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▶ Reducing the impact of alcohol-related harm to Londoners – how well are we doing?

Penfold M., Rand H.
London: Alcohol Concern, 2011.

Seven years after the first alcohol harm reduction strategy for England, this audit finds treatment access and brief intervention work has progressed in London but funding is often precarious and GP services are surprisingly under-developed.

Summary Seven years on from publication of the Alcohol Harm Reduction Strategy for England, this report audits progress in London, focusing mainly on local strategic frameworks and the development of treatment systems. It asks:
• To what extent is alcohol-related harm recognised as a local priority by strategic partners in terms of investment?
• How much progress has been made by strategic partnerships in addressing alcohol-related harm since the publication of national and local strategies?
• Does the progress made reflect a response that is comprehensive, balanced and sustainable?

To address these issues, in 2010 an online questionnaire was forwarded to all identified alcohol leads in London-based multi-agency partnerships concerned with coordinating alcohol strategy, which all completed. Where answers were inconsistent or contradictory, respondents were contacted to validate responses. Following this main audit, respondents were asked supplementary questions suggested by the initial sweep and it was decided to complete a brief audit of hospital alcohol liaison nurses, seen as an important extension of the alcohol treatment system and pivotal to reducing the alcohol-related burden on hospital services. The brief self-completion questionnaire was designed to review issues of role definition, capacity and the level of integration and pathways with the main alcohol treatment system.

As well as this fresh research, previous audits of alcohol services in England were used to assess progress over the past six to seven years. A brief literature search was carried out to evidence alcohol-related need amongst 'high risk' clusters and to establish parameters for outcome-focused practice against which current treatment systems could be

measured. Policies and frameworks relating to alcohol-related harm were reviewed in order to inform consideration of audit findings and subsequent conclusions or recommendations. Several data sources further informed the audit and its conclusions, including the national treatment caseload monitoring system (NDTMS), the London probation service, National Audit Office and Local Alcohol Profiles for England.

Main findings

In summarising the report's findings the authors asked the three key questions below.

What shapes the challenge of reducing alcohol-related harm in London? London houses one of the largest and most diverse populations in the western world. Despite its burgeoning hospitality industry and the comparative youth of its population, Londoners drink less than adults in most other parts of the UK. Its challenge lies in a population that is mobile and characterised by high levels of social deprivation, mental illness, drug use and alcohol-related crime. It is these characteristics, along with one of the largest and most diverse health systems in Europe, which shape the challenge for the capital in responding to alcohol-related harm.

Have local alcohol harm reduction strategies been a vehicle for a sustainable response? Responses to this audit suggest that all 31 local coordinating partnerships have established strategic frameworks for addressing alcohol-related harm. The vast majority have published strategies informed by local assessments of need, although there is limited evidence that strategies are subject to the level and frequency of review applied to local drug treatment plans. The extent to which these frameworks are resourced to deliver against identified local objectives is highly variable. Many partnerships are unable to provide an accurate figure for the partnership spend on alcohol treatment, echoing a common finding in a number of previous audits. This limits the ability of partnerships to measure the effective use of limited resources and ensure that funding is focused on local priorities. There is evidence of growth in treatment services across London, with the capital continuing to provide better access to treatment than many other parts of England. There are, though, indications that this progress could be undermined with the funding of some posts identified as non-recurrent and others uncertain. Partnerships have applied a range of strategies to improve access to treatment including procurement and integration with drug treatment services.

Are commissioning decisions informed by the evidence base underpinning alcohol harm reduction interventions? All partnerships report commissioning some activity in each of the tiers identified in the Models of Care for Alcohol Misusers national guidance, although provision in some areas falls far short of need. Despite strong evidence of the importance general practice in identifying and treating alcohol use disorders, investment in brief interventions for risky drinkers is heavily focused on hospital accident and emergency departments, while treatment for alcohol dependence is focused on community alcohol teams. Within this context, primary care, which should sit at the forefront of alcohol harm reduction frameworks, appears to be the focus of limited attention by commissioners. General hospitals encounter a greater volume and diversity of alcohol-related presentations than any other health setting, a fact reflected in the alcohol-related burden borne by this sector. This is a particular issue for the capital due to the size of its population and the number of hospitals serving the population. Evidence indicates that hospital-based alcohol harm reduction frameworks, supported in delivery by specialist

alcohol nurse liaison teams, have the potential to reduce this economic burden and deliver health gain. Most partnerships in the capital report commissioning such posts in their hospitals. Further analysis suggests that these posts are not supported in delivery by partnership frameworks, which should include support from both hospital staff and community services. These hospital based alcohol harm reduction frameworks will take time to deliver substantive and measurable benefits, and this should be reflected in commissioning frameworks.

Selected observations

Apart from the summary above, of interest are the following points from the body of the report selected by Findings:

- A third of partnerships said they had a full-time strategic lead for alcohol; in most others the post-holder had a wider commissioning or public health brief.
- Along with reducing alcohol-related crime, improving access to treatment was the most common priority (25 or 26 of 31 partnerships), objectives towards which about half of partnerships thought they had made at least good progress. Reducing alcohol-related hospital admissions was rarely (6 of 31) a priority.
- Investment in alcohol harm reduction can deliver significant health and economic gains, making such initiatives strong candidates for funding through the Invest to Save framework. However, just 4 in 10 alcohol leads had submitted a bid and only a third had been successful. This suggests that primary care trusts did not recognise the potential benefits and health gains. The challenge for commissioners is formulating bids that can deliver measurable cost-benefits within local timescales and cost pressures. The pressure on NHS commissioners is to deliver quick and easily quantifiable gains, but, for example, while alcohol screening could make a significant contribution to reducing alcohol-related liver disease, this would only be realised over a relatively long period.
- NDTMS data for alcohol treatment suggests that the proportion of the 'in need' population accessing treatment in London by March 2010 was 1 in 10, an improvement on the same period in 2009 when it was nearly 1 in 12, but still a low level of penetration. Most partnerships said treatment waiting times had fallen in the past three years; for outpatient detoxification the average wait was three weeks, six weeks for counselling or a day programme.
- About two thirds of partnerships had commissioning dedicated alcohol intervention and brief advice workers in primary care and about the same proportion in accident and emergency departments, though training was relatively rarely commissioned and provision relatively rarely reviewed. Few commissioned such posts in mental health or criminal justice settings. In hospitals, alcohol liaison nurses provided brief advice and referral to treatment, spending most of their time working with dependent as opposed to harmful/hazardous drinkers. Most felt under time pressure and all but a few faced the challenge of a lack of support for screening by other medical and nursing staff.
- Responses from London alcohol leads indicated low levels of investment in developing the role of GPs in screening and treating alcohol use disorders. Few local partnerships had invested in or developed systems beyond alcohol direct enhanced services, with only 11 of 31 reporting locally enhanced service agreements for screening, and five for GP-led detoxification. Though the evidence would support such developments, commissioners and public health leads may be deterred by the level of investment required, and challenges in measuring both quality and outcome of interventions across multiple sites as opposed to a much smaller number of specialist providers. The contradiction is that

the absence of effective treatment frameworks for alcohol misuse in primary care simply increases pressure on specialist community alcohol teams.

- All but one of the alcohol leads said they commissioned a specialist community alcohol team – services employing medical, nursing and other specialists trained in addictions who focus on more severe alcohol dependence and patients with complex needs such as physical or mental co-morbidity. Half said this was an integrated drug and alcohol team. Two thirds said their community alcohol teams treated all alcohol dependent adults, including those moderately dependent. This may in part reflect the lack of investment in primary care treatment options; all those who said their teams treated only the most severely dependent also commissioned alcohol specialist nurses in primary care.

The authors' conclusions

London-based partnerships coordinating local alcohol service delivery are making good progress in delivering systems for identifying and treating alcohol use disorders, although protected and sustained funding linked to a more detailed treatment planning process is essential if progress is to be maintained. Greater investment is needed in health settings such as primary care and hospital-based services, pivotal to delivering sustainable and effective alcohol harm reduction frameworks.

Last revised 10 September 2011

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