outcome KPIs to be measured.

3. Scope

3.1 Aims and objectives of service

This service will:

- Deliver an integrated approach to managing alcohol use disorders across health and social care, local authorities, emergency services and 3rd sector which ensures those at risk of health harm are identified, educated to understand risk levels associated with alcohol consumption, signposted where required to additional support and gain improved access to new and existing services and treatments.
- Provide a high quality integrated service in line with NICE guidance (CG115/PH24) and Quality Standards (QS11) and any NICE TA recommendations around medications.
- Improve the public awareness, education, early identification and treatment of people with alcohol use disorders in Thanet and South Kent Coast CCGs
- Assist the CCGs in developing Alcohol QIPP efficiencies.
- Develop both CCGs as beacon example Integrated Service Specification for Alcohol, to be profiled as a case study of ways in which services may be designed to reduce the harm caused by alcohol across Kent and the wider geography.

3.2 Service description/care pathway

This service will covers 4 key pathway processes which are to be commissioned in an integrated fashion and delivered in stepped care (please see Interactive Alcohol Integrated Care Pathway tool).

- Prevention Pathway Responsibilities – Population based awareness and education driven by all stakeholders via alcohol conversations (MoCAM Tier 1). Simple screening and advice using scratch card.
- Screening and Early Identification Services – Evidence based AUDIT C/Full AUDIT Screening and risk stratification delivered in “WellBeing Appointment” locally enhanced service see appendix (MoCAM Tier 1)
- Diagnosis and Risk Management Services – Evidence based FRAMES or BRENDA Brief Advice (Tier 1) or referral to specialist services (MoCAM Tier 2-4)
- Specialist Treatment Services (MoCAM Tier 2-4)

This pathway, although not intended to be seen as a pilot in the selected CCG areas, is an innovative approach to improve alcohol services in Kent, and as such will need to be evaluated to support the development of the evidence base and expansion to other CCGs in East Kent and West Kent. It must also be noted that that the current proposed pathway may not be fully in line with all current NICE evidence but has been developed through engagement with as many stakeholders as possible and is therefore a
compromise on what is in NICE guidelines, what is evidence based, what budgets can currently fund and what current service providers/partners are able to deliver within the remits of their current contracts and organisational responsibilities.

3.2.1 Prevention Pathway Responsibilities

NICE PH24 suggests that population-level prevention approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole population’s risk of alcohol-related harm. The Kent-wide alcohol strategy defines alcohol is a shared commissioning issue, it is important that all partners across health, social care, emergency services, councils and other organisations ensure that prevention strategies for their populations are employed to help reduce the development of long term conditions or acute alcohol related admissions to secondary care.

This PREVENTION part of the ICP is to ensure:

- there is a better overall awareness in Thanet and SKC CCGs populations of the acute and long term health risk associated with increasing and high risk drinking so that we can help prevent people from drinking at increasing or high risk levels in the first place.
- those who are not in regular contact with the relevant services are signposted by a range of services they may need to access if they have increasing or higher risk drinking behaviour
- those who have been specifically advised to reduce their alcohol intake can do so in an environment which is non-judgemental, does not create stigma and that supports lower-risk drinking.

The plans and interventions in this part of the pathway are aimed at generating a simple approach to spreading prevention and education across as broad a group as possible. This part of the pathway will ensure individuals are more aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as NICE PH24 states they are most likely to change their behaviour if it is tackled early, and also that prompt intervention could prevent more extensive and costly addictions and health harm in the future. Screening, education and advice effectively reduces increasing and high risk drinking behaviours. The proposed delivery of simple screening, advice and signposting using a scratch card has been profiled and discussed across a broad stakeholder group as a balance between what current clinical evidence and NICE guidance would suggest, and what broad stakeholder group (e.g. Police, Ambulance etc.) were actually prepared to deliver in real life practice.

The Prevention Conversation (educational approach for all stakeholders):

For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where
possible, encouraging them to tear off the AUDIT C section and retain the advice section.

- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point's Alcohol Help and Advice Line using the number of the scratch card - **0300 123 1186**
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
  - Agree a referral to their local GP practices/Pharmacies in CCGs for a “WellBeing Appointment”
- Return the detachable AUDIT C QUESTIONS SECTIONS of ALL COMPLETE SCRATCH CARDS once per quarter in an envelope to:
  - Kent Public Health Alcohol Pathway Project, Lundbeck Ltd, Freepost L0844, Milton Keynes, MK7 8BR
  - PLEASE ADD YOUR ORGANISATIONS SENDER DETAILS TO THE REAR OF THE ENVELOPE so each services use can be measured and replacement scratch cards issued.
  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

N.B The detachable section of the cards contain no patient identifiable data, this information will be used by Kent Public Health Team to assess the uptake and success of the scratch cards, but also to audit drinking risk in your area or service.

The interaction all professionals using the scratch cards should have should be a ‘conversational approach’ following themes identified by Alcohol Concern in their 2013 conference, and reiterated in their 15:15 report which encourages integrated care, education and making every contact count. This approach is designed to fit into professionals daily responsibilities without impinging upon the broad range of partners individual key performance indicators (e.g. during ambulance conveyances/police work/housing inspections etc.). It is estimated this should take no more than a minute or so. Its goal is to encourage the broader population to consider their own, friends and/or relatives drinking habits in an effort to improve education and drive treatment seeking behaviour where someone recognizes support is required.

The supporting Scratch Info Card and NHS ‘Your Drinking and You Leaflet’ can be seen in Appendix 1 accompanying this specification. The partners who will be engaged to deliver this prevention strategy are as follows:

- Community Matrons and District Nurses
- Local authority or voluntary services for adults and children e.g. Jobcentre, social services, domestic abuse etc.
• Dentists
• Pharmacists
• Maternity Services
• Health visitors
• Fire services
• Police and community safety services
• Ambulance service
• Mental Health Service providers
• Others who may include:
  o Employers
  o Sport/leisure
  o Others who may show willingness to engage
• Acute secondary care health care staff
• Primary care practice professionals and staff
• Acute Trust Emergency Department

Important note on duty of care for all NHS professionals to deliver IBA in line with NICE guidance:

- It is important to note that for partners working in NHS settings, if a patient is suspected of increasing or higher risk drinking levels during the ‘Alcohol Conversation’ outlined above (i.e. the scratch card highlights an AUDIT C score suggesting increasing or higher risk drinking) that the responsibilities of the “WellBeing Appointment” should implemented (see 3.2.7.). Where this is not immediately possible, an appointment must be made where a “WellBeing Appointment” can be delivered (see 3.2.7).

NB: The national or local evidence and guidance on why it is necessary to implement this prevention strategy across stakeholders is collated in appendix 7 and made relevant to their roles.

3.2.2 Screening and Early Identification Services

The need for early identification and appropriate screening is imperative. However, it is recognized by most health care economies that this is not done, or accepted by many health and social care providers as a quality or contractual Key Performance Indicator. This has been summarised by the Kent JSNA.

It is important to note that people with alcohol-use disorders commonly present to health, social and criminal justice agencies, often with problems associated with their alcohol use, but they less often seek help for the alcohol problem itself. Further, alcohol-use disorders are seldom identified by health and social care professionals. One study found that UK GPs routinely identify only a small proportion of people with alcohol-use disorders who present to primary care (less than 2% of hazardous or harmful drinkers and less than 5% of alcohol-dependent drinkers) (Cheeta et al., 2008). This may be due to a number of factors locally, including:

- A lack of national or local contracts which include screening/early intervention as a KPI
• Poor education across the population around health harm of alcohol meaning little treatment seeking behaviour
• The perceived stigma discussions around alcohol can create a fear of being labelled as an alcoholic

The above factors and their impact have important implications for the prevention and treatment of alcohol-use disorders. Failure to identify alcohol-use disorders means that many people do not get access to alcohol interventions until their problems are more chronic and difficult to treat. Further, failure to address an underlying alcohol problem may undermine the effectiveness of treatment for the presenting health problem (for example, depression or high blood pressure).

As these issues are likely to be engrained in both CCG’s populations, there is a need for marketing approaches and an assertive stance to be taken to normalize our population to seek a “healthier” approach to their drinking and that this is seen in the same light as other health and wellbeing issues affecting our population. This will be driven through the prevention approach described above. Screening and identification does not need to be seen as a burden to health and social care professionals, and if it is a simple approach, this will help with gaining by in.

3.2.3 Screening and Early Identification Responsibilities
Research suggests that around one third of people affected by alcohol use disorders will self-present to specialist alcohol services in England36. The goal of this integrated service is to ensure that the prevention services defined in section 3.2.1 drive either treatment seeking behaviours, or a reduction in alcohol consumption in people who are given the materials. Evidence suggests that screening and information leaflet approaches in those with increasing risk/high risk drinking behaviours can reduce alcohol consumption to lower risk levels in approximately 1 in 3 of those targeted37. Identification and brief advice (IBA), or ‘screening and brief advice’, has also been shown to lead to 1 in 8 people reducing their drinking: IBA is one of the most effective health interventions available to reduce alcohol related harm.38

The materials in appendix 1 contain evidence-based screening tools (AUDIT-C) and are designed to encourage people to can reach out to services that can help them. This shortened version of the Alcohol Use Disorders Identification Test (AUDIT) is less accurate than the full AUDIT and does not clearly differentiate between increasing risk (hazardous) and higher risk (harmful and possibly dependent) drinking. This is why it is essential that all professionals outlined in 3.2.1 refer those with suspected increased or higher risk drinking to the single points of access outlined in sections 3.2.4 or to the services listed below.

• GP or practice nurse
• Local Pharmacist
• Alcohol Liaison Nurse/Worker (where the person was presenting in A&E or Acute Hospital Departments)

It is aimed that these 4 points of access (Turning point/GP/community pharmacist/alcohol liaison) will be able to either signpost onwards or deliver the more comprehensive screening and brief advice services
3.2.4 Turning Point Single Point of Contact (SPoC) - Help and Advice Line

Turning Point’s Single Point of Contact (SPoC) Help and Advice Line Telephone service is designed to triage callers, assess their risk more comprehensively and, where required deliver advice, counselling or onward admission into Turning Point Specialist Services, or potential signposting people to a ‘WellBeing Appointment’ at GP surgery/community pharmacist. Turning Point may also refer younger people onto KCA services which are commissioned for 10-19 year olds, other 3 sector services where required (e.g. Alcoholics Anonymous etc.). The may also assist the caller with other services that might help with more complex needs (e.g. Housing, Employment etc.).

Screening and brief intervention delivered by a non-specialist practitioner is a cost effective approach for increasing risk (hazardous) and higher risk (harmful) drinking behaviours (NICE, 2010a). This telephone service will provide telephone based screening, brief advice, counselling and signposting to appropriate services.

At the point of entry to treatment it is essential that patients are appropriately diagnosed and assessed in order to decide on the most appropriate treatment and management, assess the level of risk, such as self-harm and risk to others, and identify co-occurring problems that may need particular attention, for example psychiatric comorbidity, physical illness, problems with housing, vulnerability and pregnancy (National Treatment Agency for Substance Misuse, 2006).

The service will use recognised assessment tools such as AUDIT. Below is a typical flow that might be expected by a caller into the SPoC line:

- It this identifies a drinker a lower risk, it will congratulate and reinforce benefits of lower risk drinking.
- If it flags increasing or higher risk drinking it will deliver brief advice in line with the FRAMES (Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy)\(^{39}\) or BRENDA (Biopsychosocial, Report, Empathy, Needs, Direct advice, Adjusting treatment plan)\(^{40}\) principles. See appendix 5 for details of how to deliver FRAMES or BRENDA.
- It may choose to refer those wanting to see primary care services who have less complicated increasing risk or high risk drinking to a local ‘WellBeing Appointment’ at GP surgery/community pharmacist in line with the locally enhanced service outlined in Appendix 2.
- For people who are alcohol dependent, brief interventions are inappropriate (Moyer et al., 2002) and Turning Point would seek to reach out to those suspected of dependant drinking levels and ensure they engage with their specialist services.

3.2.5 Alcohol Liaison Service Model – See interactive pathway for more detail on this service.

3.2.6 GP/Practice Nurse/Local Pharmacist General Appointments and Referral to DPS Enhanced Service (see appendix 2)
It is expected that any people who present to GP, practice nurse or pharmacist who are seen due to other health reasons but are suspected to be increasing risk or high risk drinkers are engaged and that a duty of care exists to deliver IBA in line with NICE guidance:

- It is important to note that in primary care settings, if a patient is suspected of increasing or higher risk drinking during typical consultations, the responsibilities of the WELLBEING APPOINTMENT should implemented (see 3.2.7.).
- Where this is not possible, an appointment must be made where a WELLBEING APPOINTMENT can be delivered in full (see 3.2.7).

3.2.7 The role and responsibilities of the WELLBEING APPOINTMENT at GP surgery/community pharmacist (see appendix 2 for DPS Enhanced Service Specification and Payments)

Screening and brief intervention delivered by a non-specialist practitioner is a cost effective approach for hazardous and harmful drinkers (NICE, 2010a). However, it is important to note at the point of entry to treatment it is essential that patients are appropriately diagnosed and assessed in order to decide on the most appropriate treatment and management, assess the level of risk, such as self-harm and risk to others, and identify co-occurring problems that may need particular attention, for example psychiatric comorbidity, physical illness, problems with housing, vulnerability and pregnancy (National Treatment Agency for Substance Misuse, 2006).

The service will use the AUDIT C screening tool on the Too Much Scratch Card, and if positive continue to deliver a full AUDIT. To do this the “Turning Point Alcohol Click Website” can be used.

Please visit:

https://alcoholaudit.turning-point.co.uk/

Utilise the passwords for you locality and the system will allow you to complete a full AUDIT Score. Before referring to Turning Point consider the following actions in line with appendix 2. Referral can be completed if required using the “refer” button on the Turning Point website. Alternatively, call Turning Point on 0300 123 1186
The Wellbeing appointment enhanced service will deliver the following actions based on level of risk gathered from the full AUDIT SCORE:

**AUDIT-C (3 questions)**

- **USE SCRATCH CARD**

**Where individual scores 5+, ask remaining 7 AUDIT questions for total score**

- **AUDIT Score 0-7**
- **AUDIT Score 8-15**
- **AUDIT Score 16-19**
- **AUDIT Score 20+**

**Actions based on results:**

- **Audit 0-7** – lower risk drinking - congratulate and reinforce benefits of lower risk drinking
- **Audit 8-15** - increasing risk without other complications or social care needs it will provide brief advice in line with FRAMES/BRENDA. See appendix 5 for details of how to deliver FRAMES or BRENDA. Please use the “NHS – Your Drinking and You” leaflet shown in appendix 1‡ to support brief advice and give a copy to patients should they require more information.
- **Audit 8-15** - with other complexities or social care needs it will deliver brief advice in line with FRAMES/BRENDA but connect the person with social services and or 3rd sector providers outlined in the Alcohol Service Directory in the Alcohol Integrated Care Pathway Tool.
- **Audit 16-19** – Higher risk drinking. Here, consider conducting a SADQ to assess potential level of dependence. Deliver brief advice and refer to turning point if SADQ not conducted.
  - Where SADQ Score 0-3 no dependence – deliver brief advice in line with FRAMES/BRENDA
  - 4-19 mild dependence - deliver brief advice in line with FRAMES/BRENDA.
  - 20-30 moderate dependence – Refer to specialist services
  - 31-44+ severe dependence - Refer to specialist services
  - 45+ very severe dependence - Refer to specialist services
  - Please use the “NHS – Your Drinking and You” leaflet shown in appendix 1 to support brief advice and give a copy to patients should they require more information§.
- **Score on AUDIT 20+ and/or 20+ on SADQ** = Do not delay here as suspected moderate or severe dependence means engage the person directly into specialist services during their appointment – **call Turning Point on 0300 123 1186** (Turning Point offer services for mild, moderate and severe dependence including medically assisted detoxification).

‡ Leaflet available as PDF for printing at:

§ Leaflet available as PDF for printing at:
• It is also important for the clinic to link the person into all other possible support networks and services, especially if they are higher risk or dependent. Some people may benefit from different types of service model (e.g. Alcoholics Anonymous) or need the support of a wider network of support for other complications (social and/or health). Staff are encouraged to refer to the East Kent Service Directory in the Interactive Pathway Tool (see CCG website for download).

• Where brief advice in line with FRAMES/BRENDA is delivered and patient is not referred to specialist services, book a follow up appointment. It is suggested that this is between 2 and 6 weeks post positive AUDIT-C.

• At follow up, those at ‘increasing risk’ at first appointment follow up can be held on the telephone. If drinking is still ‘increasing risk’, deliver a further brief advice intervention in line with FRAMES/BRENDA.

• At follow up those ‘higher risk’ at first appointment, follow up should be in person. Where the person remains ‘higher risk’ and not reducing their consumption brief advice should be given and the patient should be offered a choice of extended interventions with Turning Point in specialist services (subject to availability) where their treatment may also include pharmacological therapy (e.g. Nalmefene**). Nalmefene may be prescribed by Turning Point services as part of this pathway. The costs of this medication will be met by Public Health (call Turning Point on 0300 123 1186). Should patients wish to stay under the care of their GP, the GP must be confident in prescribing and supporting the patient with any psychosocial support required in line with NICE guidance, clinical evidence and drug license. Public Health will meet the costs of prescribing this medication should this be required in primary care outside Turning Point services.

• All clinicians must consider that extended brief interventions may be preferred by people to pharmacological therapy.

• As with all prescribing, any medications considered used must be must be prescribed in line with it licences by a qualified prescriber, and must be delivered with recommended psychosocial support by the prescriber and in line with prescribing guidelines (see appendix 3 for more information). A website is available to support psychosocial interventions and provide self-help with reducing consumption (www.reduceyourdrinking.co.uk).

• If the person does not show a response to extended interventions once referred on to Turning Point, an alternative may be to consider other pharmacological interventions in addition to extended interventions in Turning Point services.

• If a person is higher risk or suspected dependent and is non-adherent, withdraws from treatment or has a non-response to any of the above therapy steps, including medications they should be referred to Turning Point as outlined in the section 3.3 of the full ICP service specification.

• People who have not met treatment objectives (e.g. high drinking risk level after 6 months up to 1 year) may have dependant drinking patterns. This group who do not respond to harm reduction at

** Nalmefene is currently being reviewed by NICE in an STA process expected to be published in November 2014. The greyed out section of the pathway around this medication will become live subject to NICE TA recommendations. For more information see https://www.nice.org.uk/Guidance/InDevelopment/GID-TAG442 Nalmefene will be funded by Public Health as part of the ICP pilot in Thanet and SKC CCGs.

N.B: See Appendix 3 of full ICP specification document for evidence based review of all medications.
GP surgery/community pharmacist should be referred to specialist services for more intensive group therapy and other specialist interventions (call Turning Point on 0300 123 1186).

- Score on AUDIT 20+ and/or 20+ on SADQ = Do not delay here as suspected moderate or severe dependence means engage the person directly into specialist services during their appointment (Turning Point provide services for mild, moderate and severe dependence including medically assisted detoxification).

Higher risk drinkers requiring additional support beyond GP or pharmacy based interventions should be referred to Turning Point for extended brief advice and/or medications to support reduction or abstinence where required.

### 3.3 Specialist Treatment – Turning Point Services - call 0300 123 1186

This service is commissioned by Public Health Kent and is an East Kent-wide service dealing with substance misuse including Alcohol.

#### 3.3.1 Single Point of Contact

Turning Point ensure provision of a 24/7†† single point of contact phone number that complies with DIP 24/7 client single point of contact guidance‡‡

- Has a named contact in each district for all relevant professional bodies
- Maintains a single point of contact for secure email and a fax number for referrals.
- See section 3.2.4 for details of telephone line.
- See section 3.2.7 for details of Turning Point GP Click Website.

#### 3.3.2 Eligibility Criteria

- The service is open to residents of East Kent aged 18 years and above. Those under 18 should be referred to KCA Younger People Services (see section 3.4)
- The service must address the needs of both service users attending on a voluntary basis and those who are required to attend treatment as part of a court order such as a Drug Rehabilitation Requirement (DRR) or Alcohol Treatment Requirement (ATR).
- Interventions provided as part of this service must be available for service users’ primary substance misuse problems.
- In order to access the service the service user must be an ordinary resident within one of the following districts:
  - Dover
  - Shepway
  - Thanet
  - Swale
  - Ashford
  - Canterbury
- ‘Care of’ addresses will only be accepted if the service user fulfils the principle of ordinary residence

†† i.e. to be made available 24 hours a day, every day of the year
as prescribed in the National Assistance Act 1948§§.

3.3.3 What can the Referrer Expect: Screening and Assessment

Turning Point undertake appropriate levels of screening for substance misusers and those identified as needing structured treatment must be offered a comprehensive assessment using the Kent Adult Substance Misuse Combined Comprehensive Assessment Form to ensure that Service User’s needs and risks are identified and addressed.

The comprehensive assessment will:

- Identify the service users’ needs and goals to aid recovery
- Identify relevant family issues that may have a bearing on the service user’s recovery and re-integration
- Establish which other agencies are involved with the Service User
- Identify any need for referrals to other services (e.g. mental health and community family services)
- Ensure that the service user has read and understood how information about them will be handled and shared
- Assess risk of self-harm or harm to others
- Establish whether any risk management plans are currently in place

3.3.4 What can the Referrer Expect: Recovery planning and review

Turning Point work with the service user (and other parties as necessary) to develop and agree a suitable recovery and risk management plan on the basis of the comprehensive assessment.

At the recovery planning stage, service users must receive an induction, which must include:

- Details about the service
- Details of service user involvement, peer support and carer support
- General expectations
- Code of conduct
- Policies and protocols regarding suspension or exclusion
- The complaints procedure

This induction will be revisited after a period of stabilisation and at regular periods thereafter to ensure clarity and understanding.

Turning Point ensures suitable and appropriate care co-ordination and review (including regular completion of a Treatment Outcome Profile*** throughout a Service User’s treatment journey. As part of this, Turning Point ensures provision of recovery plan reviews at suitable intervals.

3.3.5 What can the Referrer Expect: Interventions

Turning Point offer the following interventions:

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*** A Treatment Outcome Profile must be completed at least every 26 weeks
• Advice, information, brief interventions and extended brief interventions to help prevent and minimise problematic substance misuse or dependency
• Assertive outreach to attract substance misusers not currently engaged in services
• A substance misuse Arrest Referral Scheme as part of a cell intervention service (adhering to the expectations of the Drug Intervention Programme requirements) for substance misusing offenders in all local police custody suites
• A specialist support service for individuals leaving prison and living within East Kent
• Intensive key-working (comprising regular meetings with a nominated professional) to help enable the service user’s recovery and re-integration
• Substitute prescribing services and supervised consumption (e.g. through pharmacies) and the provision of biological drug and alcohol testing facilities
• A GP with special interest (GPwSI) post, Consultant or Clinical Director post, who will liaise with GPs to provide advice, information and assistance in the management of service users on prescribed medication (e.g. Benzodiazepines), as well as providing support to shared care, in line with clinical governance guidelines
• Community detoxification (drugs and alcohol)
• A choice of residential rehabilitation models and packages
• In-patient stabilisation and detoxification
• A rolling programme of suitable care planned interventions, individually tailored, according to service user need
• Residential and community interventions in line with court requirements such as a Drug Rehabilitation Requirement (DRR), or Alcohol Treatment Requirement (ATR) including drug and alcohol testing requirements where required as part of the sentencing framework
• Structured psychosocial interventions
• Tailored interventions designed to improve social functioning and enhance life skills (e.g. groups on budgeting, CV workshops, self-esteem and general activities which are not focused on substance misuse).
• Close integration with community resources dealing with provision for improving physical and mental health, education, training, employment and housing
• Opportunities to promote general physical improvement via access to health care, advice, support and screening (including dental, sexual health and smoking cessation); access to physical exercise programmes/facilities
• Sufficient provision of accessible needle and syringe programmes throughout East Kent (in line with National Institute for Health and Clinical Excellence (NICE) guidance) and provision for safe disposal
of used injecting equipment

- Overdose prevention and harm reduction advice, including the provision of Naloxone training and prescribing for injecting drug users presenting as high risk
- Pro-active relapse prevention advice and support, including prescribing interventions (e.g. Naltrexone, Disulfiram, Acamprosate)
- Information on Hepatitis A / B / C and HIV with access to screening, testing, vaccination and referral pathways into appropriate treatment services
- Liaison with appropriate services e.g. acute medical and psychiatric health services (such as antenatal, mental health or clinical hepatology services) and social care, children’s services (such as child care and housing services and other generic services)
- Clinical leadership and pharmacological management and access to needle and syringe programmes for young people in line with current best practice and guidance
- A full range of post discharge support to help sustain long term recovery, for example
  - Recovery check ups
  - Drop ins
  - Peer led activities
  - Family focused interventions, especially where an adult parent or carer of a young person is accessing specialist treatment
  - Appropriate interventions for increasing and high risk drinkers as defined in Models of Care for Alcohol Misuse 2006 (MOCAM).

### 3.3.6 Priority Groups

Priority groups for the service will include, but are not limited to:

<table>
<thead>
<tr>
<th>Priority Group</th>
<th>Description</th>
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<tbody>
<tr>
<td>3.3.6.1 Service users who have not previously accessed structured treatment services</td>
<td>Service users who have not previously accessed structured treatment services</td>
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<tr>
<td>3.3.6.2 Service users in families where there are safeguarding concerns</td>
<td>Service users in families where there are safeguarding concerns</td>
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<tr>
<td>3.3.6.3 Service users who are prison leavers with current or recent substance misuse problems</td>
<td>Service users who are prison leavers with current or recent substance misuse problems</td>
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<td>3.3.6.4 Prolific offenders with a history of substance misuse problems</td>
<td>Prolific offenders with a history of substance misuse problems</td>
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<tr>
<td>3.3.6.5 Service Users with co-existing mental health and substance misuse problems (dual diagnosis)</td>
<td>Service Users with co-existing mental health and substance misuse problems (dual diagnosis)</td>
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<td>3.3.6.6 Those who present with severe physical co-morbidity, including but not limited to BBV and HIV symptomatic</td>
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<td>3.3.6.7 Service users who are pregnant</td>
<td>Service users who are pregnant</td>
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<td>3.3.6.8 Service users who are currently or have previously been a survivor or perpetrator of Domestic Abuse.</td>
<td>Service users who are currently or have previously been a survivor or perpetrator of Domestic Abuse.</td>
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<td>3.3.6.9 Ex-Military Personnel</td>
<td>Ex-Military Personnel</td>
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### 3.4 Specialist Treatment – KCA Children and Adolescents Services

This service should be referred to for all children and adolescents. Turning Point’s Single Point of
Contact (SPoC) Help and Advice Line Telephone service outlined in 3.2.4 will also refer children and adolescents to this service.

3.4.1 Entry criteria:
- The service will be made available to children and young people resident in Kent as well as their families and carers.
- The services will work with children and young people aged 11 to 18 (or 19 for young people who are young offenders)
- The early intervention service will be available for young people who are at risk of developing problematic misuse including LAC, young offenders, truants and excluded young people, with housing related needs, refugees and asylum seekers and children affected by their parental/families substance misuse.
- Access and referral: Referrals will be accepted from a range of sources including self-referrals from young people and their parents or carers.

3.4.2 What can the referrer expect of KCA services:
- Comprehensive Screening & Assessment: Before starting structured treatment, service users must receive a comprehensive assessment by a competent worker. The assessment may include a home visit and should be conducted as a joint process with CAMHS, YOS or Children’s Social Care services. Information sharing by other professionals will be key to ensuring the most effective assessment of the young person’s need.
- Early Intervention Services are for young people who are at risk of developing problematic substance misuse and are involved in risk taking behaviour.
- At the assessment stage service users must receive an induction, which includes:
  - Details about the service.
  - General expectations about the service young people and their parents will receive.
  - Methods of communication
  - Code of conduct
  - The complaints procedure.
  - The confidentiality policy including the sharing of information with partners’ agencies and with parents and carers
  - In the case of young people who are parents, information sharing in relation to their children or those in their care and other adults who have care for their children should also be covered.
- Treatment action planning and review - The service provider must work with the service user (and other parties as necessary) to develop and agree a suitable plan on the basis of the comprehensive assessment
- Treatment Action Plan: Following assessment the service user must receive a written plan to ensure a fully structured and integrated approach is offered. In line with NTA Guidance (2007).
- Care Coordination: The lead professional and care coordination for a young person who is known
to YOS remains the Youth Offending Worker. The lead professional for a Looked After Child remains the 16 plus worker, Kent Social Worker or the Social Worker from another authority if the child is looked after by another local authority but placed in Kent

- **Specialist Community Treatment**: Specialist community treatment is a care planned medical, psychosocial or specialist harm reduction intervention aimed at alleviating current harm caused by a service users substance misuse

- **Specialist interventions offered must include, but are not limited to**:
  - Pharmacological Interventions in line with Kent Policy on Pharmacological Interventions for Young People in Kent.
  - Structured psychosocial interventions
  - Family focused interventions
  - Specialist harm reduction including needle exchange
  - Access to support in residential treatment settings

- **Intensive Interventions for young people with complex needs**: A small number of young people referred to the service will have complex unmet needs and chaotic substance misuse that requires a more intensive form of community support. Intensive community support may include specialist harm reduction and access to pharmacological interventions or numerous short sessions during the week or sessions of a longer duration. It may in also include joint working with CAMHS for those young people with a dual diagnosis need. The focus of these sessions may be the proactive support required for the young person to address their unmet needs, e.g. facilitating access to health care, supporting a young person to access benefits or suitable accommodation, advocating for the young person at schools/ colleges/ employment, enabling a swift access to the CAMHS for those young people with Dual Diagnosis needs. Care coordination, joint working and attendance at multi agency and child protection meetings will be key to best addressing the complex needs of this client group

- **Early Onset of Substance Misuse - services for those aged under 15**: The early onset of substance misuse is disproportionately associated with current behavioural issues and poor prognosis in adulthood. With this age group, care must be taken to ensure an integrated response is provided to the young person and their parents, carers and siblings through the CAF, SPA, integrated working with CAMHS and access to ongoing parenting work.

- **Working with 13 year olds or under in Specialist Community Treatment**: For young people referred to Specialist Community Treatment who are aged 13 years or under, the service must not work in isolation and must be part of a multi-agency package of care led by a statutory children’s service.

### 3.5 Interdependence with other services/providers

This service specification is for ‘integrated care’. Integrated care pathways are structured multidisciplinary care plans which outline essential steps in the care of patients with a specific clinical problem. They are used to translate national guidance into local protocols and clinical practice, in order to promote more efficient patient-centred care. In addition, they are used to reach or exceed existing standards, improve communication and care planning, and decrease inconsistencies in practice. As ICPs are associated...
with a number of positive outcomes including a reduction in the length of stay in hospital, reduction of costs of patient care, improved patient outcomes (improved quality of life, reduced complications), increased patient satisfaction, and improved communication between doctors and nurses. This is the first ever ICP for Alcohol in Surrey. As such we recognise it will not be perfect, but it is the responsibility of the interdependent organisations involved to ensure it improves through regular quarterly and annual review processes.

The national statistics and local data outlined in sections 1.3, 1.4 and 1.5 above show a grave picture for alcohol dependent and increasing/high risk taking drinkers who may not be engaged with services, seeking help, or even aware of the harm they are causing themselves and/or those around them. As interdependence is crucial to the flow of a person through services, it is very important for all organisations work hard to form a team that puts the person at the centre of care. Despite the commissioning and provision of alcohol services in this specification being the responsibility of many different health, social, local authority, 3rd sector an charitable organisations, the service user must feel in the ‘safest hands possible’.

It is the responsibility of each stakeholder involved in this pathway to ‘hold the hand’ of the person at risk of harm and help them navigate from one service to another to ensure that they are not lost from service before they are at lower risk of harming themselves or others around them.

### 4. Applicable Service Standards

#### 4.1 Applicable national standards (e.g. NICE)
- NICE QS11: Alcohol dependence and harmful alcohol use: NICE support for commissioners and others
- NICE CG115: Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence
- NICE CG100: Alcohol-use disorders: physical complications
- NICE PH24: Alcohol-use disorders - preventing harmful drinking
- NICE PH7: Interventions in schools to prevent and reduce alcohol use among children and young people.

#### 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)
- British Association of Psychiatry 2012: Evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP

#### 4.3 Applicable local standards

This service specification defines the locally expected service standards. These should be accepted as the
local best practice. The service specification should operate with budgetary constraints and with appropriate regard to the management of resources with due consideration to local eligibility criteria and priorities.

Effective and economical deployment of limited resources, giving the greatest good for the greatest number, requires prescription of the best value for money with consideration to the whole life costs, which will meet the people engaged in the pathway’s clinical and lifestyle needs. All organisations engaged in the development, appraisal, improvement and implementation of this integrated care pathway service specification should give consideration to whole life costs.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])
NICE QS11: Alcohol dependence and harmful alcohol use: NICE support for commissioners and others

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])
CQUIN goals may be part of Public Health Contracts with Specialist Service providers but are not relevant to this service specification.

6. Location of Provider Premises

ALL PHARMACIES AND GP SURGERIES WHO SIGN UP TO THE ENHANCED SERVICE WILL BE ADDED HERE.
Appendix 1: Scratch Card and other materials

Too Much Scratch Info Card Front – NB: NOT TO SCALE (red line indicates tear off for patient retention)

**Too much?**
Time to think about your drink?

<table>
<thead>
<tr>
<th>How often do you have an alcoholic drink?</th>
<th>0 POINTS</th>
<th>1 POINT</th>
<th>2 POINTS</th>
<th>3 POINTS</th>
<th>4 POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many units of alcohol do you consume on a typical day when you are drinking?</td>
<td>0 POINTS</td>
<td>1 POINT</td>
<td>2 POINTS</td>
<td>3 POINTS</td>
<td>4 POINTS</td>
</tr>
<tr>
<td>How often do you consume 6 or more units (if female,) or 8 or more (if male), on a single occasion?</td>
<td>0 POINTS</td>
<td>1 POINT</td>
<td>2 POINTS</td>
<td>3 POINTS</td>
<td>4 POINTS</td>
</tr>
</tbody>
</table>

**Take the Scratchcard Test Today and Total Your Score**
Check how many units you currently consume and then turn over to find out your alcohol consumption rating.

Now Turn Over..

Too Much Scratch Info Card Back - NB: NOT TO SCALE (red line indicates tear off for patient retention)

**If you scored 0-4**
You are drinking within guidelines and are less likely to develop alcohol related problems
Well done, it looks like you're in control of your drinking

**If you scored 5-12**
You are potentially drinking too much and could be putting your health at risk
For discreet & confidential advice call 0300 123 1186

**Did your numbers come up?**
Check how many units are in your drink

- **Pint of beer/ lager/cider (560ml)**: 2 UNITS
- **1 medium glass of wine (175ml)**: 2 UNITS
- **Bottle of alcopop (275ml)**: 1.4 UNITS
- **1 single measure of spirits**: 1 UNIT
- **Bottle of wine**: 9 UNITS

Liver Cirrhosis | Breast Cancer | High Blood Pressure | Heart Disease | Liver Cancer | Lip, Throat & Mouth Cancer | Alcoholism | Being Over Weight

**These are all increased risks of drinking too much.**

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Too Much Poster:

Too much?
Time to think about your drink?

Whether it’s beer, wine or spirits, many of us like a drink now and then to help us unwind. But do you find yourself wondering if you’re drinking more than you should?

It doesn’t hurt to check out your alcohol consumption. After all, if you are drinking more than the recommended guidelines, your alcohol consumption could be starting to hurt you.

Think about your drink and take the alcohol scratchcard test today

Kent Alcohol Integrated Care Pathway Project
NHS Leaflet - Your Drinking and you – To be utilised in all settings alongside the Too Much Scratch card to deliver brief advice.
Appendix 2: Alcohol Screening and Brief Advice – Dynamic Purchasing System (DPS) Specification and Payments

TO BE ADDED TO WEBSITE AS SEPARATE DOCUMENTS TO DOWNLOAD IN OCTOBER 2014.
3.1 Disulfiram – Evidence For Pathway Position (Extracted and adapted from BAP Guidelines 2012)

The intervention: Disulfiram has been used for many years to help people remain abstinent. Disulfiram blocks aldehyde dehydrogenase, causing accumulation of acetaldehyde if alcohol is consumed, resulting in nausea, flushing, and palpitations. This deters people from drinking (Fuller and Roth, 1979). Disulfiram also blocks dopamine-b-hydroxylase in the brain, so increasing dopamine and reducing noradrenaline, and this may contribute to its clinical effects in alcoholism or cocaine addiction.

Licence and who should prescribe: Disulfiram is indicated as an alcohol deterrent compound and as an adjuvant in the treatment of carefully selected and co-operative patients with drinking problems. It is recommended this medication should be initiated and supervised by a physician experienced in the treatment of alcohol-addicted patients. Locally, Turning Point are likely to be the service who prescribe this drug. Their drug budget is funded by Public Health.

The fact that the disulfiram–alcohol reaction can have potentially severe adverse consequences often makes practitioners cautious of using disulfiram. For more information about the safety of disulfiram, see Chick (1999) and Malcolm et al. (2008). To optimise compliance, witnessing (now the preferred term to ‘supervision’) disulfiram intake has been shown to be an important contributor to effectiveness, since otherwise disulfiram is no better than basic support (Chick et al., 1992).

Many of the trials of disulfiram were conducted some decades ago and were therefore not as rigorously undertaken as those for newer medications. In addition, due to the alcohol–disulfiram reaction, patients entering trials of disulfiram have to be aware they could be taking disulfiram. Systematic reviews of older trials report that disulfiram is no better than placebo in preventing lapse to drinking (NICE 2011a; Slattery et al., 2003). More recent trials of disulfiram have compared it with newer medications such as naltrexone, acamprosate or topiramate (de Sousa and de Sousa, 2004, 2005; de Sousa et al., 2008; Laaksonen et al., 2008). When taking medication for 12 weeks, disulfiram has been shown to be superior to naltrexone or acamprosate in prolonging time to first drink and number of ‘heavy drinking days’ (Laaksonen et al., 2008). All medication was ‘supervised’ by someone. However, in a subsequent 12-week phase of targeted medication taken in ‘a craving situation’, there were no differences between disulfiram, naltrexone and acamprosate (Laaksonen et al., 2008). Two open but randomised pragmatic trials of disulfiram in a private clinic in Mumbai reported that disulfiram (250 mg/day) was superior to either naltrexone (50 mg/day) or topiramate (150 mg/day) in lengthening time to relapse and maintaining abstinence (de Sousa and de Sousa, 2004, 2005; de Sousa et al., 2008).

When to start and how long to prescribe for? NICE (2011a) recommended that disulfiram should be tried after acamprosate or naltrexone, or where the patient indicates a preference for it. There is no
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Evidence to guide how long to prescribe disulfiram, but clearly it can only be started once alcohol free for at least 24 hr. Patients must also be warned about potential for a reaction with alcohol for up to 7 days after stopping disulfiram. An open prospective study lasting 9 years reported that 2 years of treatment with disulfiram or calcium carbimide resulted in overall abstinence rates of 50%; however, not all patients could take disulfiram or calcium carbimide so received ‘sham’ treatment, and the authors emphasised the importance of its psychological ingredient (Krampe et al., 2006)

While in the UK the usual daily disulfiram dose is 200 mg once a day, it can be given in higher doses. For instance, in trials with comorbid alcohol and cocaine dependence, 500 mg/day was used (Carroll et al., 1998). In addition, disulfiram can be given in larger doses less frequently than daily, which might be advantageous if asking patients to attend a service and have their medication supervised or witnessed. However, Ulrichsen et al. (2010) reported that 800 mg of supervised disulfiram given twice a week over 26 weeks was no better than just attending twice a week without taking disulfiram. Notably, over half of recruits failed to be randomised since some definitely wanted disulfiram and others failed to show up.

3.2 Acamprosate – Guidance and evidence For Pathway Position (extracted and adapted from BAP Guidelines 2012)

The Intervention: Acamprosate acts as a functional glutamatergic NMDA antagonist, and since alcohol dependence and particularly withdrawal are associated with a hyperglutamatergic system, it can reduce this (Mann et al., 2008; Mason and Heyser, 2010). Acamprosate is generally well tolerated, with gastrointestinal disturbance (e.g. nausea, diarrhoea) being the most common side-effect reported (Mason and Heyser, 2010; NICE, 2011a). It can be given safely to a wide number of patients with physical comorbidity, although with caution or even contraindicated in those with severe liver and renal impairment (see SPC).

Licence: Acamprosate is indicated as therapy to maintain abstinence in alcohol-dependent patients. It is recommended this medication should be initiated and supervised by a physician experienced in the treatment of alcohol-addicted patients43. Locally, Turning Point are likely to be the service who prescribe this drug. Their drug budget is funded by Public Health.

There are a number of good-quality systematic reviews and meta-analyses of trials of acamprosate including those by Cochrane (Rösner et al., 2010a) , NICE (2011a) , Health Technology Board of Scotland (Slattery et al., 2003) , Swedish Board (Berglund et al., 2003) , and the Spanish Agency for Health Technology Assessment (Bouza et al., 2004) in addition to those by Mann et al. (2004), Kranzler and van Kirk (2001), Mason and Ownby (2000), Rösner et al. (2008) and Mason and Heyser (2010) . These reviews broadly come to the same conclusion that compared with placebo, acamprosate is moderately effective in increasing the amount of abstinence after detoxification; for example Rösner et al. (2010a) report RR 0.86 (95% CI 0.81–0.91), and NICE CG115 (2011a) report RR = 0.83 (95% CI = 0.77–0.88). The ‘number needed to treat’ (NNT) was calculated as 9–11 (e.g. Rösner et al., 2010a; Slattery et al., 2003). Notably, later systematic reviews and meta-analyses report smaller effect sizes due to three reasonably sized recent
negative Lingford-Hughes et al. studies conducted in the USA and Australia (COMBINE, Anton et al., 2006 (see below); Mason et al., 2006; Morley et al., 2006). However, some of these studies included low-severity patients with few withdrawal symptoms, that is, patients who may be less likely to respond to acamprosate.

While the most potent consistent effect of acamprosate is to improve abstinence, some but not all meta-analyses or reviews have found evidence that acamprosate can reduce ‘heavy drinking’ in patients who have relapsed (Chick et al., 2003; NICE 2011a) as was also found for naltrexone by Rösner et al. (2010b).

**When to start and how long to prescribe for?** In most trials of acamprosate, patients were abstinent from alcohol for several days, and currently it is recommended that this drug should be started as soon as possible after detoxification. This recommendation was influenced by the UK study which did not find acamprosate to be superior to placebo; this might have been due to the greater mean length of time after detoxification that acamprosate was started compared with other studies (Chick et al., 2000). A secondary analysis of COMBINE has shown that a longer period of pre-treatment abstinence resulted in a poorer response with acamprosate (Gueorguieva et al., 2011). Given this evidence and acamprosate’s potential neuroprotective effect, we recommend it should be started during detoxification, despite Kampman et al. (2009) reporting in a preliminary trial that some drinking outcomes may worsen.

Currently the SPC recommends acamprosate be given for 1 year. Mann et al. (2004) reported from their meta-analysis that acamprosate’s effect size for abstinent rates increased with time from 1.33 at 3 months, to 1.5 at 6 months and 1.95 at 12 months. NICE (2011a) recommends medication should be prescribed for 6 months but stopped if drinking persists after 4–6 weeks. Pragmatically it is sensible not to continue prescribing any medication without review if drinking behaviour is not changing.

The benefits of acamprosate in maintaining abstinence have been shown to persist for 3–12 months after stopping treatment, with a 9% lower risk to return to any drinking in patients who received acamprosate than those who received placebo (RR = 0.91; 95% CI 0.87–0.96) and a 9% higher continuous abstinence duration (MD 8.92; 95% CI 5.08–12.77; Rösner et al., 2010a). The NNT for an additional prevention of drinking until the post-treatment evaluation was estimated at NNTB 12.5 (95% CI 9.09–25.00).

**Who to give it to?** Given that many people do not respond to acamprosate, are there any predictors to guide the clinician? While acamprosate has been referred to as ‘anti-craving’, recent trials have failed to show such an effect (Richardson et al., 2008). One trial reported a slight anxiolytic effect (Chick et al., 2000) and insomnia, common in the early weeks of abstinence, seems to be helped by acamprosate (Staner et al., 2006). Recently secondary analyses of the COMBINE dataset suggest those with subsyndromal anxiety and/or a significant past psychiatric history may particularly benefit from acamprosate, as do ‘very frequent drinkers’, but those who manage to stop drinking >14 days pretreatment may do worse (Gueorguieva et al., 2011; Mason and Leher, 2010). Mason et al. (2006) had previously reported that acamprosate was effective in those motivated for abstinence. However, while individual
studies may report post-hoc associations between clinical variables and outcome, meta-analyses of trials have not found robust predictors for ‘treatment-matching’. Verheul et al. (2005) used data from seven European trials and reported that high physiological dependence at baseline, negative family history of alcoholism, late age of onset, serious anxiety symptomatology at baseline, severe craving at baseline, and female gender did not predict response to acamprosate.

Since acamprosate’s proposed mechanism of action is to correct glutamate–GABA imbalance, it has been hypothesised that since those more severely dependent are more likely to have such an imbalance, they are more likely to respond to acamprosate. There is some supporting evidence, since Morley et al. (2010) reported an interaction between dependence severity and acamprosate treatment, such that higher levels of dependence severity at baseline predicted a beneficial response to acamprosate. In addition, failure of the two US trials to find acamprosate effective would fit with this hypothesis, since participants were less severely dependent (COMBINE, Anton et al., 2006; Mason et al., 2006). However, evidence from meta-analyses has not been found in support of this (NICE, 2011a; Verheul et al., 2005). Verheul et al. (2005) indeed concluded that acamprosate is potentially effective for anyone with alcohol dependence. At the time of writing these guidelines, a large prospective study set up to define if there are any subgroups who respond to either acamprosate or naltrexone, ‘project PREDICT’ has yet to formally publish its results (Mann et al., 2009).

Psychosocial intervention. Whether one psychosocial approach is preferable to another when prescribing acamprosate has not been investigated except in the COMBINE study, where acamprosate lacked efficacy with each of the three modes of psychosocial support offered (Anton et al., 2006). One study reported no additional benefit of minimal and brief psychosocial interventions to acamprosate (de Wildt et al., 2002). Nevertheless, we suggest that a patient should be advised to engage with whatever approach they find available and acceptable.

3.3 Naltrexone – Guidance and evidence For Pathway Position (Extracted and Adapted from BAP Guidelines 2012)

The Intervention: Naltrexone is a non-selective opioid antagonist. There is growing evidence for a role of the endogenous opioid system and its receptors in addiction (see Lingford-Hughes et al., 2010). The mu opioid receptor modulates dopaminergic cell firing in the ventral tegmental area, and therefore blocking the mu opioid receptor with naltrexone prevents any increase in dopaminergic activity. Consequently, naltrexone reduces alcohol’s rewarding effects and also motivation to drink or ‘craving’ (Drobes et al., 2004; NICE, 2011a). A role of the endogenous opioid system in impulsive behaviour is being increasingly characterised, with reduced opioid activity associated with lower levels of impulsivity. Consistent with this, naltrexone has been shown to be effective in some impulse-control disorders such as pathological gambling, in particular those with a family history of alcoholism (Grant et al., 2008).

Licence and who should prescribe: Adepend (naltrexone) is licensed in the UK for the maintenance of abstinence in alcohol dependence. It is recommended this medication should be initiated and supervised by
a physician experienced in the treatment of alcohol-addicted patients”. Locally, Turning Point are likely to be the service who prescribe this drug. Their drug budget is funded by Public Health.

Naltrexone is an oral tablet that can be offered to those who are moderately to severely dependent, or drinking at lower levels but failing to improve. Early trials used dose of 50 mg/day, although more recent US studies have used 100 mg/day. In the UK, 50 mg/day is more typically used, and it is unclear whether or how much extra benefit is accrued from higher doses.

There have been several meta-analyses and systematic reviews which broadly have the same conclusion that oral naltrexone significantly reduces return to heavy drinking, probably by reducing ‘lapse to relapse’, but does not necessarily improve cumulative or continuous abstinence rates. The meta-analysis by NICE (2011a) revealed that compared with placebo, naltrexone significantly reduced relapse to heavy drinking (RR = 0.83, 95% CI = 0.75–0.91). A Cochrane review found naltrexone reduced the risk of heavy drinking to 83% of the risk in the placebo group RR = 0.83 (95% CI 0.76–0.90) and decreased drinking days by about 4%, MD -3.89 (95% CI -5.75 to -2.04 (Rösner et al., 2010b)). The most common side-effects are nausea and sedation (Rösner et al., 2010b).

**When to start and how long to prescribe for:** Naltrexone can be used safely while someone is still drinking, but in trials for relapse prevention it is started soon after stopping drinking. Most trials conducted were for 3 or 6 months. One study has reported that those who had naltrexone for 24 weeks rather than 12 weeks had better drinking outcomes (Longabaugh et al., 2009). It is not clear if there is an optimal length of time; however, 6 months of treatment is reasonable, with stopping the medication if drinking persists for 4–6 weeks. Early studies of naltrexone suggest its beneficial effects did not persist for 14 or 16 weeks after stopping (Anton et al., 2001; O’Malley et al., 1996). However, more recent evidence from the COMBINE study reported continued benefit persisting for up to a year (Donovan et al., 2008).

**Who to give it to:** As for acamprosate, naltrexone does not help everyone and post-hoc analyses of trials have been undertaken to indicate who might respond. While several studies including more severely dependent individuals have suggested that naltrexone may be less effective in this group (e.g. Krystal et al., 2001; Morley et al., 2006, 2010), meta-analyses have not supported this; indeed, the reverse has been found (e.g. NICE, 2011a). Nevertheless, naltrexone has been shown to be beneficial in ‘heavy drinkers’ as well as ‘dependent drinkers’ (see below). A beneficial response has been reported as more likely in those with a positive family history (Monterosso et al., 2001; Rohsenow et al., 2007; Rubio et al., 2005). Gueorguieva et al. (2007, 2010) applied their ‘trajectory modelling’ to several naltrexone trials, including those that did not find in favour of naltrexone, and reported that naltrexone increased the probability of a lower risk trajectory such as abstainer or ‘nearly daily drinking’. There have been several secondary analyses of the COMBINE dataset. In the medical management condition, naltrexone improves outcome in ‘type A’ (after Babor, less severe, later onset, weak/absent family history, less psychiatric comorbidity), but no such advantage was seen in type B alcoholics (Bogenschutz et al., 2009). African Americans may not respond as well to naltrexone, although benefit has been shown for American Indian and Alaskan natives.
Concerning gender, Greenfield et al. (2010) reported no gender differences in response to naltrexone in the COMBINE study. In comorbid cocaine/alcohol dependence, naltrexone (150 mg/day) resulted in reduced cocaine and alcohol use in men but not women; indeed, their cocaine use increased (Pettinati et al., 2008b). A functional polymorphism, Asp40 allele, of the μ opioid receptor gene has been shown to predict naltrexone treatment response in alcohol-dependent individuals (Anton et al., 2008; Kim et al., 2009; Oroszi et al., 2009; Oslin et al., 2003), but its impact may be moderated by other efficacious treatment or patient variables such as motivation, since such an association has not always been found (Gelernter et al., 2007). The impact of depressive symptoms or depression on naltrexone’s effectiveness is not clear, with evidence from some trials suggesting their presence is associated with greater improvements (Kiefer et al., 2003; Krystal et al., 2008; Morley et al., 2010). For further discussion about effectiveness of naltrexone in depressed patients, see Comorbidity section.

Naltrexone, unlike Nalmefene, is a full non-selective, opioid receptor antagonist with full antagonism at the κ receptor, which has been associated with dysphoria and anxiety experienced in alcohol dependence and withdrawal. Naltrexone’s licence in alcohol dependence is also for treatment against alcoholism to reduce the risk of relapse, as support treatment in abstinence and to reduce the craving for alcohol, rather than reduction of alcohol. It also is not recommended PRN but 1 tablet daily. Naltrexone also carries a risk of hepatotoxicity and as such carries a special warning as well as requiring liver function tests (LFTs) to be conducted before and during therapy. Nalmefene does not require LFTs to be conducted.

Naltrexone + psychosocial interventions: The interaction between a number of different psychosocial interventions and naltrexone has been investigated, with no clear advantage of one approach. Several studies have suggested cognitive behavioural therapy (CBT) has a beneficial interaction with naltrexone and to be superior to supportive therapy (Ballin et al., 2003), motivational enhancement therapy (Anton et al., 2005), and equal to medical management (O’Malley et al., 2003). Supportive therapy has been shown to be better than coping skills therapy (O’Malley et al., 1992). In the COMBINE study, comparable outcomes resulted from combined behavioural intervention (CBI) alone, naltrexone, and the combination of CBI and naltrexone (Anton et al., 2006). Broad spectrum treatment (BST) has been shown to result in better drinking outcomes than motivational enhancement therapy (MET) only with 24 rather than 12 weeks of naltrexone (Longabaugh et al., 2009). However, many people may not be able to or want to access such intensive or comprehensive psychosocial treatment. It is therefore of interest that naltrexone has been shown to be effective with ‘medical management’ which involves regular but short meetings with a practitioner, often a nurse, monitoring compliance and supporting abstinence (Anton et al., 2006; O’Malley et al., 2003).

3.4 Nalmefene – Evidence and Recommendations For Pathway Position

Nalmefene is currently being reviewed by NICE in an STA process expected to be published in November 2014. The greyed out section of the pathway around this medication will become live subject to NICE TA recommendations. For more information see https://www.nice.org.uk/Guidance/InDevelopment/GiD-
Nalmefene will be funded by Public Health as part of the ICP pilot in Thanet and SKC CCGs. N.B: See Appendix 3 of full ICP specification document for evidence based review of all medications. Nalmefene must be prescribed in line with its licence which includes regular psychosocial support. **An online support programme can be used to assist with this requirement if this is needed by primary care prescribers or Turning Point specialists. This can be found at [www.reduceyourdrinking.co.uk](http://www.reduceyourdrinking.co.uk)**

**The Intervention:** The concept of reduction of alcohol consumption is associated with reduced risk of morbidity and mortality in patients with alcohol dependence. Nalmefene is the first pharmacological treatment indicated for the ‘reduction of alcohol consumption’ in adult patients with alcohol dependence who have a high drinking risk level (DRL) (i.e. alcohol consumption >60g or 7.5 units /day for men and >40g or 5 units/day for women), without physical withdrawal symptoms and who do not require immediate detoxification. Nalmefene should be prescribed in conjunction with continuous psychosocial support focused on treatment adherence and reducing alcohol consumption. Nalmefene should be initiated only in patients who continue to have a high DRL two weeks after initial assessment.

**How does it work:** Nalmefene is an opioid system modulator, which is believed to work by interrupting the reward mechanisms in the brain in people who are dependent on alcohol, thereby controlling the urge to continue drinking.

**How to prescribe:** Nalmefene is taken as-needed (PRN), a maximum of one tablet a day, ideally 1–2 hours before alcohol is consumed. A patient will only take the drug if they are going to drink alcohol on any one day. This as-needed approach has been shown to engage patients in active and responsible management of their illness and may increase awareness of the amount of alcohol consumed and drinking patterns, thus facilitating the identification of at-risk situations, which is an integral part of disease management. It may also help keep patients in treatment by empowering them to take charge of their daily treatment decisions.

**Care setting:** Nalmefene can be initiated in primary care and is not a specialist only drug, however, it is recognised that some GPs may wish this medication to be prescribed and supported by Turning Point services. This is clearly outlined in the ICP interactive tool. There may be limited use of this product in specialist settings of T3/4. Data from non-clinical studies, clinical studies, and the literature do not suggest any form of dependence or abuse potential with Nalmefene, which supports its potential to be given in all of the above settings including primary care.

**Frequency:** At an initial visit, the patient’s clinical status, alcohol dependence, and level of alcohol consumption (based on patient reporting) should be evaluated. Thereafter, the patient should be asked to record his or her alcohol consumption for approximately two weeks. At the next visit, nalmefene may be initiated in patients **who continue to have a high DRL over this two-week period**, and must be given in conjunction with psychosocial support focused on treatment adherence and reducing alcohol consumption. This guidance was decided upon by the European Medicines Agency (EMA) as a considerable number of...
subjects (18% in study ESENSE 1, 33% in study ESENSE 2 and 48% in SENSE) almost entirely finished drinking during the 2 week time period between screening and randomization.

This initial screening visit could be considered a relevant brief intervention for alcohol, and reiterates the evidence base for screening and brief advice as an effective intervention in primary care. These pre-randomisation-reducers would not have met entry criteria at randomisation, and there was virtually no space for further improvement either by BRENDA interventions or study medication intake. As such, the licence and data reviewed in section 3 follows EMA guidance on licencing of nalmefene, and focuses on those who retain a high or very high DRL after initial screening.

During trials the greatest improvement was observed within the first 4 weeks. As such it would be suggested that alternative treatments may be considered if response has not been seen early in the treatment regime. The patient's response to treatment and the need for continued pharmacotherapy should be evaluated on a regular (for example, monthly) basis. The physician should continue to assess the patient's progress in reducing alcohol consumption, overall functioning, treatment adherence, and any potential side effects.

Clinical data for the use of Nalmefene under randomised controlled conditions are available for a period of 6 to 12 months. Caution is advised if Nalmefene is prescribed for more than 1 year. It might be assumed here that 'reduction therapy' may not be effective in this type of patient if they continue to drink at higher risk levels for a period of this length.

Naltrexone, unlike Nalmefene, is a full non-selective, opioid receptor antagonist with full antagonism at the \( \kappa \) receptor, which has been associated with dysphoria and anxiety experienced in alcohol dependence and withdrawal. Naltrexone’s licence in alcohol dependence is also for treatment against alcoholism to reduce the risk of relapse, as support treatment in abstinence and to reduce the craving for alcohol, rather than reduction of alcohol. It also is not recommended PRN but 1 tablet daily. Naltrexone also carries a risk of hepatotoxicity and as such carries a special warning as well as requiring liver function tests (LFTs) to be conducted before and during therapy. Nalmefene does not require LFTs to be conducted.

**Effectiveness**

**Expected benefits**

Nalmefene with psychosocial support reduces alcohol consumption by up to 61% at 6 months in patients with at least high drinking risk levels. This reduction corresponds to approximately 160 additional days per year with no heavy drinking and to the equivalent of 330 fewer bottles of wine consumed per year.

**Side-effects/complications**

Over 3,000 patients have been exposed to nalmefene in clinical studies. Overall, the safety profile appears consistent across all the clinical studies conducted. The frequencies of the adverse reactions in Table 1 below are extracted from the SPC and were calculated based on three randomised, double-blind, placebo-
controlled studies in patients with alcohol dependence (1,144 patients exposed to Nalmefene as-needed and 797 exposed to placebo as-needed). The most common adverse reactions were nausea, dizziness, insomnia, and headache. The majority of these reactions were mild or moderate, associated with treatment initiation, and of short duration\textsuperscript{42}.

Confusional state and, rarely, hallucinations and dissociation were reported in the clinical studies. The majority of these reactions were mild or moderate, associated with treatment initiation, and of short duration (a few hours to a few days). Most of these adverse reactions resolved during continued treatment and did not recur upon repeated administration. While these events were generally short lasting, they could represent alcoholic psychosis, alcohol withdrawal syndrome, or comorbid psychiatric disease.\textsuperscript{42}

\textbf{Evidence Based}

There are two 6 month studies, ESENSE1 and ESENSE2, a 12 month study SENSE and feasibility study of ‘as-needed’ use of nalmefene. ESENSE 1, ESENSE 2 and SENSE were Lundbeck-sponsored Phase III studies designed to demonstrate the efficacy, safety, and tolerability of Nalmefene, administered as-needed, for the reduction of alcohol consumption in adult patients with alcohol dependence.

All three studies were multicentre, randomised, double-blind, placebo-controlled, parallel group studies of 18mg Nalmefene, as-needed, in patients with alcohol dependence. In these studies, the patient population consisted of patients with a diagnosis of alcohol dependence according to the DSM-IV-TR criteria. The three studies were conducted in different regions in Europe to ensure that different drinking cultures were represented. The 1-year study SENSE was primarily designed to collect long-term safety data on Nalmefene to comply with the population exposure requirements for safety evaluation. All patients were aged 18 years or over and had a diagnosis of alcohol dependence diagnosed according to DSM-IV-TR.

In terms of study design, ESENSE 1 and 2 were identical. All patients had a diagnosis of alcohol dependence according to DSM-IV-TR. Patients had to have had (in the 4 weeks before the Screening Visit): ≥6 heavy drinking days, ≥medium WHO drinking risk level, and ≤14 consecutive abstinent days. Key reasons for exclusion were: S-ASAT and/or S-ALAT levels >3 times upper normal limit, a CIWA-Ar score ≥10 and presence of psychiatric comorbidities. The studies were conducted over a 34 week period (12 visits) in total and consisted of four sequential periods: a 2-week screening period, a 24-week double-blind treatment period, a 4-week double-blind placebo-controlled run-out in each of the treatment arms and finally a 4-week safety follow-up.

One to two weeks after the Screening Visit, the patients were randomised 1:1 to 24 weeks of as-needed, double-blind treatment with nalmefene (18 mg) or placebo. The patients who completed 24 weeks of double-blind treatment entered a 4-week, double-blind run-out period where patients initially randomised to Nalmefene were re-randomised 1:1 to receive Nalmefene or placebo. The Timeline Follow-back (TLFB) method was used to collect self-reported drinking data. At the Screening Visit, each patient provided a retrospective estimate of their daily drinking over the previous month (28 consecutive days). At each
subsequent visit, the patient was to provide information on their drinking since the previous visit.

All participants took part in a psychosocial programme (BRENDA) which is similar to other brief advice and psychosocial support and motivational interviewing models, such as FRAMES, which local services in Surrey may utilise. The aim of this was to enhance medication and treatment compliance at each visit. BRENDA was administered by trained site personnel (see appendix 5).

SENSE was a multicentre, randomised, double-blind, parallel-group, placebo-controlled, fixed-dose, as-needed-use study in outpatients with alcohol dependence. It was primarily designed to collect long-term safety data on Nalmefene, but also provides supportive evidence of the long-term efficacy of Nalmefene in the treatment of alcohol dependence. Similar to the two 6-month studies, the SENSE study included an initial screening period lasting 1–2 weeks. Following this, patients were randomised to treatment with Nalmefene or placebo for 52 weeks.

In all of the studies, study medication was to be taken on an as-needed basis. The patient was instructed to take a maximum of one tablet each day that they perceived a risk of drinking alcohol, preferably 1 to 2 hours prior to the anticipated time of drinking. If the patient had started drinking without taking study medication, the patient was to take one tablet as soon as possible. If there was no risk of drinking on a given day, the patient was not to take any study medication. Importantly, for patients who anticipated a risk of drinking every day, the as-needed dosing regimen allowed them to take the medication daily.

Primary end points:
1. Change to baseline in total consumption of alcohol (TAC, per month, presented as amount of pure alcohol in grams per day)
2. Reduction in number of Heavy Drinking Days (HDD defined as more than 60 grams of pure alcohol in men and 40 grams in women)

Secondary end points:
A Responder Analysis was built into ESENSE 1&2. This was defined as two-category downward shift from baseline Drinking Risk Level (from either very high risk to medium risk; or high risk to low risk) at Month 6. WHO classifies drinking risk levels (DRLs) into low, medium, high and very high, where high risk is defined as daily alcohol consumption above 60g for men and 40g for women. This equates to 7.5 units per day (3 pints of 4.4% beer) for men and 5 units per day (1/2 of an average 750ml bottle of 12.5% wine) for women.

Patient numbers, demographics and inclusion/exclusion:
In total, approximately 2,000 patients were recruited across the three Nalmefene studies. Two thirds of the patients were male. On average, patients were aged between 45 and 52 years. Regarding socio-demographics, the majority of patients were living with someone, and the majority were employed.
The information collected at screening on alcohol drinking history showed a very high rate of treatment-naive patients, ranging from 59 to 70%. This was despite the fact that the average time since onset of drinking problems was 11 to 14 years. In other words, a large proportion of patients had been suffering from alcohol problems for a long time, but had never been treated prior to enrolling in the nalmefene studies. This could be seen as common and as national data suggests only 6% of alcohol dependent patients aged 16–65 years receiving treatment each year. Furthermore, about half of the patients had a family history of alcohol problems.

Pooled Analysis and EMA licence:
A significant reduction in the number of HDDs and TAC occurred in some patients in the period between the initial visit (screening) and randomisation due to non-pharmacological effects. In ESENSE 1 (n=579), and ESENSE 2 (n=655), 18% and 33%, of the total population respectively, considerably reduced their alcohol consumption in the period between screening and randomisation. As concerns the patients with high or very high DRL at baseline, 35% of patients experienced improvement due to non-pharmacological effects in the period between the initial visit (screening) and randomisation. At randomisation, these patients consumed such a small amount of alcohol that there was little room for further improvement (floor effect). Therefore, the patients who maintained a high or very high DRL at randomisation were defined post hoc as the target population. In this post hoc population, the treatment effect was larger than that in the total population.

At the request of the European Medicines Agency (EMA), the clinical efficacy and the clinical relevance of nalmefene were analysed in this post hoc patient group with a high or very high DRL at screening and randomisation. At baseline, the patients had, on average, 23 HDDs per month (11% of patients had fewer than 14 HDDs per month) and consumed 106 g/day. The majority of the patients had low (55% had a score of 0-13) or intermediate (36% had a score of 14-21) alcohol dependence according to the Alcohol Dependence Scale. Post hoc efficacy analysis in patients who maintained a high or very high DRL at randomisation. In Study 1, the proportion of patients who withdrew was higher in the nalmefene group than in the placebo group (50% versus 32%, respectively). For HDDs there were 23 days/month at baseline in the nalmefene group (n=171) and 23 days/month at baseline in the placebo group (n=167). For the patients who continued in the study and provided efficacy data at Month 6, the number of HDDs was 9 days/month in the nalmefene group (n=85) and 14 days/month in the placebo group (n=114). The TAC was 102 g/day at baseline in the nalmefene group (n=171) and 99 g/day at baseline in the placebo group (n=167). For the patients who continued in the study and provided efficacy data at Month 6, the TAC was 40 g/day in the nalmefene group (n=85) and 57 g/day in the placebo group (n=114). In Study 2, the proportion of patients who withdrew was higher in the nalmefene group than in the placebo group (30% versus 28% respectively).

For HDDs there were 23 days/month at baseline in the nalmefene group (n=148) and 22 days/month at baseline in the placebo group (n=155). For the patients who continued in the study and provided efficacy data at Month 6, the number of HDDs was 10 days/month in the nalmefene group (n=103) and 12 days/month in the placebo group (n=111). The TAC was 113 g/day at baseline in the nalmefene group
(n=148) and 108 g/day at baseline in the placebo group (n=155). For the patients who continued in the study and provided efficacy data at Month 6, the TAC was 44 g/day in the nalmefene group (n=103) and 52 g/day in the placebo group (n=111).

Key results:
The main endpoint results can be summarised for ESENSE1, 2 and SENSE in the tables below. They include the Observe Cases analysis and Mixed-effect Model of Reported Measures:

Table 1: Summary of results and statistical analysis ESENSE 1

Table 2: Summary of results and statistical analysis ESENSE 2

Table 3 Summary of Results For 12 Month Study – SENSE on secondary endpoints
Secondary End Point Data:

In ESENSE1, the drinking risk level-response rate at month 6 (proportion of patients with a two-category downshift in drinking risk level) was 43% for placebo and 61% for nalmefene, corresponding to an odds ratio of 2.15 [95% CI:1.38 to 3.36]; p=0.0006. Similarly, in ESENSE2, the drinking risk level-response rate at month 6 (proportion of patients with a two-category downshift in drinking risk level) was 41% for placebo and 52% for nalmefene, corresponding to an odds ratio of 1.59 [95% CI:0.98 to 2.59]; p=0.0620.

A pooled analysis (data on file at Lundbeck) of ESENSE 1 and 2 secondary endpoint with response defined as a downward shift of at least two drinking-risk levels. 57% of the patients in the Nalmefene group and 42% of the patients in the placebo group were responders at Month 6. This was significantly in favour of Nalmefene (p>0.001). The odds ratio for response was 1.87, with a 95% confidence interval of 1.35 to 2.59. This translates to a number NNT of $7^{59}$.

Nalmefene has recently been reviewed by HTA bodies nationally including the Scottish Medicines Consortium (accepted for use within NHS Scotland)$^{60}$ and All Wales Medicines Strategy Group (recommended as an option for use within NHS Wales for the reduction of alcohol consumption)$^{61}$ for use in line with its license. NICE are currently conducting an STA analysis due to report in November 2014.

3.5 – FOR ASSISTED WITHDRAWAL AND RELAPSE PREVENTION PROGRAMMES - Evidence and Recommendations For Pathway Position (Extracted and adapted from BAP Guidelines 2012)

This section largely covers specialist medications which may be used by Turning Point services.

Acute alcohol withdrawal, its associated risks and management including settings and pharmacological management or ‘medically assisted withdrawal’, has been systematically reviewed for NICE guidelines, by groups led by Royal College of Physicians (NICE, CG100, 2010c) and by Royal College of Psychiatrists (NICE, CG115, 2011a) as well as by Cochrane (Amato et al., 2010; Minozzi et al., 2010).

The recommendations in both NICE guidelines are broadly in agreement with our previous recommendations supporting the use of benzodiazepines. One difference, however, was that the CG100 guidelines, whose remit was management within a general medical inpatient setting, recommended a ‘symptom-triggered’ regimen (see Hecksel et al. (2008) regarding issues of managing in general medical setting) (III). However, the CG115 guidelines emphasised that this approach was only for inpatients or residential settings if the appropriate level of monitoring was available. These NICE guidelines recommended a fixed-dose regimen for community-based withdrawal. A recent study not available for inclusion in either NICE guidelines reported that outpatient alcohol withdrawal could be managed effectively and safely using chlordiazepoxide either with a symptom triggered or a fixed-schedule regimen (Elholm et al., 2011). The median of total doses of chlordiazepoxide over 10 days were 725mg in symptom triggered
The use of anticonvulsants continues to receive attention, since reducing glutamate over activity is now thought to be key in reducing risk of brain toxicity during withdrawal. Undergoing more than two detoxifications has been associated with poorer performance on some cognitive tasks although a causal link has not been proven (Duka et al., 2004; Loeber et al., 2010). Krupitsky et al. (2007) reported that a range of antiglutamatergic approaches such as memantine (NMDA antagonist), topiramate (AMPA/kainate inhibitor) or lamotrigine (glutamate release inhibitor) were efficacious in treating alcohol withdrawal similarly to diazepam. A Cochrane review (Minozzi et al., 2010) was cautious about anticonvulsants, stating that there was ‘insufficient evidence in favour of anticonvulsants for treatment of alcohol withdrawal’ although they seemed to have ‘limited side effects’ and ‘might be effective for some symptoms’, for example seizures. NICE, CG100, (2010c) recommended using carbamazepine or benzodiazepines, although in the UK there is less clinical experience in using anticonvulsants. NICE, CG115, (2011a) guidelines did not comment on use of carbamazepine. Due to concerns about carbamazepine’s safety and tolerability, alternative anticonvulsants, for example oxcarbazepine, levetiracetam, pregabalin, have been investigated. Studies may show benefits compared with placebo but no one anticonvulsant has emerged as preferential (e.g. Anton et al., 2009; Barrons and Roberts, 2010; Bonnet et al., 2010 (III); Di Nicola et al., 2010; Martinotti et al., 2010; Richter et al., 2010). The role for anticonvulsants in alcohol withdrawal therefore still remains unclear. However, the finding that using carbamazepine during withdrawal was followed by longer time to eventual return to drinking than with using the benzodiazepine, lorazepam (Malcolm et al., 2002), raises the question of whether benzodiazepine withdrawal leaves the brain vulnerable to relapse. Consequently, determining how to measure impact on markers of neurotoxicity is critical to answer this important question. Acamprosate has been shown to reduce the hyperglutamatergic state during alcohol withdrawal in animal models and may have neuroprotective potential (Mann et al., 2008) (IV). A clinical study showed acamprosate reduced glutamate levels in the brain 25 days after initiation of benzodiazepine-treated alcohol withdrawal (Umhau et al., 2010). Starting acamprosate 8 days prior to detoxification and continuing for 15 days without other medication for withdrawal resulted in reduced arousal level measured with magnetoencephalography and improved decreased wake time after sleep onset and increased stage 3 and REM sleep latency (Boeijinga et al., 2004; Staner et al., 2006). Gual and Lehert (2001) and anecdotally, clinicians who routinely use acamprosate during detoxification in addition to usual medication for alcohol withdrawal report no unwanted events and suggest acamprosate improves symptoms. However, a full randomised placebo-controlled trial has yet to be completed. Another small (n = 16 vs. 18) trial designed to see if giving acamprosate in addition to medication for alcohol withdrawal rather than starting it at the end of the detoxification improved drinking outcomes, found no benefit in drinking outcomes, indeed this approach might worsen some (Kampman et al., 2009).

There are a number of medications that may be useful not only in treating withdrawal but also in relapse prevention, and are further described in this section below. These include baclofen, some anticonvulsants...
(e.g. topiramate) and gamma-hydroxybutyric acid (GHB or sodium oxybate; see Relapse Prevention, Other medications below), but there is limited evidence currently (Caputo and Bernardi, 2010; Leone et al., 2010; Liu and Wang, 2011). Clearly if a medication can be used to treat withdrawal and reduce the risk of complications and prevent lapses/relapses during early abstinence, it may have advantages to patients who would otherwise have to wait until after detoxification before starting relapse prevention medication.

**Alcohol withdrawal-related seizures.** Bråthen et al. (2005) have produced consensus recommendations for diagnosis and management of alcohol-related seizures based on a systematic review of the evidence. They recommend longer-acting benzodiazepines, for example diazepam, or if not available lorazepam, since they are efficacious for primary and secondary seizure prevention. They concluded that there is insufficient evidence for other pharmacological approaches.

**BAP Recommendations: management of alcohol withdrawal and detoxification.** Although many alcohol-withdrawal episodes take place without any pharmacological support, particularly in those patients with a mild level of alcohol dependence, in the presence of symptoms medication should be given. Detoxification should be planned as part of a treatment programme to increase the likelihood of patients successfully altering their subsequent drinking behaviour. Early identification and treatment of alcohol dependence can reduce the level of complications.

**Treatment regimens**
- Benzodiazepines are efficacious in reducing signs and symptoms of withdrawal (A); fixed-dose regimens are recommended for routine use with symptom-triggered dosing reserved for use only with adequate monitoring (D)
- Carbamazepine has also been shown to be equally efficacious to benzodiazepines (A)
- Clomethiazole is reserved for inpatient settings only after due consideration of its safety (A)

**Seizures**
- Benzodiazepines, particularly diazepam, prevent de novo seizures (A)
- Anticonvulsants are equally as efficacious as benzodiazepines in seizure prevention, but there is no advantage when combined (A)
- In preventing a second seizure in the same withdrawal episode, lorazepam but not phenytoin has been shown to be effective (A)

**Appendix 4: Screening and Diagnosis Tools**

See Interactive Pathway Tool for AUDIT C, AUDIT, SADQ
Appendix 5: FRAMES or BRENDA – Information and Models for Brief Advice

**FRAMES:** Utilise this short approach (up to 5 minute conversation) with the NHS Your Alcohol and You Leaflet

- Feedback on personal consequences and comparative drinking levels
- Responsibility and its attribution
- Advice – to cut down or stop, as appropriate and why
- Menu – options on how to achieve change
- Empathy – aim to build rapport, lower defensiveness, circumvent denial
- Self-efficacy – building self-esteem and belief in autonomy & capability

More information is available at:

**BRENDA:** Utilise this short approach (up to 5 minute conversation) with the NHS Your Alcohol and You Leaflet

The BRENDA approach has 6 components:

1) a biopsychosocial evaluation (overall health, medications, comorbid psychiatric conditions, social and coping skills, psychological assessment
2) a report of findings from the evaluation discussed with the patient;
3) empathy;
4) addressing patient needs;
5) providing direct advice; and
6) assessing patient reaction to advice and adjusting the treatment plan as needed.

More information is available at:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2764009/
Appendix 7: Prevention Approach – Evidence and Guidance to Services

GENERAL PRACTICE (GPs and Practice Nurses) – Prevention Guidance for Local Service

Why is this important?
General Practitioners, practice nurses and practice staff play a unique role in terms of their relationship with patients and their role as first line services and gate keeper to secondary care. They have access to people who may abuse alcohol and do not just see people at times of crisis but also on a long term basis throughout their life cycle. Moreover, their role in promoting the welfare of local people places them in a unique position to promote resilience to long term harm from alcohol.

It important that GPs, practice nurses and practice staff should be in a position to be able to:

- Identify patients where alcohol misuse may be a problem
- Offer appropriate advice to patients who may be abusing alcohol, which may include brief interventions as well as referral elsewhere.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - 0300 123 1186
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
  - Agree a referral to their local GP practices/Pharmacies in CCGs for a “WellBeing Appointment”
- Return the detachable AUDIT C QUESTIONS SECTIONS of ALL COMPLETE SCRATCH CARDS once per quarter in an envelope to:
  - Kent Public Health Alcohol Pathway Project, Lundbeck Ltd, Freepost L0844, Milton Keynes, MK7 8BR
  - PLEASE ADD YOUR ORGANISATIONS SENDER DETAILS TO THE REAR OF THE ENVELOPE so each services use can be measured and replacement scratch cards issued.
  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

Important note on duty of care for all NHS professionals to deliver IBA in line with NICE guidance:
It is important to note that for partners working in NHS settings, if a patient is suspected of increasing or higher risk drinking levels during the ‘Alcohol Conversation’ outlined above (i.e. the scratch card highlights an AUDIT C score suggesting increasing or higher risk drinking that the responsibilities of the ‘WellBeing Appointment’ should implemented (see 3.2.7 of service specification). Where this is not immediately possible, an appointment must be made where a ‘WellBeing Appointment’ can be delivered in full (see 3.2.7 of service specification).

Evidence

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<td>Interface with the prevention agenda - GPs, practice nurses and practice staff should recognise their role in the primary care setting in supporting the whole prevention agenda and follow the NICE guidance in this area:</td>
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<td><a href="http://www.nice.org.uk/nicem">http://www.nice.org.uk/nicem</a></td>
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Alcohol-related harm is a major health problem. The guidance identifies how government policies on alcohol pricing, its availability and how it is marketed could be used to combat such harm (see recommendation 1 to 3). Changes in policy in these areas are likely to be more effective in reducing alcohol-related harm among the population as a whole than actions undertaken by local health professionals.

The recommendations for practice (recommendations 4 to 12) support, complement – and are reinforced by – these policy options. They cover:

- Licensing.
- Resources for identifying and helping people with alcohol-related problems.
- Children and young people aged 10 to 15 years – assessing their ability to consent, judging their alcohol use, discussion and referral to specialist services.
- Young people aged 16 and 17 years – identification, offering motivational support or referral to specialist services.
- Adults – screening, brief advice, motivational support or referral.

GPs and practice nurses should also take into account NICE guidance CG115 which covers the entrance into the health service:

This guideline makes recommendations on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10–17 years.

**Key Priorities detailed in CG115:**

**Identification and assessment in all settings**

- Staff working in services provided and funded by the NHS who care for people who potentially misuse alcohol should be competent to identify harmful drinking and alcohol dependence. They should be competent to initially assess the need for an intervention or, if they are not competent, they should refer people who misuse alcohol to a service that can provide an assessment of need.

**Assessment in specialist alcohol services**

- Consider a comprehensive assessment for all adults referred to specialist services who score more than 15 on the Alcohol Use Disorders Identification Test (AUDIT). A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools and cover the following areas: – alcohol use, including:
  - consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
  - dependence (using, for example, SADQ or Leeds Dependence Questionnaire [LDQ])
- alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
  - other drug misuse, including over-the-counter medication
  - physical health problems
  - psychological and social problems
  - cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
  - readiness and belief in ability to change.

**General principles for all interventions**

- Consider offering interventions to promote abstinence and prevent relapse as part of an intensive structured community-based
intervention for people with moderate and severe alcohol dependence who have:
– very limited social support (for example, they are living alone or have very little contact with family or friends) or
– complex physical or psychiatric comorbidities or
– not responded to initial community-based interventions (see page 12).

• All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological interventions should be administered by specialist and competent staff. Psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention. Staff should consider using competence frameworks developed from the relevant treatment manuals and for all interventions should:
  – receive regular supervision from individuals competent in both the intervention and supervision
  - routinely use outcome measurements to make sure that the person who misuses alcohol is involved in reviewing the effectiveness of treatment
  – engage in monitoring and evaluation of treatment adherence and practice competence, for example, by using video and audio tapes and external audit and scrutiny if appropriate.

Interventions for harmful drinking and mild alcohol dependence

• For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

Assessment for assisted alcohol withdrawal

• For service users who typically drink over 15 units of alcohol per day, and/or who score 20 or more on the AUDIT, consider offering:
  – an assessment for and delivery of a community-based assisted withdrawal, or
  – assessment and management in specialist alcohol services if there are safety concerns about a community-based assisted withdrawal.

Interventions for moderate and severe alcohol dependence

• After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone2 in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse.

Assessment and interventions for children and young people who misuse alcohol

• For children and young people aged 10–17 years who misuse alcohol offer:
  – individual cognitive behavioural therapy for those with limited comorbidities and good social support
  – multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support.

Interventions for conditions comorbid with alcohol misuse
• For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety. If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, undertake an assessment of the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder.

Appropriate Training and development of staff also needs to be taken into account:

Training and development of staff
For health and social care staff recommendations are made through the Quality Statement for NICE QS11. Training and awareness is covered in Quality Statement 1 and Quality Statement 4.

Quality Statement 1: Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.
   a) Evidence of local arrangements to ensure that alcohol awareness training that promotes respectful, non-judgmental care is delivered to all health and social care staff who potentially work with patients or service users who misuse alcohol.
   b) Evidence of local arrangements to ensure that local patient and service user feedback, in the form of surveys and complaints, is collected, analysed and acted upon within all health and social care settings.

Quality Statement 4:
People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff.
   a) Evidence of local implementation of current guidance from the Royal College of Psychiatrists and Royal College of General Practitioners on training and competence for doctors working in substance misuse.
   b) Evidence of local arrangements to ensure that all staff carrying out initial assessments in specialist alcohol services are trained in the key elements of motivational interviewing.
   c) Evidence of local arrangements to ensure that care coordination with other agencies (for example, housing, employment and social care) is delivered by appropriately trained and competent staff working in specialist alcohol services.
   d) Evidence of local arrangements to ensure the use of competence frameworks developed from relevant treatment manuals that guide the structure and duration of psychological interventions for people who misuse alcohol.
   e) Evidence of local arrangements to ensure that staff responsible for assessing and managing assisted alcohol withdrawal are trained and competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms, and the use of drug regimens appropriate to the setting in which the withdrawal is managed.
   f) Evidence of local arrangements to ensure that staff working in specialist alcohol services receive appropriate monitoring and supervision.

RCGP guidance and training
There is a range of guidance on the Royal College of GPs web site that provides training packages for GPs.

Practice nurses:

The RCN provides guidance for all nurses:
Nurses are faced with the consequences of alcohol misuse every day - from dealing with violent and aggressive patients in A&E to caring for people suffering from long term poor health as a result of sustained alcohol abuse. All nurses also have a role in health promotion to support the population to make healthier choices.

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<th>Local action plan for your service / practice / provider</th>
<th>References/web links/dates</th>
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<td>Please describe how you will implement the alcohol conversation in your organisations below:</td>
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**POLICE SERVICE AND SAFETY – Prevention Guidance for Local Service**

**Why is this important?**
The Government is determined to see continued reductions in domestic violence and abuse and the police play a key role in responding to, and protecting victims. It is therefore essential that the police response is as effective as it can be and has the confidence of victims. Professionals in the Police may come into contact with people who abusing alcohol and who are not accessing any other services. Alcohol has been seen nationally to have huge implications for police services. A preventative approach from the police professionals when educating local people an incident may help service users to reduce their intake.

**What should you do? Take the Prevention Conversation Approach:**
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- **Explain** that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- **Encourage** the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- **Discuss** their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- **Agree** with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point's Alcohol Help and Advice Line using the number of the scratch card - **0300 123 1186**
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
  - Agree a referral to their local GP practices/Pharmacies in CCGs for a “WellBeing Appointment”
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  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

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<td><strong>What does the national information say?</strong> Drug-related and alcohol-related crime remains a serious problem: offenders using heroin, crack and cocaine are estimated to commit between a third and a half of acquisitive crime and nearly half of violent crime is fuelled by alcohol. The UK has amongst the highest rates of young people’s cannabis use and binge drinking in Europe. In 2011, almost one million violent crimes were alcohol-related (see pp 11 of referenced doc). The Government have reformed the Licensing Act 2003, giving new powers to local residents to challenge the licences of premises that are causing alcohol-related crime, disorder and anti-social behaviour. The Government has given local authorities more powers to refuse and revoke licences and deal with the problems caused by late-night drinking. The Government has introduced a late night levy to allow licensing authorities to collect a contribution from business towards the cost of policing in the night-time economy. There are strong links between alcohol and violent crime. In half of all violent incidents the victim believed the offender to be under the influence of alcohol: Crime in England and Wales 2009/10. Home Office Statistical Bulletin 12/10.</td>
<td><a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97825/new-approach-fighting-crime.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97825/new-approach-fighting-crime.pdf</a></td>
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**AMBULANCE: Prevention Guidance for Local Service:**

### Why is this important?

Alcohol-related incidents have a major impact on ambulance services. Their crews are at the front line of dealing with alcohol incidents and the consequences of excessive alcohol consumption every day. Professionals in Ambulance services may come into contact with people who abusing alcohol and who are not accessing any other services. A preventative approach from the ambulance service professionals with people using the ambulance service may help service users to reduce their intake.

### What should you do? Take the Prevention Conversation Approach:

For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
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### Evidence

**What does the information say nationally?**

Ambulance services are increasingly looking at alternatives to taking patients with alcohol-related conditions to A&E, which may not always be the most appropriate place.

Alcohol-related incidents have a major impact on ambulance services. Their crews are at the front line of dealing with alcohol incidents and the consequences of excessive alcohol consumption every day.

- Over 6 per cent of calls to London ambulances are alcohol-related incidents. This is approximately 60,000 calls a year. And, since the crews only record the illness and not the cause of the illness, the figure is likely to be much higher.
- Changes in binge drinking behaviour and the increasing affordability of alcohol may be reflected in other ambulance service trends such as the increased number of calls to London Ambulance Service from 20-29-year-olds.
- The number of calls handled by ambulance services in England is increasing on average by 6.5 per cent each year.

### References/web links

http://www.nhsconfed.org/Publications/Documents/Briefing_193_Alcohol_costs_the_NHS.pdf
emergency department.

Example one – South East Alcohol Innovation Project
The project trained healthcare support workers in Accident & Emergency, Medical Assessment Unit and gastroenterology wards in simple IBA techniques. Healthcare support workers come into contact with all patients admitted and usually have more time available to deal with patients than nursing and medical staff. The project trained these workers to screen patients to identify problematic alcohol use and deliver brief advice to these patients whilst performing basic care tasks thereby effectively delivering information at a point of crisis for individuals, to impact on their alcohol use and reduce repeat admissions for alcohol related conditions.

Example two - West Midlands Ambulance Service
As part of a consultancy programme for the whole ambulance service, Alcohol Concern provided training for the service’s ambulance crews, enabling them to recognise different kinds of drinking and assess needs on a case-by-case basis and react accordingly. This has led to a reduction in the burden on A&E from casual binge drinkers and better referral of individuals with issues of problem drinking.

The Scottish ambulance services show a similar picture states - Alcohol has a significant impact on ambulance operations in Scotland and is linked to increases in 999 calls, as well as incidents of abuse and assault on ambulance crews.

At weekends, 68% of all life threatening emergencies involve alcohol. There are around 3,000 alcohol related incidents and 400 drug related incidents at weekends each year in Glasgow city centre, which costs the Service £663,646.

After a weekend Old Firm fixture there is an increase in emergencies of between 15% and 20% in demand. The increase after a midweek evening fixture is around 5%. In almost all of these emergencies alcohol is a factor and often violence is involved.

The Service has agreed a process with the police to manage drunk and incapable people safely in the community and ensure that they are referred appropriately. In some cities and at particularly busy times, such as the festive season, the Service works with local authorities and other agencies to provide create city centre triage and rest and recuperation areas to better manage the care of drunk and incapable patients and reduce the unnecessary visits to busy A&E departments.

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**FIRE - Prevention Guidance for Local Service**

### Why is this important?
Fire professionals may come into contact with people who abusing alcohol and who are not accessing any other services. Alcohol has been seen nationally to have huge implications for the fire service. A preventative approach from the Fire professionals when educating local people about fire or managing an incident may help service users to reduce their intake.

### What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - **0300 123 1186**
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
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### Evidence

What does the information say nationally?

Key issues exist relating to alcohol and fire. These include information such as in 2011-12 (see document link opposite):

- In 2011-12, there were 30,709 accidental dwelling fires in England. In 8% (2,483) of these fires where impairment due to suspected drug or alcohol use was recorded as a contributory factor.
- Impairment due to alcohol or drug resulted in 41 deaths and 1,208 injuries from 2,483 dwelling fires.
- Average fatality rate where alcohol or drug impairment suspected to be an influencing factor is three times more compared to where alcohol or drug impairment was not an influencing factor.
- The rate of serious injuries is four times higher where drug or alcohol impairment was a contributory factor than where alcohol or drug impairment was not a factor.
- Male casualties outnumbered females by two to one in dwelling fires where impairment due to suspected alcohol or drug use was an influencing factor.
- More than half (56%) of casualties in accidental dwelling fires where impairment due to alcohol or drugs was a contributory factor were themselves not suspected to be under the influence of alcohol or drugs.

References/ web links

Local action plan for your service / practice / provider | References/web links/dates
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Please describe how you will implement the alcohol conversation in your organisations below:
CRIMINAL JUSTICE - Prevention Guidance for Local Service

Why is this important?

Professionals in Criminal Justice may come into contact with people who are abusing alcohol and who are not accessing any other services. Alcohol has been seen nationally to have implications for criminal justice systems. A preventative approach from the criminal justice professionals when educating local people about fire or managing an incident may help service users to reduce their intake.

What should you do? Take the Prevention Conversation Approach:

For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
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- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - 0300 123 1186
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Evidence

What does the information say nationally?

The World Health Organization (WHO) have released a document outlining the scale of the link between alcohol and offending, and the missed opportunities to address alcohol misuse within the Criminal Justice System and prisons in particular.

Download 'Alcohol problems in the criminal justice system: an opportunity for intervention' [pdf]

The document describes an integrated model of care for alcohol problems in prisoners, with elements for best practice. The model starts with assessment of prisoners’ alcohol problems, using a validated screening tool, the WHO Alcohol Use Disorders Identification Test (AUDIT), and calls for interventions tailored to prisoners’ specific needs.

Other reports have previously made calls for further attention and action to address alcohol-related offending needs. In 2011 the Centre for Mental Health published the report A Label for Exclusion: Support for alcohol-misusing offenders

In 2010 the National Offender Management Service (NOMS) published comprehensive Alcohol Interventions Guidance for probation staff on the effective commissioning, management and delivery of a range of interventions for alcohol

References/ web links


www.drugscope.org.uk/Resources/Drugscope/.../alcoholarrest.pdf

http://content.met.police.uk/News/Cadets-make-the-grade-on-Alcohol-Awareness-Course/1400012017159/1257246745756
misusing offenders.

See here for relevant bulletins from Findings bank and here for further Offender Health publications and links on the Alcohol Learning Centre.

**Criminal Justice – Overall Information**

Information on the criminal Justice system for alcohol management is available from the Alcohol Learning Centre. Articles are broadly organised by date and International/UK articles are differentiated.

**Criminal Justice - SIPS evidence in criminal justice**

Key messages from SIPs work:

- Whilst it may be a challenge to implement alcohol screening and brief interventions in typical probation settings, successful implementation can be achieved with support from specialist alcohol health workers.
- Successful implementation of screening and brief intervention depends on significant managerial support and local champions of screening and brief interventions in the probation setting.
- The Fast Alcohol Screening Test is the most efficient and effective screening tool in the probation setting.

**Criminal Justice - Alcohol Arrest Referral - Guidance for setting up a scheme.**

This document was produced by the Home Office in 2009 to help commissioners of services e.g. Drug and Alcohol Action teams (DAATs) and project teams who are considering establishing or further developing Alcohol Arrest Referral (AAR) schemes. Arrest referral is a term generally used to describe the process of engaging in terms of a brief intervention with a detained person in a police custody suite and facilitating their referral into treatment or some other diversionary channel. This is typically done by conducting a brief intervention with the offender. Alcohol Arrest Referral schemes specifically look at individuals committing alcohol related offending and so are quite different from interventions designed to improve the health of an individual.

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HEALTH VISITING – Prevention Guidance for Local Service

Why is this important?
Health visitors play a unique role in terms of their relationship with, and access to, families with very young children. They have ready access to the home environment and, unlike, say, social workers, do not just see people at times of crisis; unlike teachers they often see the whole family group, rather than just one member of it in isolation. Moreover, their role in promoting the welfare of the family as a whole offers a clear route into considering the impact that parents’ drinking may be having on their children and places them in a unique position to promote resilience to long term harm from alcohol.

It important that health visitors should be in a position to be able to:

- Identify families where parental alcohol misuse may be a problem
- Make a reasonable judgement of the extent to which parental drinking is, and is not, affecting good enough parenting
- Offer appropriate advice to parents misusing alcohol, which may include brief interventions as well as referral elsewhere.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - 0300 123 1186
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Evidence  References/ web links
What does the information say nationally?
The role of health visitors is an integral one within NHS community health services. The aim of the health visiting service is to promote the health of the whole community and to help in promoting healthy lifestyles, addressing concerns about physical and mental well-being, with the key principles including:

- The search for health needs
- The stimulation of an awareness of health needs
- The facilitation of health-enhancing activities

The National Health Services Act provides the legal framework for the provision of preventive and school health services including the provision of health visitors. As professionals in their own right it is, under the legislation, up
to an individual practitioner to judge whether instructions or arrangements place them in breach of the common law duty of care or the Nursing and Midwifery Council (NMC) code of professional conduct.

Whilst being independent practitioners with broad responsibilities, national targets and pressures on services are focusing the work of health visitors towards key areas and government targets. These are focusing their work with individuals on a minimum number of child health development checks.

In respect of working with individuals and families health visitors work within the frameworks and guidance set out in:

- Working Together to Safeguard Children
- Department of Health Framework for Assessment
- Health Visitor Practice Development Resource Pack

The implications of the first two of these documents in relation to practice around parental alcohol misuse.

Alcohol is a factor in many of the priority health issues that health visitors need to address, including mental health, coronary heart disease, stroke, accidents and some cancers. Problem drinking can also severely affect the well-being of families through its association with child abuse and neglect and domestic violence. Serious drinking during pregnancy may give rise to foetal alcohol syndrome. Health visitors can raise the issue of alcohol intake in a non-stigmatising way, particularly as part of a family health plan.

The guidance suggests that health visitors can:

- Advise on sensible drinking
- Be aware of local agencies that can help with alcohol related problems
- Feed in information about gaps in services to policy makers
- Become trained in delivering brief interventions
- Work with families to reduce the impact of problem drinking
- Identify particular at-risk groups
- Contribute to or initiate awareness raising
- Ensure care programmes are in place for pregnant women with alcohol problems
- Get involved in a local multi-agency forum.

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PRIMARY CARE NURSES, COMMUNITY NURSES/MATRONS: Prevention Guidance for local service

Why is this important?
Nurses in general practice (termed practice nurses) and community nurses are an under-utilized resource for the detection and management of patients with alcohol misuse. They have expert skills and can be the only contact that a patient has with the NHS. A preventative approach from the practice/community nurses across East Surrey when treating local people may help service users to reduce their intake. Early detection and intervention are also effective and these are areas where community pharmacy has a potential role to play.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- **Explain** that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.

- **Encourage** the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.

- **Discuss** their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).

- **Agree** with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - **0300 123 1186**
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Evidence

- There is some evidence suggesting that patients with alcohol-related problems do consult their general practice. For example, Wallace and Haines (1984) reported that 4% of patients surveyed had a problem with alcohol. A report by McMenamin (1997) suggests that these figures may be higher, with 13% of men and 2.5% of women having an alcohol-use disorder. A more recent questionnaire survey of practice nurses showed that an average of 3.1 patients/month with potential alcohol problems are seen in general practice (Deehan et al., 1998).

- Health promotion is a key element of primary care (Atkin et al., 1993). This is carried out not only by the GP, but by the whole primary care team. An essential member of the team is the practice nurse. In recognition of this, there has been a massive increase in practice nurse numbers from less than 5000 in 1989 to over 10 000 in 1995 (Department of Health, 1995a). Given the potential for primary care to have a major role in the detection and treatment of alcohol misuse, it has been suggested that practice nurses may be an under-utilized resource for the management of such patients (Deehan et al., 1998). This is clearly appropriate given that practice nurses: (1) perceive themselves as specialists in health promotion (Mackereth, 1995); (2) are generally more accessible than the GP and have more time (Atkin and Lunt, 1996). Indeed, the first and often the only contact for individuals with potential alcohol-related problems may be the practice nurse-led clinics in general practice. Such clinics could be utilized to deliver advice on alcohol-related issues.

Clearly, it is important to ensure that practice and community nurses are
properly qualified and trained to develop their role in screening for alcohol misuse and possibly delivering brief intervention.

The minimum training and competence requirements for practice nurses must include (a) an ability to take a careful alcohol history (which is often not done by doctors (Kitchens, 1994; Roche and Richard, 1994; Volk et al., 1996)); (b) a knowledge of sensible limits of drinking as defined by the Royal Colleges of Physicians, Psychiatrists and General Practitioners (1995); (c) the ability to administer simple screening tools, such as CAGE, to detect problem drinkers; and (d) an awareness of the services which are available in the community to which patients who are misusing alcohol can be referred.

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DENTAL – Prevention Guidance for Local Services

Why is this important?
Dental practitioners may come into contact with people who abusing alcohol and who are not accessing any other health or social care services. People who present at Dental surgeries may not identify that they have an alcohol issue and would not normally approach services for help due to reasons such as social class and stigma. However, a preventative approach from the dental practitioners may help service users to reduce their intake.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

• Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
• Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
• Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
• Agree with the person to take at least one of 3 approaches:
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Evidence

What does the information say nationally?
The British Dental Health Foundation states that alcohol is one of the main causes of dental erosion and this may be further affected by vomiting due to alcohol. Other issues are caused by the use of high sugar in some alcoholic drinks. Data also indicates that According to alcohol impairs the body's primary immunologic defense mechanisms to fight infection. Consequently, bacterial overgrowth and increased penetration into gingival tissues can occur. Consumption of 10 or more drinks per week results in higher periodontitis risk compared to those who consume fewer than 10 drinks per week. Increasing alcohol consumption from five units to 20 units a week increases the risk of periodontal disease from 10 percent to 40 percent. Alcohol causes dehydration of the mouth, so bacteria are not washed away by saliva, and plaque formation occurs faster.

There are studies on the detriment of alcohol on dental health and the higher incidence of dental caries experienced. Studies can be accessed below.

Tooth decay in alcohol and tobacco abusers.

Tooth decay in alcohol abusers compared to alcohol and drug abusers.
Dasanayake AP, Warnakulasuriya S, Harris CK, Cooper DJ, Peters TJ,

References/web links

http://www.dentalhealth.org/
Local action plan for your service / practice / provider

Please describe how you will implement the alcohol conversation in your organisations below:

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Housing professionals may come into contact with people who abusing alcohol and who are not accessing any other services. People who present at for housing, re-housing or housing advice may not identify that they have an alcohol issue and would not normally approach services for help due to reasons such as social class and stigma. However, a preventative approach from the Housing professionals may help service users to reduce their intake.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - 0300 123 1186
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
  - Agree a referral to their local GP practices/Pharmacies in CCGs for a “WellBeing Appointment”
- Return the detachable AUDIT C QUESTIONS SECTIONS of ALL COMPLETE SCRATCH CARDS once per quarter in an envelope to:
  - Kent Public Health Alcohol Pathway Project, Lundbeck Ltd, Freepost L0844, Milton Keynes, MK7 8BR
  - PLEASE ADD YOUR ORGANISATIONS SENDER DETAILS TO THE REAR OF THE ENVELOPE so each services use can be measured and replacement scratch cards issued.
  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

Evidence

What does the information say nationally?

Key issues exist relating to alcohol and housing. These include:

- the links between alcohol and homelessness
- harmful drinking in the home including support for older people and those who experience domestic violence or ‘hidden harm’ linked to alcohol use,
- unacknowledged drinking in the home
- positive impact of a good home life and housing and the reduction of alcohol use
- hidden drinking in BME communities
- the role of hostels in recovery.

Although alcohol is not specifically mentioned in the England Housing Strategy there is a section on the management of vulnerable people.

Local action plan for your service / practice / provider

Please describe how you will implement the alcohol conversation in your organisations below:
PRISONS – Prevention Guidance for Local Services

Why is this important?
People may present to prison services who have an alcohol disorder and may not interact with statutory services.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

• Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
• Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
• Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
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  o PLEASE ADD YOUR ORGANISATIONS SENDER DETAILS TO THE REAR OF THE ENVELOPE so each services use can be measured and replacement scratch cards issued.
  o Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

Evidence

Rates of alcohol misuse among prisoners are considerably higher than in the general population:62

• 63% of male sentenced prisoners reported drinking at increasing risk levels prior to entering prison, with 30% having severe drinking problems
• 39% of female sentenced prisoners reported drinking at increasing risk levels, with 19% having severe drinking problems

References/web links

To be added

Local action plan for your service / practice / provider

Please describe how you will implement the alcohol conversation in your organisations below:
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<tr>
<th>Name</th>
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<tr>
<td>Linda Smith</td>
<td><a href="mailto:linda.smith2@kent.gov.uk">linda.smith2@kent.gov.uk</a></td>
</tr>
<tr>
<td>Gillian Montgomery</td>
<td><a href="mailto:Gillian.montgomery@kent.gov.uk">Gillian.montgomery@kent.gov.uk</a></td>
</tr>
</tbody>
</table>
DOMESTIC ABUSE – Guidance for Local Services

Why is this important?
Professionals in Domestic abuse may come into contact with people who abusing alcohol and who are not accessing any other services. Alcohol has been seen nationally to have huge implications for domestic abuse service. A preventative approach from the domestic abuse health professionals when educating local people about domestic abuse may help service users to reduce their intake.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
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  - To confidentially call Turning Point's Alcohol Help and Advice Line using the number of the scratch card - 0300 123 1186
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  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

Evidence

What does the information say nationally?
Alcohol is frequently seen as a contributory factor to domestic abuse. In April 2011, the Government implemented section 9 of the Domestic Violence, Crime and Victims Act 2004. This means that local areas are expected to undertake a multi-agency review, following a domestic homicide, to assist all those involved in the review process, in identifying the lessons that can be learned with a view to preventing future homicides and violence.

A review of cases found that in a number of cases the victim and/or the perpetrator had complex needs which could include domestic violence and abuse, sexual abuse, alcohol, substance misuse and mental health illness. In some cases the domestic violence and abuse was not always identified because agencies were focusing on addressing, for example, the mental health or substance misuse. In these cases there was often more silo working which meant an appropriate multi-agency intervention was not considered. There appeared to be a need to raise awareness and understanding of how best to engage and work with those with complex needs.

The domestic homicide reviews suggests that Drug and alcohol services should review, amend and make robust use of their risk assessment frameworks, which involve assessment of risk in relation to violence and abuse.

References/ web links

Please describe how you will implement the alcohol conversation in your organisations below:
Why is this important?
Occupational health departments within organisations have the opportunity to address both the prevention agenda and early implementation for people who may have an alcohol problem but who may not interact with statutory services.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
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Evidence

What does the information say nationally?
There is guidance from the health and safety executive regarding alcohol at work:

While for many people, drinking alcohol is a positive part of life and does not cause any problems, the misuse of alcohol can lead to reduced productivity, taking time off work, and accidents at work. Employers should adopt an alcohol policy, in consultation with their staff. This should include matters such as:

1. how the organisation expects employees to limit their drinking;
2. how problem drinking will be recognised and help offered; and
3. at what point and in what circumstances you will treat an employee's drinking as a matter for discipline rather than as a health problem.

Some employers have decided to adopt alcohol screening as part of their alcohol policy. If you think you want to do the same, think very carefully about what you want screening to do, and what you will do with the information it generates. Screening by itself will never be the complete answer to problems caused by alcohol misuse.

- loss of productivity and poor performance;
- lateness and absenteeism;
- safety concerns;
- effect on team morale and employee relations;
- bad behaviour or poor discipline;

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- adverse effects on company image and customer relations. These concerns are equally important for small and medium-sized businesses. They fall into two main areas:

**Alcohol-related absenteeism and sickness absence.** Alcohol is estimated to cause 3-5% of all absences from work; about 8 to 14 million lost working days in the UK each year.

**The effects of drinking on productivity and safety.** Alcohol consumption may result in reduced work performance, damaged customer relations, and resentment among employees who have to ‘carry’ colleagues whose work declines because of their drinking. There are no precise figures on the number of workplace accidents where alcohol is a factor, but alcohol is known to affect judgement and physical coordination. Drinking even small amounts of alcohol before or while carrying out work that is ‘safety sensitive’ will increase the risk of an accident.

There is previous data from the faculty of public health

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Please describe how you will implement the alcohol conversation in your organisations below:
EDUCATION – Prevention Guidance for Local Services

Why is this important?
Education Professionals may come into contact with children and parents who abusing alcohol and who are not accessing any other services. A preventative approach from the educational professionals when educating local people (Adults and Children) about alcohol may help service users to reduce their intake.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - 0300 123 1186
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
  - Agree a referral to their local GP practices/Pharmacies in CCGs for a “WellBeing Appointment”
- Return the detachable AUDIT C QUESTIONS SECTIONS of ALL COMPLETE SCRATCH CARDS once per quarter in an envelope to:
  - Kent Public Health Alcohol Pathway Project, Lundbeck Ltd, Freepost L0844, Milton Keynes, MK7 8BR
  - PLEASE ADD YOUR ORGANISATIONS SENDER DETAILS TO THE REAR OF THE ENVELOPE so each services use can be measured and replacement scratch cards issued.
  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

Evidence

What does the information say nationally?

The vehicle for improving the quality of alcohol education in schools is the Healthy Schools Programme. This programme requires schools to fulfil a number of criteria to achieve Healthy Schools Status; criteria around the quality of Personal Social and Health Education (PSHE) of which alcohol education is a part.

Children can benefit enormously from high-quality Personal Social Health and Economic (PSHE) education Good PSHE supports individual young people to make safe and informed choices. It can help tackle public health issues such as substance misuse and support young people with the financial decisions they must make. We will conduct an internal review to determine how we can support schools to improve the quality of all PSHE teaching, including giving teachers the flexibility to use their judgement about how best to deliver PSHE education.


All young people need high quality drug and alcohol education so they have a thorough knowledge of their effects and harms and have the skills and confidence to choose not to use drugs and alcohol.


References/ web links


School-based interventions on alcohol issued: November 2007 NICE
http://guidance.nice.org.uk/PH7/Guidance/pdf/English

Drugs: Guidance for Schools 2004

http://www.rcn.org.uk/__data/assets/pdf_file/0005/371291/004110.pdf PSHE and Healthy Schools

Good schools will be active promoters of health in childhood and adolescence, because healthy children with high self-esteem learn and behave better at school. Within the current non-statutory personal, social and health education (PSHE) framework, schools will provide age-appropriate teaching on relationships and sexual health, substance misuse, diet, physical activity and some mental health issues.


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<td>Please describe how you will implement the alcohol conversation in your organisations below:</td>
<td>uploads/attachment_data/file/216096/dh_127424.pdf Healthy Lives, Healthy People –</td>
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**PHARMACY – Prevention Guidance for Local Services**

**Why is this important?**
Professionals in pharmacies may come into contact with people who abusing alcohol and who are not accessing any other services. A preventative approach from the pharmacy service professional when educating local people about pharmaceuticals may help service users to reduce their intake. Early detection and intervention are also effective and these are areas where community pharmacy has a potential role to play

**What should you do? Take the Prevention Conversation Approach:**
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - 0300 123 1186
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
  - Agree a referral to their local GP practices/Pharmacies in CCGs for a “WellBeing Appointment”
- Return the detachable AUDIT C QUESTIONS SECTIONS of ALL COMPLETE SCRATCH CARDS once per quarter in an envelope to:
  - Kent Public Health Alcohol Pathway Project, Lundbeck Ltd, Freepost L0844, Milton Keynes, MK7 8BR
  - PLEASE ADD YOUR ORGANISATIONS SENDER DETAILS TO THE REAR OF THE ENVELOPE so each services use can be measured and replacement scratch cards issued.
  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

**Important note on duty of care for all NHS professionals to deliver IBA in line with NICE guidance:**
It is important to note that for partners working in NHS settings, if a patient is suspected of increasing or higher risk drinking levels during the ‘Alcohol Conversation’ outlined above (i.e. the scratch card highlights an AUDIT C score suggesting increasing or higher risk drinking that the responsibilities of the ‘WellBeing Appointment’ should implemented (see 3.2.7 of service specification). Where this is not immediately possible, an appointment must be made where a ‘WellBeing Appointment’ can be delivered in full (see 3.2.7 of service specification).

**Evidence**

**What does the information say nationally?**

*Pharmacy in England: building on strengths – delivering the future* refers to the scope for pharmacists to contribute to alcohol harm reduction in five areas:
- Healthy lifestyle advice
- Brief interventions
- Prescribing/PGD supply of medicines to reduce alcohol intake
- Blood tests
- Supervised monitoring of medicines to treat alcohol withdrawal

**National initiatives:**
Healthy Living Pharmacies. The Healthy Living Pharmacy concept was developed by NHS Portsmouth (Primary Care Trust), working together with the Hampshire
and Isle of Wight Local Pharmaceutical Committee (LPC). It recognised the significant role community pharmacies could pay in helping reduce health inequalities by delivering consistent and high quality health and wellbeing services, promoting health and providing proactive health advice and interventions.

The Healthy Living Pharmacy (HLP) programme is now being rolled out across a number of other areas as part of an HLP pathfinder programme supported by the pharmacy organisations and Department of Health. The National pharmacy Association website has information on the initiative and hints and tips.

Why use pharmacists?

There is evidence of the effectiveness of community pharmacy based public health interventions such as smoking cessation and methadone maintenance for addictions. This suggests that similar benefits could be derived from their involvement with alcohol misuse,

- Pharmacists are trained health care professionals, trusted and reliable
- Conveniently located in the vast majority of communities and very accessible
- No appointments necessary, open late nights and weekends
- Patients visit pharmacies when they are healthy as well as when they are sick
- Pharmacies are good places for information to be distributed to patients and the wider public
- Large number of pharmacies now have private consultation rooms
- Pharmacies can also offer informal settings which can encourage otherwise reluctant individuals to come forward

Local action plan for your service / practice / provider

Please describe how you will implement the alcohol conversation in your organisations below:

http://www.npa.co.uk/pharmacy-services/healthy-living-pharmacies/
**SCHOOL NURSING – Prevention Guidance for Local Service**

**Why is this important?**

Although school nurses may have only infrequent contact with individual children, the contact that they do have may be at a time and in circumstances that give them a unique opportunity to address difficult issues. Unlike a teacher, they do not generally have the opportunity of spending every day getting to know a child and of forming ongoing relationship. However the very nature of the nurse’s rather more detached, yet caring, role may sometimes provide the setting in which a child is able and willing to talk about problems that they are experiencing.

Like many other professional groups, school nurses will tend to have a general view of alcohol related issues and even this may vary considerably depending on their nursing practice experience. Nonetheless, their wider background knowledge and training means that they are well equipped to play a significant role in reducing the long-term harm suffered by children as a result of their parents’ drinking

**What should you do? Take the Prevention Conversation Approach:**

For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - **0300 123 1186**
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
  - Agree a referral to their local GP practices/Pharmacies in CCGs for a "WellBeing Appointment"
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**Evidence**

**What does the evidence say nationally?**

**The national aim is that school nurses should:**

- Have information about the effects of parental alcohol misuse on children and what can be done to support these children, both individually and within the wider school context
- Have information that addresses key issues that arise within the context of schools and their educational role

**The intended outcomes are that school nurses should:**

- Feel enabled to recognise where this might be the problem
- Know what they can do to support a child and to facilitate resilience to harm
- Know when matters should be referred elsewhere (and to where) and, importantly, when they need not be referred
- Feel as confident of dealing with a child where alcohol is an issue, as they

**References/ web links**

would with a child from a family with, say, a pending divorce situation

**General awareness of the issue**

School nurses will, despite their training, have varying levels of knowledge - and views - about alcohol and alcohol-related problems. They are unlikely to have received training about the effects on children of parental alcohol misuse or about resilience factors.

**Situations arising in schools**

Alcohol-related issues are most likely to arise either as a concern about children drinking or in dealing with a parent whose behaviour is difficult due to their alcohol misuse. Awareness of, or concern about, a child who may be affected by parental drinking problems is not an issue which is commonly considered by professional staff in schools, even though 1 in 4 adults drink at levels likely to be harmful and 1 in 20 will be alcohol dependent.

However, the work undertaken in schools by School Nurses offers at least 3 possible scenarios that may yield opportunities for interventions on or about the effect of parental drinking. These are:

- Where a child has asked to see the school nurse about something and the school nurse suspects (or could do, with better information) that parental alcohol misuse is a factor

- Where the school nurse is the person to whom a child chooses to unburden him or herself (perhaps where the child asks to see the nurse at a drop-in, or has come to the nurse for another reason)

- Where a teacher or other professional asks for an opinion on a child they are generally concerned about.

Where the issue of parental drinking arises in the wider school context, school nurses are more likely to be asked to consider such issues on a ‘pan school’ basis, in contrast to teachers who, unless they have a specific PHSE responsibility, are only likely to be able to identify and address individual cases. A head teacher may well consult a school nurse about problems affecting pupils more generally and ask for assistance, say, through the provision of training for teachers or of sessions for children on a particular topic.

**NICE guidance** – there is guidance from NICE on school based interventions regarding alcohol.

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<td>Please describe how you will implement the alcohol conversation in your organisations below:</td>
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Version 5: Requests for amendments to linda.smith2@kent.gov.uk or Gillian.montgomery@kent.gov.uk
**SEXUAL HEALTH – Prevention Guidance for Local Services**

### Why is this important?
Professionals in Sexual Health may come into contact with people who are abusing alcohol and who are not accessing any other services. Alcohol has been seen nationally to have huge implications for sexual health service. Both specialist and non-specialist providers of sexual healthcare are therefore are placed to respond to problems of both alcohol use and sexual ill health. Services have an important role in providing information and signposting and should engage with teenage pregnancy coordinators and local alcohol strategy groups to co-ordinate this role. A preventative approach from the sexual health professionals when educating local people about fire or managing an incident may help service users to reduce their intake.

### What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
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- Agree with the person to take at least one of 3 approaches:
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- Return the detachable AUDIT C QUESTIONS SECTIONS of ALL COMPLETE SCRATCH CARDS once per quarter in an envelope to:
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### Evidence

**What does the information say nationally?**
There are implications and links between sexual health and alcohol. The Royal College of physicians recently published a document detailing these issue. The document found (see link):

The impact of rising alcohol consumption on population health has become increasingly evident in recent years, with steep increases in mortality and hospital admissions arising from chronic liver disease and alcohol-related accidents.

Tackling alcohol misuse has become a national priority for both government and the wider public health community.

Excessive alcohol consumption has been linked with a range of adverse health outcomes.

While apparent links between alcohol use and poor sexual health outcomes have been recognised for some time, the evidence for this link is now much more robust. Despite this, there has been little movement towards acknowledging and tackling this problem systematically and explicitly within sexual healthcare settings.

---

**References/Web links**

- [http://www.rcplondon.ac.uk/sites/default/files/rcp_and_bashh_alcohol_and_sex_a_cocktail_for_poorsexual_health.pdf](http://www.rcplondon.ac.uk/sites/default/files/rcp_and_bashh_alcohol_and_sex_a_cocktail_for_poorsexual_health.pdf)
Young people are a key risk group: 16–24-year-olds are among the highest consumers of alcohol, in terms of both prevalence and unit consumption, and have the highest rate of sexually transmitted infections.

Consumption of higher strength alcoholic drinks has increased, particularly among girls, and although men still consume more alcohol than women, young women are more likely to report feeling drunk. Earlier alcohol use is associated with early onset of sexual activity and is a marker of later sexual risk-taking, including lack of condom use, multiple sexual partners, sexually transmitted infection and teenage pregnancy.

Sexual assault is strongly correlated with alcohol use by both victim and perpetrator. Responding to the problems of alcohol use among young people requires a multi-faceted approach. Restricting the availability of alcohol through pricing and strict enforcement of laws surrounding under-age drinking are particularly effective national policy options that can reduce alcohol use amongst young people.

However, community-level and school-based interventions add an important component to a multi-dimensional strategy.

Surveys in sexual health services suggest that as many as 1 in 5 attendees consume hazardous levels of alcohol. People who approach their general practitioner (GP) with problems related to sexual health may also have alcohol-related concerns.

Preliminary research suggests that screening and provision of brief interventions (SBI) for alcohol misuse is acceptable to both providers and users in sexual health clinics and general practice and this approach is recommended. Computer-based interventions have produced promising results in other clinical settings and could be further explored as a useful adjunct.

Robust links and clear care pathways with ongoing support, where needed, are necessary for successful implementation of SBI, as well as adequate training and support for clinicians. Training should be embedded in undergraduate curricula and specialist training programmes as well as becoming an integral part of sexual health competency frameworks. The impact of such initiatives in sexual health settings has not been evaluated, although studies to investigate SBI implementation are underway. Despite this lack of robust evidence of effectiveness, it is important that sexual health services do take action, and that this occurs within a culture of evaluation that enables wider learning across the sexual health community.

Making the links between Alcohol and Sexual Health – Sullivan (this paper may be slightly out of date but has references and examples of integrated care) There are many examples of referral pathways between alcohol services, sexual health services, domestic abuse services, primary care, emergency departments and sexual assault referral centres (SARCs). In some areas, teams are either jointly located or integrated into one service to tackle a range of issues associated with risk taking. Paper gives full examples of Integrated Care (pp 14)

There is support regarding alcohol and sexual health on the "LiveWell" website with a range of tips for young people who may drink alcohol and have sex.

Local action plan for your service / practice / provider

Please describe how you will implement the alcohol conversation in your organisations below:
Version 5: Requests for amendments to linda.smith2@kent.gov.uk or Gillian.montgomery@kent.gov.uk
**MENTAL HEALTH – Prevention Guidance for Local Service**

**Why is this important?**

Mental health practitioners may come into contact with people who are abusing alcohol and who are not accessing any other health or social care services. People who present with mental health services may not identify that they have an alcohol issue. However, a preventative approach from the mental health practitioners may help service users to reduce their intake.

**What should you do? Take the Prevention Conversation Approach:**

For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - **0300 123 1186**
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
  - Agree a referral to their local GP practices/Pharmacies in CCGs for a “WellBeing Appointment”
- Return the detachable AUDIT C QUESTIONS SECTIONS of ALL COMPLETE SCRATCH CARDS once per quarter in an envelope to:
  - Kent Public Health Alcohol Pathway Project, Lundbeck Ltd, Freepost L0844, Milton Keynes, MK7 8BR
  - PLEASE ADD YOUR ORGANISATIONS SENDER DETAILS TO THE REAR OF THE ENVELOPE so each services use can be measured and replacement scratch cards issued.
  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

**Evidence**

NICE CG115 states that:

Comorbid mental health disorders commonly include depression, anxiety disorders and drug misuse, some of which may remit with abstinence from alcohol but others may persist and need specific treatment.

NICE guidance is to:

Assess comorbid mental health problems as part of any comprehensive assessment, and throughout care for the alcohol misuse, because many comorbid problems (though not all) will improve with treatment for alcohol misuse. Use the assessment of comorbid mental health problems to inform the development of the overall care plan.

For service users whose comorbid mental health problems do not significantly improve after abstinence from alcohol (typically after 3–4 weeks), consider providing or referring for specific treatment (see the relevant NICE guideline for the particular disorder)

Refer all children and young people aged 10–15 years to a specialist child adolescent mental health service (CAMHS) for a comprehensive assessment of their needs, if their alcohol misuse is associated with physical, psychological, educational and social problems and/or comorbid drug misuse.

Refer people who misuse alcohol and have a significant comorbid mental health disorder, and those assessed to be at high risk of suicide, to a psychiatrist to make sure that effective assessment, treatment and risk management plans are in place.

**References/web links**

- [www.nice](http://www.nice)
**The Mental Health Foundation also gives advice:**

Alcohol problems are more common among people with more severe mental health problems. This does not necessarily mean that alcohol causes severe mental illness. Drinking to deal with difficult feelings or symptoms of mental illness is sometimes called ‘self-medication’ by people in the mental health field. This is often why people with mental health problems drink. But it can make existing mental health problems worse.

Evidence shows that people who consume high amounts of alcohol are vulnerable to higher levels of mental ill health and it can be a contributory factor in some mental illnesses, such as depression.

**Alcohol concern has a downloadable factsheet (see reference)**

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Why is this important?
Accident and Emergency staff have a key role in supporting the management of people with alcohol disorders. They have access to people who may abuse alcohol. Emergency Departments have an essential role in addressing the problems and harms associated with alcohol use in the UK. Whilst the effective treatment of those with established alcohol dependence and advanced liver disease is important there are many more individuals, generally young adults, who are at significant risk for the future. Members of this vulnerable group attend Emergency Departments following alcohol excess, and have been shown to be an effective target for preventative measures. Moreover, their role in promoting the welfare of local people places them in a unique position to promote resilience to long term harm from alcohol.

It important that accident and emergency staff should be in a position to be able to:

- Identify patients where alcohol misuse may be a problem
- Offer appropriate advice to patients who may be abusing alcohol, which may include brief interventions as well as referral elsewhere.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

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As you are involved with acute hospital trust, ALL patients suspected should be referred to Alcohol Liaison Team.

Evidence

What does the information say nationally?
Information from the College of Emergency Medicine

There is strong evidence that attending an Emergency Department as a result of hazardous drinking creates a “teachable moment” that can be used to modify subsequent behaviour. Every Emergency Department clinician should be able to deliver health advice regarding alcohol consumption at this point. Brief interventions, delivered by extra specialist staff, to those patients identified as being most at risk by Emergency Department staff, are effective in reducing alcohol consumption, alcohol related costs and future healthcare use. The College of Emergency Medicine is keen to further develop this preventative role, and believes that it should be prioritised for additional investment. Such an approach would reduce the long-term health burdens of...
alcohol use by targeting those most at risk before they have established
dependency or long-term health disability. It would therefore urge the UK
Government to take steps to support screening, brief advice and brief
intervention in all Emergency Departments in the UK, including the
establishment of alcohol specialist workers who are able to provide the
required expertise. These alcohol specialist workers should have ready access
to clear and responsive pathways, and to planned community detoxification
programs.

Emergency Departments have a key role in collecting and collating information
relating to harmful and hazardous drinking behaviour. Pioneering work in
Cardiff, subsequently confirmed elsewhere, has demonstrated that Emergency
Departments are capable of collecting valuable data on patients attending as a
result of alcohol use and working in partnership with local organisations such
as police, social services, public health, industry CEM Position Statement:
Alcohol-Related Harm (Sept 2010) representatives and local authorities to
develop effective strategies for local intervention.

The sharing of data across services has been shown to promote and inform
the development of community-based interventions that target specific
premises and areas. In summary, the College urges policy-makers to take co-
ordinated action on alcohol related harm:

- Improved alcohol control: mandatory labelling, minimum pricing, advertising
  standards, training of door and serving staff and more stringent drink driving
  legislation
- Development of a proactive role to identify hazardous and harmful drinkers
- Development of the alcohol health worker role within hospitals
- Improved co-ordination of local services between hospitals and their
  communities
- Improved data collection from emergency departments, and sharing at a local
  level to inform and drive community action.

Interface with the prevention agenda

Accident and Emergency staff should be aware of their role in supporting the
prevention agenda.

**Prevention -NICE - PH 24**

Alcohol-related harm is a major health problem. The guidance identifies how
government policies on alcohol pricing, its availability and how it is marketed
could be used to combat such harm (see recommendation 1 to 3). Changes in
policy in these areas is likely to be more effective in reducing alcohol-related
harm among the population as a whole than actions undertaken by local health
professionals.

The recommendations for practice (recommendations 4 to 12) support,
complement – and are reinforced by – these policy options. They cover:

- Licensing.
- Resources for identifying and helping people with alcohol-related problems.
- Children and young people aged 10 to 15 years – assessing their ability to
  consent, judging their alcohol use, discussion and referral to specialist
  services.
- Young people aged 16 and 17 years – identification, offering motivational
  support or referral to specialist services.
- Adults – screening, brief advice, motivational support or referral.

Accident and Emergency staff should also take into account NICE guidance
CG115 which covers the entrance into the health service:

This guideline makes recommendations on the diagnosis, assessment and
management of harmful drinking and alcohol dependence in adults and in

http://guidance.nice.org.uk/PH24
young people aged 10–17 years.

**Key Priorities detailed in CG115**

### Identification and assessment in all settings

- Staff working in services provided and funded by the NHS who care for people who potentially misuse alcohol should be competent to identify harmful drinking and alcohol dependence. They should be competent to initially assess the need for an intervention or, if they are not competent, they should refer people who misuse alcohol to a service that can provide an assessment of need.

### Assessment in specialist alcohol services

- Consider a comprehensive assessment for all adults referred to specialist services who score more than 15 on the Alcohol Use Disorders Identification Test (AUDIT). A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools and cover the following areas: -- alcohol use, including:
  - consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
  - dependence (using, for example, SADQ or Leeds Dependence Questionnaire [LDQ])
  - alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
    - other drug misuse, including over-the-counter medication
    - physical health problems
    - psychological and social problems
    - cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
  - readiness and belief in ability to change.

### General principles for all interventions

- Consider offering interventions to promote abstinence and prevent relapse as part of an intensive structured community-based intervention for people with moderate and severe alcohol dependence who have:
  - very limited social support (for example, they are living alone or have very little contact with family or friends) or
  - complex physical or psychiatric comorbidities or
  - not responded to initial community-based interventions (see page 12).

- All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological interventions should be administered by specialist and competent staff. Psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention. Staff should consider using competence frameworks developed from the relevant treatment manuals and for all interventions should:
  - receive regular supervision from individuals competent in both the intervention and supervision
  - routinely use outcome measurements to make sure that the person who misuses alcohol is involved in reviewing the effectiveness of treatment
  - engage in monitoring and evaluation of treatment adherence and practice competence, for example, by using video and audio tapes and external audit and scrutiny if appropriate.

Interventions for harmful drinking and mild alcohol dependence

- For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

Assessment for assisted alcohol withdrawal

- For service users who typically drink over 15 units of alcohol per day, and/or who score 20 or more on the AUDIT, consider offering:
  - an assessment for and delivery of a community-based assisted withdrawal, or
  - assessment and management in specialist alcohol services if there are safety concerns about a community-based assisted withdrawal.

Interventions for moderate and severe alcohol dependence

- After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse.

Assessment and interventions for children and young people who misuse alcohol

- For children and young people aged 10–17 years who misuse alcohol offer:
  - individual cognitive behavioural therapy for those with limited comorbidities and good social support
  - multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support.

Interventions for conditions comorbid with alcohol misuse

- For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety. If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, undertake an assessment of the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder.

Appropriate Training and development of staff also needs to be taken into account across secondary care settings:

Training and development of staff

For health and social care staff recommendations are made through the Quality Statement for NICE QS11. Training and awareness is covered in Quality Statement 1 and Quality Statement 4.

Quality Statement 1: Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.

a) Evidence of local arrangements to ensure that alcohol awareness training that promotes respectful, no judgmental care is delivered to all health and social care staff who potentially work with patients or service users who misuse alcohol.

b) Evidence of local arrangements to ensure that local patient and service user...
feedback, in the form of surveys and complaints, is collected, analysed and acted upon within all health and social care settings.

**Quality Statement 4:**
People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff.

- a) Evidence of local implementation of current guidance from the Royal College of Psychiatrists and Royal College of General Practitioners on training and competence for doctors working in substance misuse.
- b) Evidence of local arrangements to ensure that all staff carrying out initial assessments in specialist alcohol services are trained in the key elements of motivational interviewing.
- c) Evidence of local arrangements to ensure that care coordination with other agencies (for example, housing, employment and social care) is delivered by appropriately trained and competent staff working in specialist alcohol services.
- d) Evidence of local arrangements to ensure the use of competence frameworks developed from relevant treatment manuals that guide the structure and duration of psychological interventions for people who misuse alcohol.
- e) Evidence of local arrangements to ensure that staff responsible for assessing and managing assisted alcohol withdrawal are trained and competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms, and the use of drug regimens appropriate to the setting in which the withdrawal is managed.
- f) Evidence of local arrangements to ensure that staff working in specialist alcohol services receive appropriate monitoring and supervision.

Public health England has a range of advice on managing people with alcohol problems in A&E departments. See link.

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| Please describe how you will implement the alcohol conversation in your organisations below: | care-staff
Why is this important?

Employers can make a positive difference to the lives of their staff by offering and delivering screening and brief interventions for alcohol misuse in the workplace.

It is important that Employers should be in a position to be able to:

- Develop local policies and procedures to manage staff with (suspected) alcohol misuse issues.
- Have tools and policies to identify staff where alcohol misuse may be a problem.
- Offer appropriate advice to patients who may be abusing alcohol, which may include brief interventions as well as referral elsewhere.

What should you do? Take the Prevention Conversation Approach:

For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

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- Agree with the person to take at least one of 3 approaches:
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  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
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  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

Evidence

What does the information say nationally?

Data indicates Alcohol and drug use increases the risk of problems in the workplace such as absenteeism, presenteeism, low productivity and inappropriate behaviour.

It can impair a person’s performance at work through poor decision making and impaired reaction times causing lost productivity, inferior goods or services, errors and accidents.

What can employers do?

- Employers have a general duty under the Health and Safety at Work etc Act 1974 to ensure, as far as is reasonably practicable, the health, safety and welfare at work of their employees.
- It is advisable for employers to have an alcohol and drug (substance use) policy.
- Managers and supervisors should be trained to recognise the signs of...
problems with alcohol and illicit drug use. They should know what to do if they suspect an employee has a problem or if they are approached by an employee who declares a problem.

- Alcohol and illicit drug problems should be considered to be health problems and dealt with strict confidentiality.
- Sickness absence will be authorised if indicated. Absence relating to alcohol or illicit drug use will be treated no differently to absence from any other cause under absence policies.

**What can employees do?**

- Employees should not attend work under the influence of alcohol or illicit drugs.
- An employee is expected to comply reasonably with the management of his or her condition.
- Employees with alcohol or drug-related problems should have access to occupational health services.

**Role of the medical profession**

GPs are being told it is 'fundamental' they understand the risks associated with alcohol and drug use in people who work. According to the British Medical Association they also need to understand the employment aspects of drug and alcohol misuse and how patients can access fitness-to-work advice and reports. The Association has published guidance for doctors to help address the problem. The guidance recognises the prevalence of alcohol and drug misuse among people who work, and the impact on employers in terms of absenteeism and behavioural issues.

The BMA’s guidelines, ‘Alcohol and drugs in the workplace: The role of medical professionals’, offers information, support and advice to health professionals, including:

- Employers should ensure that staff who have alcohol or drug-related problems have access to an occupational health service
- There should be greater awareness amongst employers as to the issues related to alcohol and illicit drug use and the impact on the workplace including absenteeism and inappropriate behaviour
- Workplaces provide venues and captive audiences for health education and opportunities to identify individuals who have problems with alcohol and illicit drugs.

Local action plan for your business / practice / provider

Please describe how you will implement the alcohol conversation in your organisations below:
Version 5: Requests for amendments to linda.smith2@kent.gov.uk or Gillian.montgomery@kent.gov.uk
**DISTRICT NURSES—Prevention Guidance for Local Service**

**Why is this important?**

District Nurses can make a positive difference to the lives of their patients by leading and delivering screening and brief interventions for alcohol misuse during the provision of routine nursing care. In the great tradition of nursing, this “having a word” approach reaps great benefits for patients, their families and the community. District nurses may have a long term relationship with certain patients who have co-morbidities such as depression and anxiety and may be best placed to take a preventative approach.

It important that District Nurses should be in a position to be able to:

- Identify patients where alcohol misuse may be a problem
- Offer appropriate advice to patients who may be abusing alcohol, which may include brief interventions as well as referral elsewhere.

**What should you do? Take the Prevention Conversation Approach:**

For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
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**Evidence**

**What does the information say nationally?**

Guidance from the National Institute for Health and Clinical Excellence (2010) recommends that health professionals should routinely carry out alcohol screening as an integral part of their practice.

A position statement from the Royal College of Surgeons of England (2010), endorsed by the Royal College of Nursing, recommends brief, cognitive advice delivered by nursing staff as part of care for conditions resulting from alcohol misuse.

Along with evidence from numerous clinical trials and systematic reviews in a range of healthcare settings, trials conducted by the Violence Research Group at Cardiff University demonstrate the effectiveness of brief interventions.

**Interface with the prevention agenda**

District Nurses staff should recognise their role in the primary care setting in...
Alcohol-related harm is a major health problem. The guidance identifies how government policies on alcohol pricing, its availability and how it is marketed could be used to combat such harm (see recommendation 1 to 3). Changes in policy in these areas is likely to be more effective in reducing alcohol-related harm among the population as a whole than actions undertaken by local health professionals.

The recommendations for practice (recommendations 4 to 12) support, complement – and are reinforced by – these policy options. They cover:

- Licensing.
- Resources for identifying and helping people with alcohol-related problems.
- Children and young people aged 10 to 15 years – assessing their ability to consent, judging their alcohol use, discussion and referral to specialist services.
- Young people aged 16 and 17 years – identification, offering motivational support or referral to specialist services.
- Adults – screening, brief advice, motivational support or referral.

The RCN provides guidance for all nurses:

Nurses are faced with the consequences of alcohol misuse every day - from dealing with violent and aggressive patients in A&E to caring for people suffering from long term poor health as a result of sustained alcohol abuse. All nurses also have a role in health promotion to support the population to make healthier choices.

Nurses are best placed to deliver brief interventions for a variety of reasons. They often have a natural rapport with patients that doctors sometimes do not. Patients are known to respond to nurses because they see them as “non-threatening and approachable” (Mistral and Velleman, 1999), and providing a brief intervention is simply an extension of this role.


Please describe how you will implement the alcohol conversation in your organisations below:
MATERNITY – Prevention Guidance for Local Service

Why is this important?
Maternity staff and midwives play a unique role in terms of their relationship with, and access to expectant mothers and young families. They have ready access to expectant women and their families and, unlike, say, social workers, do not just see people at times of crisis. Moreover, their role in promoting the welfare of the mother and family as a whole offers a clear route into considering the impact that drinking may be having on their unborn child and other children and places them in a unique position to promote resilience to long term harm from alcohol.

It important that maternity staff and midwives should be in a position to be able to:
- Identify expectant mothers and their families where parental alcohol misuse may be a problem
- Offer appropriate advice to expectant and new mothers misusing alcohol, which may include brief interventions as well as referral elsewhere.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:
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Evidence
What does the information say nationally?
In the UK approximately half of women drink alcohol during pregnancy, 8% drink above recommended safe limits (1 or 2 units once or twice a week), and a quarter receive no health advice on safe levels of consumption.1,2 It is widely accepted that high alcohol consumption or regular binge drinking during pregnancy increases the risk of miscarriage, premature birth and a low birth weight.3,4 It can also cause foetal alcohol spectrum disorder (FASD), a range of physical and mental disabilities that persist throughout life.5 Although evidence reviews have concluded that there is no consistent evidence of harm caused by low to moderate alcohol consumption during pregnancy, new evidence continues to emerge of the potential risks (e.g. for low birth weight and foetal death).6,7,8

As part of the ‘Responsibility Deal Alcohol Network (RDAN)’, the Government is working with the alcohol industry to ‘foster a culture of responsible drinking’ and to ensure that alcohol products will have ‘a warning about drinking when pregnant’.9 In addition the UK Alcohol Strategy encourages hospitals to identify and support pregnant women who drink during pregnancy.10 In support of this policy Diageo (an international drinks retailer) will provide funding for the

References/ web links
http://ukpolicymatters.t helancet.com/midwifery-led-alcohol-education/

Lancet: D. Cooper.
UKPolicy Matters: Midwifery led alcohol services,: Feb21/2013
National Organisation for Foetal Alcohol Syndrome (NOFAS-UK) to provide face-to-face, online and distance learning to 10,000 midwives (one-third of the England and Wales workforce). Midwives will be trained to:

- Provide information and advice about the dangers of alcohol during pregnancy,
- Encourage complete abstinence from alcohol during pregnancy. NOFAS believe that any amount of alcohol carries a risk of FASD.
- Screen women for patterns of alcohol use,
- Deliver brief interventions or referral to appropriate specialists for all women who drink alcohol.

Evidence of the benefits

The aim of the midwife-led scheme is to encourage women not to drink during pregnancy and to reduce the incidence of alcohol related birth defects. Various evidence reviews have concluded that brief advice and interventions are effective in reducing alcohol consumption and alcohol-related harm in adults. These interventions appear effective when delivered in primary care (GP surgeries), rather than hospital settings. A single evidence review has looked at interventions for reducing alcohol consumption during pregnancy (for women attending hospital antenatal care). This found sparse and weak evidence that psychological and educational interventions led to reduced alcohol consumption or increased abstinence. The authors concluded that there was no information on whether interventions led to positive health effects for mothers and babies. Further work has reviewed studies looking at midwife home visits after birth finding no evidence of a reduction in alcohol use or proven health benefits. Secondary benefits of midwife-led interventions have also been explored. These demonstrate an increased emphasis on the safeguarding of children that arise from midwife-led alcohol interventions. In addition a single study has demonstrated that screening women during antenatal care improves disclosure of problem drinking. There has been more research looking at midwife-led support for women with substance misuse (specifically heroine/methadone). Here, single studies have shown interventions can result in:

- A more positive attitude towards women with drug or alcohol problems
- A greater likelihood of referral to other specialist services and continuity of care
- Earlier identification of women with alcohol problems and reduced hospital admissions

Evidence of the risks

The risk of an increased focus on alcohol is that it may deter women from attending antenatal care, lead to fear of losing custody of their children and cause them to feel ‘policed’ (particularly during home visits). A further danger is that heavy investment, specifically in midwife training, may deflect or delay investment in broader and more evidence-based interventions. For example, NICE have recommended that women who misuse alcohol should receive care packages coordinated across agencies, and that training about complex needs should cross professional boundaries. Finally, Diageo’s investment appears to support their efforts towards corporate social responsibility, but may in fact deflect attention from their opposition to more evidence based pledges within alcohol policy, e.g. minimum alcohol pricing.

Implications for health and well-being

There is limited evidence that midwife-led advice and brief interventions reduce alcohol consumption during pregnancy, or reduce alcohol related birth defects. However, research into the needs of pregnant women who misuse alcohol or drugs support the use of specialist midwives based within
multiagency teams. The NOFAS-UK scheme supports abstinence for all pregnant women regardless of alcohol consumption so its impact is difficult to predict. The UK Government should clarify how this scheme is to be evaluated and encourage further research into how midwife-led interventions can reduce alcohol related harm.\textsuperscript{16}

\textbf{References}


17. Clark KA, Dawson S, Martin SL. The effect of implementing a more
comprehensive screening for substance use among pregnant women in North Carolina. *Matern Child Health*


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SECONDARY CARE – Prevention Guidance for Local Service

Why is this important?
Secondary care staff have a key role in supporting the management of people with alcohol disorders. They have access to people who may abuse alcohol. Moreover, their role in promoting the welfare of local people places them in a unique position to promote resilience to long term harm from alcohol.

It important that secondary care staff should be in a position to be able to:

- Identify patients where alcohol misuse may be a problem
- Offer appropriate advice to patients who may be abusing alcohol, which may include brief interventions as well as referral elsewhere.

What should you do? Take the Prevention Conversation Approach:
For all professionals engaging with people who are accessing their services where alcohol may be a consideration in their entry to that service, a short non-confrontational conversation should be conducted in the following way:

- Explain that locally health and social care partners are raising the issue of health harm caused by increasing and higher risk drinking.
- Encourage the person to scratch off the AUDIT C questions within the conversation where possible, encouraging them to tear off the AUDIT C section and retain the advice section.
- Discuss their alcohol consumption using the Alcohol Scratch Info Card as a reference for units and health risks (see back of scratch card in Appendix 1).
- Agree with the person to take at least one of 3 approaches:
  - To confidentially call Turning Point’s Alcohol Help and Advice Line using the number of the scratch card - 0300 123 1186
  - If person is engaged with Acute Trust, agree to refer them to the Alcohol Liaison Nurse/Worker in the trust, or in reach Turning Point Services
  - Agree a referral to their local GP practices/Pharmacies in CCGs for a “WellBeing Appointment”
- Return the detachable AUDIT C QUESTIONS SECTIONS of ALL COMPLETE SCRATCH CARDS once per quarter in an envelope to:
  - Kent Public Health Alcohol Pathway Project, Lundbeck Ltd, Freepost L0844, Milton Keynes, MK7 8BR
  - PLEASE ADD YOUR ORGANISATIONS SENDER DETAILS TO THE REAR OF THE ENVELOPE so each services use can be measured and replacement scratch cards issued.
  - Please contact Gillian.Montgomery@kent.gov.uk, alup@lundbeck.com or pxm@lundbeck.com to order replacement scratch cards.

As you are involved with acute hospital trust, ALL patients suspected should be referred to Alcohol Liaison Team.

Evidence References/ web links
What does the information say nationally?
Interface with the prevention agenda

Secondary care staff should be aware of their role in supporting the prevention agenda.

Prevention -NICE - PH 24
Alcohol-related harm is a major health problem. The guidance identifies how government policies on alcohol pricing, its availability and how it is marketed could be used to combat such harm (see recommendation 1 to 3). Changes in policy in these areas is likely to be more effective in reducing alcohol-related harm among the population as a whole than actions undertaken by local health professionals.

The recommendations for practice (recommendations 4 to 12) support, complement – and are reinforced by – these policy options. They cover:
- Licensing.

• Resources for identifying and helping people with alcohol-related problems.
• Children and young people aged 10 to 15 years – assessing their ability to consent, judging their alcohol use, discussion and referral to specialist services.
• Young people aged 16 and 17 years – identification, offering motivational support or referral to specialist services.
• Adults – screening, brief advice, motivational support or referral.

Secondary care staff should also take into account NICE guidance CG115 which covers the entrance into the health service:

This guideline makes recommendations on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10–17 years.

Key Priorities detailed in CG115

Identification and assessment in all settings
• Staff working in services provided and funded by the NHS who care for people who potentially misuse alcohol should be competent to identify harmful drinking and alcohol dependence. They should be competent to initially assess the need for an intervention or, if they are not competent, they should refer people who misuse alcohol to a service that can provide an assessment of need.

Assessment in specialist alcohol services
• Consider a comprehensive assessment for all adults referred to specialist services who score more than 15 on the Alcohol Use Disorders Identification Test (AUDIT). A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools and cover the following areas:
  – alcohol use, including:
    • consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
    • dependence (using, for example, SADQ or Leeds Dependence Questionnaire [LDQ])
    • alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
      – other drug misuse, including over-the-counter medication
      – physical health problems
      – psychological and social problems
      – cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
    – readiness and belief in ability to change.

General principles for all interventions
• Consider offering interventions to promote abstinence and prevent relapse as part of an intensive structured community-based intervention for people with moderate and severe alcohol dependence who have:
  – very limited social support (for example, they are living alone or have very little contact with family or friends) or
  – complex physical or psychiatric comorbidities or
  – not responded to initial community-based interventions (see page 12).
• All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological interventions should be administered by specialist and competent...
staff. Psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention. Staff should consider using competence frameworks developed from the relevant treatment manuals and for all interventions should:
- receive regular supervision from individuals competent in both the intervention and supervision
- routinely use outcome measurements to make sure that the person who misuses alcohol is involved in reviewing the effectiveness of treatment
- engage in monitoring and evaluation of treatment adherence and practice competence, for example, by using video and audio tapes and external audit and scrutiny if appropriate.

**Interventions for harmful drinking and mild alcohol dependence**

- For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

**Assessment for assisted alcohol withdrawal**

- For service users who typically drink over 15 units of alcohol per day, and/or who score 20 or more on the AUDIT, consider offering:
  - an assessment for and delivery of a community-based assisted withdrawal, or
  - assessment and management in specialist alcohol services if there are safety concerns about a community-based assisted withdrawal.

**Interventions for moderate and severe alcohol dependence**

- After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone2 in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse.

**Assessment and interventions for children and young people who misuse alcohol**

- For children and young people aged 10–17 years who misuse alcohol offer:
  - individual cognitive behavioural therapy for those with limited comorbidities and good social support
  - multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support.

**Interventions for conditions comorbid with alcohol misuse**

- For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety. If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, undertake an assessment of the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder.
Appropriate **Training and development** of staff also needs to be taken into account across secondary care settings:

**Training and development of staff**

For health and social care staff recommendations are made through the Quality Statement for NICE QS11. Training and awareness is covered in Quality Statement 1 and Quality Statement 4.

**Quality Statement 1**: Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.

- a) Evidence of local arrangements to ensure that alcohol awareness training that promotes respectful, non-judgmental care is delivered to all health and social care staff who potentially work with patients or service users who misuse alcohol.
- b) Evidence of local arrangements to ensure that local patient and service user feedback, in the form of surveys and complaints, is collected, analysed and acted upon within all health and social care settings.

**Quality Statement 4**: People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff.

- a) Evidence of local implementation of current guidance from the Royal College of Psychiatrists and Royal College of General Practitioners on training and competence for doctors working in substance misuse.
- b) Evidence of local arrangements to ensure that all staff carrying out initial assessments in specialist alcohol services are trained in the key elements of motivational interviewing.
- c) Evidence of local arrangements to ensure that care coordination with other agencies (for example, housing, employment and social care) is delivered by appropriately trained and competent staff working in specialist alcohol services.
- d) Evidence of local arrangements to ensure the use of competence frameworks developed from relevant treatment manuals that guide the structure and duration of psychological interventions for people who misuse alcohol.
- e) Evidence of local arrangements to ensure that staff responsible for assessing and managing assisted alcohol withdrawal are trained and competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms, and the use of drug regimens appropriate to the setting in which the withdrawal is managed.
- f) Evidence of local arrangements to ensure that staff working in specialist alcohol services receive appropriate monitoring and supervision.

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<tr>
<th>Local action plan for your business / practice / provider</th>
<th>References/web links/dates</th>
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<tbody>
<tr>
<td>Please describe how you will implement the alcohol conversation in your organisations below:</td>
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2 Alcohol Concern. Investing in Alcohol Treatment - Reducing Costs and Improving Lives: Alcohol Concern’s learning from 10 years of consultancy and training. 2010.
15 Alcohol Concern. Investing in Alcohol Treatment - Reducing Costs and Improving Lives: Alcohol Concern’s learning from 10 years of consultancy and training. 2010.
18 Lister, G (September 2007), 'Evaluating social marketing for health – the need for consensus. Proceedings of the National Social Marketing Centre'; Prime Minister's Strategy Unit (2004), 'Alcohol harm reduction strategy for England', London: Prime Minister's Strategy Unit
Societal costs were sourced from a report titled “The economic and social costs of alcohol-related harm in Leeds 2008-09”. The costs were inflated to 2012 values using HM Treasury GDP deflators.

Criminal justice system costs were comprised of:
- Alcohol-specific crimes
- Alcohol-related crimes

Workplace and productivity costs were comprised of:
- Presenteeism (alcohol-related reduced productivity in the workplace)
- Absenteeism
- Unemployment
- Premature mortality
- Wider social and economic costs
- Fire service attendance at alcohol-related house fires and RTAs
- Lost value of non-paid work and activities before retirement
- Lost value of non-paid work and activities after retirement
- Intangible costs
- School failure and reduced educational attainment
- Alcohol-related litter

The 2011 census estimated the population of Leeds to be 751,500. The estimated alcohol dependent population of Leeds is derived by applying the prevalence of alcohol dependence in adults (5.9%) to the population of Leeds. The annual social care cost components are divided by the alcohol dependent population of Leeds to give cost per person. It is assumed that the social care cost per person in Leeds is equivalent to all areas in the UK.

Extracted from Alcohol Impact Model (2013) NHIS Ltd, supported by an educational grant from Lundbeck

Alcohol Concern. Investing in Alcohol Treatment - Reducing Costs and Improving Lives: Alcohol Concern’s learning from 10 years of consultancy and training. 2010.


SIPS (2013) Available at: http://www.sips.iop.kcl.ac.uk/ [accessed 15/4/14]


NICE CG115 (2011) Available at: http://guidance.nice.org.uk/CG115

SIPS (2013) Available at: http://www.sips.iop.kcl.ac.uk/ [accessed 15/4/14]

Department of health - Case for change – Commissioning Identification and Brief Advice to improve health and justice outcomes in offender populations


Disulfiram SPC [available at http://www.medicines.org.uk/emc/medicine/1042/SPC Acamprosate SPC]


Adepend Naltrexone SPC [available at http://www.mhra.gov.uk/Safetyinformation/%20Medicinesinformation/SPCandPILs/index.htm?prodName=ADEPEND%2050%20MG%20FILM-COATED%20TABLETS&subName=NALTREXONE%20HYDROCHLORIDE&pageID=SecondLevel


Nalmefene (nalinefene) Summary of Product Characteristics.


International guide for monitoring alcohol consumption and related harm. WHO 2000

Drinkaware website: www.drinkaware.co.uk


SMC (2014) Available at: http://www.scottishmedicines.org.uk/SMC_Advice/Advice/917_13_nalmefene_Selincro/nalmefene_Selincro

AWMSG (2014) Available at: http://www.awmsg.org/awmsgonline/app/appraisalinfo/1259